REPORT

Streamlining the Physician Complaints Process in Ontario

February 9, 2016

Hon. Stephen Goudge, Q.C.

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PART I. THE TERMS OF REFERENCE

1. I have been retained by the Ministry of Health and Long-Term Care (the "Ministry") to make recommendations to the Minister respecting:

(a) ways by which the process used to deal with complaints about physicians to the College of Physicians and Surgeons of Ontario ("CPSO") can be streamlined to permit decisions to be made more efficiently and cost-effectively; and

(b) ways by which hearings can be reduced in number, length and cost while maintaining a fair process.

2. In the Terms of Reference, the Ministry sets out the following background to this task:

(a) the CPSO receives the largest number of complaints against physicians of any health care regulator in Canada;

(b) increasingly, physicians seek advice and representation from the Canadian Medical Protective Association ("CMPA") in response to such complaints. This represents a growing cost of business to the CMPA;

(c) the CMPA's costs are primarily paid by Ontario reimbursing physicians for their membership fees in the CMPA pursuant to an agreement with the Ontario Medical Association ("OMA");

(d) Ontario is interested in reviewing certain aspects of the physician complaint review process with a view toward streamlining that process, simplifying investigations, and reducing the complexity of hearings. The objective is to make the complaints process more efficient and cost-effective for all participants while maintaining a fair process;

(e) at the same time, Ontario anticipates that it may strike an expert panel to examine the existing legislative scheme as it relates to sexual abuse of patients by regulated health professionals with a view to modernizing and reinforcing the province's ongoing commitment to a zero tolerance policy. This would include a review of processes under the *Regulated Health Professions Act* as they apply to sexual assault complaints made to all regulated health colleges.[1]

3. Further, the Terms of Reference directed me as follows:

(a) recommendations should focus on process issues within the current legislative framework but recommendations can also address issues about complaints processes that could result in legislative changes. The review will not involve a review of processes of other regulated health professions colleges, and it will not involve a review of hospital privilege processes;

(b) recommendations should balance the right of patients to an effective evaluation of their complaints and the right of physicians to have a fair opportunity to respond to such complaints;

[1] Such an Expert Panel was appointed, under the leadership of Prof. Mary-Lou McPhedran.

(c) both the experience of the CPSO in reviewing the number of complaints and the flow of the complaints through the complaints and hearings processes, and information from the CMPA about the significant factors that affect costs at various stages of the complaints process should be drawn on.

PART II. OVERVIEW

4. The legislative framework within which I am to work provides the basic architecture for the physician complaints process. It has the following elements:

(a) an "open door" policy for receiving Public Complaints against physicians, with low institutional barriers to the filing of a complaint;

(b) a mechanism for the Registrar to initiate investigations, even in the absence of a Public Complaint;

(c) a process comprised of basic stages consisting of intake, investigation, referral to discipline and discipline hearing;

(d) an independent review mechanism for Public Complaints which are not referred to discipline by the Health Professions Appeal and Review Board ("HPARB");

(e) decisions with respect to discipline made by panels comprised of both physicians and non-physicians.

5. Within this framework, the evidence suggests there are a number of opportunities for greater efficiency with no sacrifice to fairness. An example of such evidence is that approximately 80% of all Public Complaints result in no, or essentially no action being taken against the physicians in question. The same is true for a smaller number of Registrar's Investigations. Only 0.3% of all files opened ultimately result in a fully contested discipline hearing.

6. As I will describe, I have focussed my report on the following areas of opportunity:

(a) summary review and disposition of unmeritorious Public Complaints;

(b) amendment of ADR rules and use of mediation;

(c) enhanced definition of the scope of Registrar's Investigations;

(d) increased use of non-disciplinary outcomes by the Inquiries, Complaints and Reports Committee ("ICRC");

(e) streamlining of the HPARB review mechanism;

(f) reform of pre-hearing stage, including more effective pre-hearing conferences and a form of reciprocal disclosure; and

(g) reform of some aspects of the discipline hearing stage itself.

PART III. THE CONDUCT OF THE REVIEW PROCESS

7. As I was invited to by my Terms of Reference, I have engaged in an interative process of interaction with the main players in the physician complaints process, the CPSO and the CMPA. The object was to develop:

(a) an understanding of the process as embodied in the constituent framework, and as it operates on the ground;

(b) a qualitative appreciation of the stresses, bottlenecks and resource demanding aspects of the process; and

(c) as far as possible, a body of empirical evidence regarding the progression of cases through the system, from intake to disposition.

8. I also consulted with the following individuals and organizations, all of whom I wish to thank for their thoughtful assistance:

(a) the OMA;

(b) interested physicians;

(c) the Sexual Abuse Task Force;

(d) the College of Physicians and Surgeons of Alberta; and

(e) Robert Cosman, Independent Counsel to the CPSO Discipline Committee.

9. In accordance with my Terms of Reference, I submitted a draft of this report to the Ministry in the Fall of 2015. That draft was circulated to the CMPA and the

CPSO for their review and comment. I received and considered those comments. I thank the CMPA and the CPSO for their thoughtful comments and suggestions. This final report reflects my consideration of those comments and suggestions.

10. Following my appointment, my first step was to retain Richard Stephenson as my counsel. His advice and assistance have been invaluable. I am very grateful to him. Needless to say, the recommendations I have made are entirely my responsibility.

PART IV. BACKGROUND

A. History of the Regulated Health Professions Act, 1991

11. The *Regulated Health Professions Act, 1991* ("*RHPA*") is the successor to the *Health Disciplines Act*. It was enacted after lengthy study and consultation. Ultimately, more than twenty health professions were brought under its ambit. Previously, the various professions had been under a multiplicity of statutes or no statute at all. The *RHPA* continued and expanded the system of self regulation for these professions.[2]

12. One of the key philosophies adopted by the *RHPA* is that all of the regulated professions would be governed by a single, uniform *Health Professions Procedural Code*. This would be coupled with individual professional Acts, governing specific aspects of each profession. This structure was designed to be beneficial by providing the public with the same rights and remedies in respect of all of the regulated health professions. In addition, a coordinated policy direction would be possible and the statutory amendment process would be greatly simplified.[3]

B. The Statutory and Regulatory Scheme

1. The *RHPA*

13. The *RHPA* is generic legislation which casts a single umbrella over more than twenty diverse health professions. Some of these professions are large, with a long history of sophisticated governance. Others are much smaller, some having no history of formal self governance.

[2] Report of the Health Professions Legislative Review, 1989, p. 11
[3] Report of the Health Professions Legislative Review, 1989, p. 3

14. One of the key provisions of the *RHPA* is its creation of a detailed list of "controlled acts". The *RHPA* prohibits anyone from performing these controlled acts, other than a member authorized by a health profession Act to perform the controlled act.[4] In effect, a statutory monopoly for the performance of various acts and services is thereby created. The justification for this restriction is clearly to provide protection of the public, by ensuring that these potentially harmful actions can only be performed by qualified persons, subject to a formal structure of oversight and governance.

2. The *Health Professions Procedural Code* ("*HPPC*")

15. The *RHPA* contains two "schedules", which form part of the Act. Schedule 1 enumerates the list of self governing health professions, and specifies the health profession statute governing each. Medicine is one of the enumerated professions.[5]

16. The *HPPC* is Schedule 2 to the *RHPA*. It is a lengthy and detailed document.[6] As its name suggests, it is a detailed, prescriptive code regarding the procedural rules governing the discipline process for the regulated health professions, including the physician complaints process, from intake, through disposition. However, because it has the status of a statute, amendments to it can only be made by the legislature. Moreover, if an amendment is contemplated, the legislature has to determine whether it should be limited to a single profession (thereby ending the scheme of uniformity), or whether the rationale for any proposed amendment extends to all of the other regulated professions.

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[4] *RHPA*, s.27

[5] *RHPA*, Schedule 1

[6] It is significantly longer than the *RHPA* proper.

3. The *Medicine Act, 1991*

17. Schedule 1 of the *RHPA* identifies the health profession statute which governs each profession. In the case of physicians, it is the *Medicine Act, 1991*. Pursuant to s. 1, the *HPPC* is defined to form part of the *Medicine Act*. The definition of professional misconduct applicable to physicians is prescribed by O. Reg. 856/93 made under the *Medicine Act*.

18. The definition is very broad, and encompasses various forms of unethical or improper behaviour as well as a failure to maintain the standards of practice.[7]

C. The Mandate of the CPSO

19. The CPSO is continued pursuant to the provisions of the *Medicine Act, 1991.*[8] It is designated as the college responsible for physicians under Schedule 1 of the *RHPA.* The mandate of the CPSO is to build and maintain an effective system of self-governance for physicians in Ontario. The CPSO has a duty to serve and protect the public interest by regulating the practice and the profession and governing in accordance with the *RHPA*.[9]

20. The duties of the CPSO include:

(a) issuing certificates of registration to doctors to allow them to practise medicine

[7] The text of O. Reg. 856/93 is included in Schedule "A".
[8] S.O. 1991, c. 30, s. 3
[9] CPSO Annual Report 2013, p. 2

(b) monitoring and maintaining standards of practice through peer assessment and remediation;

(c) investigating complaints about doctors on behalf of the public, and

(d) conducting discipline hearings when doctors may have committed an act of professional misconduct or may be incompetent.[10]

D. The Structure of the CPSO

21. The Council is the governing body of the CPSO. The *RHPA* stipulates that it consist of at least 32 and no more than 34 members including:

(a) 16 physicians elected by their peers on a geographical basis every three years;

(b) three physicians appointed from among the six faculties of medicine (at Western University, McMaster University, University of Toronto, Queen's University, University of Ottawa, and the Northern Ontario School of Medicine); and

(c) no fewer than 13 and no more than 15 non-physician or 'public' members appointed by the provincial government for terms decided by the government.[11]

22. The CPSO is managed by staff under the leadership of the President and the Registrar.

[10] http://www.cpso.on.ca/About-Us
[11] http://www.cpso.on.ca/About-Us/About-Council

23. Critical for my purposes are four groups within the CPSO: (a) the Investigations and Resolutions Department ("I and R Department"); (b) the Inquiries, Complaints and Reports Committee ("ICRC"); (c) the Legal Department; and (d) the Discipline Committee.

1. The Investigations and Resolutions Department

24. The I and R Department is responsible at a staff level for, *inter alia,* conducting investigations of a physician's conduct. This is true whether the triggering event is a Public Complaint, or an investigation commenced by the Registrar under s. 75 of the *HPPC* (a "Registrar's Investigation"), the two ways in which the physician complaints process is engaged. In undertaking these investigations, it is ultimately responsible to, and operates under the direction of the ICRC.

2. The ICRC

25. Under the *HPPC* every regulated health college must have an ICRC. The ICRC of the CPSO has the statutory responsibility to investigate potential professional misconduct by physicians. In practice, this responsibility is delegated to staff investigators, operating under the direction of the ICRC. The ICRC is also statutorily responsible for making the determination of whether a matter should be referred to the Discipline Committee for adjudication, or for the imposition of some other outcome, which could include administering a caution, referring to an educational program, or taking no action at all.[12]

[12] The full list of potential outcomes is listed below.

26. The ICRC is composed of both physicians (some of whom are members of the CPSO Council) and public members appointed by the government. The quorum of a panel of the ICRC is three persons, at least one of whom must be a public member.[13]

3. The Legal Department

27. The CPSO has an in-house legal department, which provides it with a variety of legal services. The legal department plays a support role to the I and R Department in relation to investigations. It plays a central role in cases once they have been referred to discipline, and is responsible for presenting cases to the Discipline Committee, and undertaking any negotiations of full or partial resolutions of cases once referred to discipline.

4. The Discipline Committee

28. Like the ICRC, the Discipline Committee is composed of both physicians (some of whom are members of the CPSO Council) and public members.

29. A discipline panel is comprised of at least three members – two must be public members and one must be a physician member of Council. Panels are usually made up of four or five members.[14]

30. If the panel finds that the physician has committed an act of professional misconduct or is incompetent, it can make an order directing the Registrar to:

(a) revoke the physician's certificate of registration;

(b) suspend the physician's certificate; and/or

[13] http://www.cpso.on.ca/About-Us/About-Council/Committees
[14] http://www.cpso.on.ca/About-Us/About-Council/Committees

(c) impose specified terms, conditions or limitations on the physician's certificate.[15]

31. If the panel finds a physician has committed an act of professional misconduct, it can also make an order:

(a) requiring the physician to appear before the panel to be reprimanded;

(b) requiring the physician to pay a fine of not more than $35,000 to the Minister of Finance; and

(c) if the act of professional misconduct was the sexual abuse of a patient, requiring the physician to reimburse the College for funding provided for the patient for counselling and therapy, and requiring the physician to post security to guarantee payment.[16]

32. In an appropriate case, the panel may also require a physician to pay all or part of the legal, investigation and hearing costs and expenses.[17]

33. If the panel finds the physician has committed an act of professional misconduct by sexually abusing a patient, the panel must:

(a) reprimand the physician; and

(b) revoke the physician's certificate if the sexual abuse consisted of or included certain acts.[18]

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[15] *supra*
[16] *supra*
[17] *supra*

34. The Discipline Committee has promulgated Rules of Procedure applicable to all the proceedings before it.

E. The Role of the CMPA in the Physician Complaints Process in Ontario

35. The CMPA is a national not-for-profit mutual defence organization created by a special Act of Parliament in 1913. In 2014 it had more than 91,000 members, the vast majority of physicians in Canada.[19] It is not an insurance company. It provides legal representation to its members in a variety of contexts, including discipline related matters.[20]

36. The CMPA operates across the country, providing similar services to its members involved in disciplinary proceedings with their provincial regulators across the country.[21]

37. The CMPA assists over 4000 of its members per year across Canada in discipline related matters. In Ontario, the CMPA provided assistance in an average of 2180 new CPSO matters annually over the period of 2010-2014.[22]

38. The CMPA has witnessed an increase in requests from its members for assistance in discipline related matters in Ontario, and across Canada, over the past decade, with a concomitant increase in the CMPA's legal expenses.[23]

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[18] *supra*
[19] 2014 CMPA Annual Report
[20] CMPA February Submission, p. 1-2
[21] CMPA February Submission, p. 2
[22] CMPA February Submission, p. 2
[23] CMPA February Submission, p. 2

39. The CMPA provides assistance to its members when they are subject to an investigation by the CPSO. When it does so, it incurs costs. It is important to understand the nature of those costs, and how, when and why those costs are incurred. There are two primary cost categories for the CMPA: in-house Medical Advisors and external legal counsel.

40. Medical Advisors are medically trained salaried employees of the CMPA. They are available to provide advice to CMPA members facing an investigation. Medical Advisors do not "docket" their time, so there is no systematic data documenting the allocation of their time and effort within the overall discipline system. However, they are involved from the early stages of an investigation. They have relatively little involvement in cases after they are referred to discipline.

41. External legal counsel are retained by the CMPA to represent members involved in the discipline process. A physician wanting legal representation can choose to retain and pay for his or her own counsel directly, and on occasion this happens. However, in the great majority of cases, representation is provided through the CMPA.

42. I was advised by the CMPA that:

(a) its annual expenditures on CPSO matters in Ontario over the past five years have been dedicated predominantly to ICRC matters, Registrar's Investigations, and Discipline Committee proceedings;

(b) the number, scope and breadth of Registrar's investigations in Ontario has meant that the CMPA spends one and a half times as much of its

provincial discipline expenditures on Registrar's Investigations than is true in the rest of Canada;

(c) similarly, its costs associated with Discipline Committee hearings in Ontario are more than double those incurred in the rest of Canada, measured as a proportion of provincial discipline expenditures; and

(d) more generally, high level cost allocation of the CMPA's expenditures reveal that the CMPA's internal expenditures associated with College matters in Ontario are 50% higher than in the rest of Canada, although it must be kept in mind that Ontario has a proportionally higher number of cases.

43. Ontario accounts for approximately 40% of all physicians in Canada, but more than 50% of total discipline related matters, and more than 60% of total CMPA lawyer hours spent on discipline related matters nationally.[24]

44. Approximately 30% of the CPSO Public Complaints that the CMPA is involved in result in either No Action or Advice. These matters comprise approximately 40% of the legal hours expended by CMPA counsel on Public Complaints.[25]

45. I make reference to the resources expended by the CMPA in Ontario and nationally to demonstrate that there is room for the streamlining of the physician complaints process in Ontario to enhance its efficiency and cost effectiveness. I do not

[24] Meeting with CMPA, April 6, 2015
[25] CMPA May 7 Submission, p. 2

suggest that any cost differential between jurisdictions is attributable to the conduct of any particular participant in the system.

PART V. IMPROVING THE EFFICIENCY AND COST EFFECTIVENESS OF THE INVESTIGATION STAGE

A. Introduction

46. The first stage in the discipline process warranting scrutiny is the investigation stage. As with the other stages in the discipline process, the resources directed to this stage will be governed by two main factors: (i) the numbers of matters; and (ii) the manner in which those matters are processed.

47. As I have described, physician complaints matters fall into two categories, Public Complaints and Registrar's Investigations. Before turning to areas that I believe can be made more efficient, one point should be made. For different reasons, I do not think that it is in the public interest to seek efficiencies by attempting to reduce the number of matters initiated in either area.

48. The decision to initiate a Public Complaint lies solely within the hands of the individual complainant. There are means by which the number of Public Complaints could be reduced, for example, by making the process used to file a complaint more difficult or expensive (eg. prescribed forms or filing fees). However, in my view such measures would not be consistent with the public interest. If a member of the public has had an unsatisfactory experience with a physician by virtue of unprofessional conduct by that physician, then it is in the public interest to have that conduct examined, to ensure that any risk to public health or safety is addressed appropriately.

49. Registrar's Investigations are commenced when the Registrar of the CPSO has reasonable and probable grounds to believe that a physician has engaged in professional misconduct. This mechanism is critical to the protection of the public

interest. Public Complaints cannot be relied on to raise every matter of individual concern let alone systemic concerns about a physician's practice. Thus, I do not think that the number of Registrar's Investigations should be curtailed in the service of efficiency.

50. Consequently, achieving efficiencies in the physician complaints process requires improvements to the manner in which Public Complaints and Registrar's Investigations are processed within the system.

51. In seeking these improvements, there is one underlying reality that must be kept in mind. More time and money is spent on a disposition in Ontario than in other jurisdictions, with little apparent benefit to the public in terms of better or safer physician services. Earlier dispositions are more efficient and therefore tend to be less expensive, and if fairness and just outcomes can be maintained, better serve the public interest.

52. Our discussions have led me to conclude that, quite simply, too many complaints and investigations are in the system too long. This has informed many of my recommendations concerning the investigation stage, but has also been important in informing my views about the later stages as well.

53. The CPSO investigation process consists of three categories.

B. Intake:

54. The "Intake" category consists of matters that come to the attention of the CPSO I and R Department through various means, but not in the form of actual Public

Complaints. Absent further action, they do not become actual Public Complaints and are not investigated as such.[26]

55. Staff considers the nature of the information provided as well as the physician's history prior to closing a matter at intake. Medical advisors review and "sign off" on all proposed file closures at Intake.[27]

56. Over 2010-14 there have been an average of 988 new Intake: matters per year (695 new matters in 2014). There has been a downward trend in the numbers over that time.[28]

57. Intake matters are dealt with relatively quickly. The median days to completion over 2011-2014 has ranged from 27 to 33 days.[29]

58. From a cost perspective, intake matters are not a material expense of the CPSO, nor do the timelines suggest inefficiencies.

C. Public Complaints:

1. The Data

59. The second category, Public Complaints, is the single most expensive and resource consuming aspect of the physician complaints process workload, for both the

[26] CPSO May Responses, p. 8
[27] CPSO May Responses, p. 8
[28] CPSO Investigations 2014 Annual Report p. 16
[29] CPSO Investigations 2014 Annual Report p. 18

CPSO and the CMPA.[30] An average of 2412 new Public Complaints were filed per year between 2010-14 (2361 in 2014).[31]

60. Focussing on the 25% of Public Complaints that have the most rapid dispositions, in 2014 it took the ICRC an average of 97 days to close one of these cases.[32]

61. Pursuant to s. 28(1) of the *HPPC* the ICRC is required to dispose of a Public Complaint within 150 days of filing. There is a mechanism by which this time can be extended.[33] As a practical matter, the 150 day deadline is not met on many occasions. Between 2011 and 2014 the median length of time from receipt to ICRC decision for Public Complaints has averaged approximately 200 days (176 days in 2014).[34]

62. There are a number of challenges that the CPSO has in completing investigations on a timely basis. These include:

(a) the iterative process of written responses and replies between the complainant and the physician can be lengthy and time consuming;

(b) there are increasing demands on the CPSO to make "full disclosure" to the member during the investigation stage. The CPSO expects these demands to increase as greater transparency is imposed on the system

[30] CMPA May 7 Submission p. 2
[31] CPSO Investigations 2014 Annual Report p. 16
[32] CPSO May Responses, p. 18
[33] *HPPC*, s. 28
[34] CPSO Investigations 2014 Annual Report p. 18

and physicians increasingly tend to perceive the stakes of the investigation stage to carry more risk for them;

(c) the existence of parallel criminal or other proceedings causes delays, particularly with respect to the accessibility of relevant documentation;

(d) many investigations are "document heavy" and obtaining the relevant records can be time consuming, particularly where they need to be obtained from third parties;

(e) retaining appropriate experts to undertake file review and assessment can be time consuming; and

(f) scheduling the matter for review by the appropriate ICRC panel can be time consuming.[35]

2. Investigating Public Complaints

63. Members of the ICRC are responsible for investigations, but the investigations themselves are undertaken by staff investigators. ICRC panels review investigations, and may ask the investigator to clarify information, obtain additional information, or ask a member to respond to a particular issue. The panel may also ask for an independent opinion on the case. In addition, ICRC members are specifically asked to approve some of the more intrusive or unusual investigative steps an investigator may wish to

[35] CPSO February Responses, p. 5-7

employ, such as summoning certain witnesses, "cold-calling" certain patients, or seeking a search warrant.[36]

64. All Public Complaints are subject to a “triage” process when they are received by the Intake Manager of the Investigations Department.[37] Cases are sorted by subject matter to one of four teams, each specializing in a specific type of investigation (eg. medical-surgical care, mental health care, sexual abuse). Alternatively, cases may be sorted by priority/complexity/apparent merit.[38]

65. Because the CPSO has no control over the content of Public Complaints, it is inevitable that some proportion will be entirely outside the CPSO’s mandate or otherwise lacking in merit.

66. The historical statistics reveal that, on average, over 80% of Public Complaints will ultimately be disposed of either as No Action or by way of Advice to the physician.[39]

67. Nevertheless, both as a matter of sound public policy, and by virtue of the provisions of the *HPPA*, these complaints must be investigated before any determination about them can be made. From an efficiency perspective, the issue is ensuring that investigations can be as proportionate to and as efficient as the underlying merit of the complaint warrants.

[36] CPSO May Responses, p. 19. This includes the powers of the ICRC exercisable under s. 75(1) (c) of the *HPPC.*
[37] CPSO May Responses, p. 9
[38] CPSO May Responses, p. 9
[39] 2014 Annual Report p. 22

68. There are different investigation streams leading to different ICRC panels, depending on the nature and seriousness of the complaint:

(a) Fast Track: This panel hears outcomes of "abbreviated investigations", in cases where the parties consent to that process (described in more detail below);

(b) Medium track: This panel deals with low-risk, or straight-forward matters. Approximately 100 cases per year fit in this category. This panel also deals with those cases identified by investigators as potentially frivolous or vexatious;

(c) High risk/priority: This panel deals with a series of types of cases that the CPSO identifies as "serious", warranting the allocation of additional or special resources. These cases involve allegations relating to: breach of an undertaking or order; disruptive physician behaviour; practising while impaired; and sexual impropriety or boundary violation; and

(d) Regular track.

69. The CPSO view is that proportionality in the allocation of investigative resources occurs naturally, in the sense that investigations curtail themselves in circumstances where the case is simple or straightforward.[40]

70. The ICRC has the power, pursuant to s. 26(4)-(5) of the *HPPC* to terminate an investigation prior to its completion, but only where it is satisfied that the complaint is

[40] CPSO May Responses p. 30

frivolous, vexatious, or have been made in bad faith. However, CPSO says that the process prescribed by the *HPPC* to make such a disposition is sufficiently time consuming that the CPSO does not frequently utilize it. In its view, it is quicker to simply conclude the investigation, and determine the outcome in the ordinary course.[41] As a result, the provisions of s. 26(4)-(5) are little used. In the last three years, the number of cases closed annually on a No Cost basis as "frivolous or vexatious" ranged from 39 to 200.[42]

71. This outlines the approach in Ontario to investigating Public Complaints. Every province has a counterpart regulatory scheme, each with its unique features. In my view the Alberta example is particularly useful. It results in very different outcomes than occur in Ontario.

72. The College of Physicians and Surgeons of Alberta ("CPSA") annually receives public complaints in a number approximately equal to the CPSO, given the relative populations of Alberta and Ontario.[43] However, in Alberta, many more public complaints are resolved far earlier than in Ontario. Only a very small number of cases (5 in total over 2011-2014) are referred to a discipline hearing, a fraction of the number referred to discipline in Ontario.[44]

[41] CPSO February Responses, p. 2

[42] 2014 I and R Annual Report, p. 23.

[43] In 2014, Ontario's population was 3.34 times larger than Alberta's (Statistics Canada: http://www.statcan.gc.ca/tables-tableaux/sum-som/l01/cst01/demo02a-eng.htm). The CPSA received 677 public complaints in 2014: 677 X 3.34 = 2261. The CPSO actually received 2361 Public Complaints in 2014 (CPSA Complaint Statistics, 2014, p. 4)

[44] CPSA Complaint Statistics, 2014, p. 3

73. The CPSA has two full-time staff persons called Patient Advocates. The express purpose of the Patient Advocate is, as the title suggests, advocacy on behalf of complainants.

74. Every public complaint received by the CPSA is reviewed first by a Patient Advocate. To the extent that the Patient Advocate is of the view that the written complaint is confusing or requires clarification or further information, the Patient Advocate proactively contacts the complainant to determine its true nature. The Patient Advocate compiles a file on every complaint. That file contains the complaint, the accompanying documentation, and any additional information that the Patient Advocate has accumulated.

75. The Patient Advocates, along with investigators, managers and administrators are part of the team that meets with the Complaints Director twice per week to review the newly arrived public complaints. There are a variety of results that can come from these meetings. One is that the Patient Advocate is sent back to obtain further information from the complainant. Approximately one-third of all files are dismissed by the Complaints Director at this stage ("outright dismissal").[45] If a case is subject to an outright dismissal, the complainant is sent a letter by the Complaints Director outlining the reasons for the dismissal, and advising of the right of appeal.

76. An additional one-third are later resolved in a collaborative manner between the physician and the complainant with the assistance of the Complaints Director (recorded as "Direct Resolution" or "Resolve with Consent"). These cases overwhelmingly pertain

[45] These dismissals occur pursuant to s. 55 (2)(f) of the *HPA*.

to medical records or medical based advertising. The final third of the cases are referred on by the Complaints Director for investigation.

77. The Alberta physician complaints process is governed by the *Health Professions Act* ("*HPA*").[46] Under s. 55(1) of the *HPA* the Complaints Director must give notice to the complainant within 30 days of the receipt of the complaint of his or her decision as to how the complaint will be dealt with.[47] Specifically, he must advise which of the eight possible dispositions prescribed under s. 55(2) he has decided upon. These potential dispositions are:

> **s. 55(2) the Complaints Director:**
>
> **(a) May encourage the complainant and the investigated person to communicate with each other and resolve the complaint,**
>
> **(a.1) May, with the consent of the complainant and the investigated person, attempt to resolve the complaint,**
>
> **(b) May make a referral to an alternative complaint resolution process under Division 2,**
>
> **(c) May request an expert to assess and provide a written report on the subject matter of the complaint,**
>
> **(d) May conduct or appoint an investigator to conduct an investigation,**
>
> **(e) If satisfied the complaint is trivial or vexatious, may dismiss the complaint,**
>
> **(f) If satisfied that there insufficient or no evidence of unprofessional conduct may dismiss the complaint, and**
>
> **(g) May make any direction under s.118.**

78. If a case is subject to an outright dismissal, the complainant has a right to appeal that decision to the Complaint Review Committee ("CRC"). In 2014, the relevant statistics are as follows:

[46] RSA 2000, c. H-7
[47] *HPA,* s. 55 (1)

(a) there were 230 outright dismissals;

(b) approximately 25 of these decisions were appealed;

(c) only one or two of those appeals were allowed, and referred back for further investigation; and

(d) in all other instances the Complaints Director's decision was upheld.[48]

79. The statistics for 2011 – 2013 are similar, both with respect to the number of appeals and the success rate.[49]

80. The following table sets out the manner in which the CPSA has disposed of complaints files and the time it took to do so:[50]

Disposition	Outright Dismissal	Direct Resolution	Resolve with Consent	Investigate /Dismiss	Investigate /Resolution	Hearing
2013	239	69	172	306	149	8
2014	230	70	92	171	87	3
Average	234.5	69.5	132	238.5	118	5.5
Average Time (days)	15	40	105	223	371.5	332

81. This small sample reveals that approximately 30% of all cases are disposed of very rapidly (within 15 days), and that almost 55% of cases are resolved within approximately 100 days. For the purposes of my review, this is the most interesting

[48] CPSA Annual Report 2014
[49] CPSA Annual Report 2014
[50] CPSA Complaint Statistics, 2013-14

statistic. As noted above, in Ontario, the average time to resolve the 25% of the cases which are disposed of most rapidly is 97 days.

82. Is there a danger that the rapid disposition of such a material number of cases results in an injustice, in the sense that a meritorious complaint is given "short shrift"? This is possible, but unlikely, for at least three reasons:

(a) first, in both Ontario and Alberta a very high proportion of public complaints are ultimately closed on a "No Action" basis. Summary or outright dismissal of the subset of these cases, which are the least meritorious, is very likely to be dealing with the "No Action" cases, and unlikely to inappropriately weed out cases with genuine merit;

(b) second, under the Alberta scheme there is an appeal route for an unsatisfied complainant to use if his or her matter is closed. Appeals are rarely taken, and even more rarely succeed; and

(c) finally, there has been no apparent public outcry in Alberta that the CPSA has been dealing with complainants in a too summary manner.

83. In Ontario, s. 26 of the *HPPC* does not permit a complaint to be disposed of other than by the ICRC, and only after it has been fully investigated. However, the evidence is clear that:

(a) a very large percentage of complaints will ultimately be dismissed as being without merit; and

(b) dealing with these complaints absorbs substantial time and resources.

84. In my view there is much to be learned from the Alberta model that can help make the investigation of Public Complaints in Ontario more efficient.

85. I recommend that the Registrar, (or the Registrar's delegate under his or her oversight, or alternatively a newly created position of Complaints Director), like the Complaints Director in Alberta, be required to conduct an early review of Public Complaints and be given the power to:

(a) approve the withdrawal of a Public Complaint by the complainant; and

(b) dismiss a Public Complaint outright where satisfied that there is no reasonable prospect of an outcome from the ICRC other than No Action".[51]

(i) in such cases, brief written reasons will be provided to the complainant; and

(ii) an appeal from a dismissal will lie to the ICRC.

86. I recognize that an amendment of the *HPPC* would be required to effect this. It would also require a legislative decision as to whether this change ought to be extended to all of the regulated health colleges. However, I have no doubt that it would make the physician complaints process more efficient and cost effective, with no sacrifice in fairness.

[51] This provision would be similar to than in s. 55 (2) (f) of the Alberta *HPA.*

87. To that end, I also recommend that the CPSO create a patient advocate position. Although this need not entail a new hire, the separate position and its title send an important signal. The patient advocate should be required to interact with the complainant immediately on filing to review and clarify the true substance of the complaint. For a significant number of complainants, who are simply not aware of the limits on the scope of the jurisdiction of the CPSO, a proper explanation from someone who is sympathetic to the patients' perspective may well satisfy them that their complaint can be withdrawn, or does not fall within the jurisdiction of the ICRC and that their remedy may lie elsewhere.

88. I now turn to the alternative resolution of Public Complaints without the need for full investigation by the ICRC, because it too provides scope for improved efficiency at the investigation stage of the physician complaints process.

89. Presently, the only exception to the mandatory "investigate and the ICRC shall decide" model established by the *HPPC* is the ADR mechanism introduced into the *HPPC* in 2007 as s. 25.1. In the event a matter is resolved through ADR under this provision, s. 25.1(4) specifically provides that the ICRC may adopt the proposed resolution, thereby disposing of the Public Complaint, without the investigation having been completed.

90. This ADR process is theoretically applicable to all Public Complaints, except those involving allegations of sexual abuse.[52] It undoubtedly was intended to

[52] *HPPC,* S. 25.1(1)(b)

encourage more and better alternative resolutions of complaints. Ironically, it seems to have had the opposite effect.

91. The CPSO advised that, prior to the adoption of these provisions, its investigators would facilitate multi-party meetings to resolve matters. The investigators would be active participants. Agreed outcomes would go to the ICRC for approval. The CPSO advises that approximately 600 cases per year were successfully resolved in this manner.[53]

92. The CPSO expressed several concerns with the ADR process which was enshrined in the *HPPC* in 2007, and came into effect in 2009. First, the process focuses on the complainant and the member, without regard to the critical public interest role of the CPSO itself. While outcomes are subject to ICRC approval, unless the CPSO is a direct participant in the process, rather than merely facilitating it, the risk is that ADR outcomes presented to the ICRC will not reflect the public interest and therefore will not be accepted.

93. In addition, the process appears to present a number of practical problems:

(a) first, all ADR communications are confidential. This places the CPSO in a difficult position if, as facilitator, it comes into possession of information relevant to its public interest mandate;

(b) second, the ADR facilitator cannot participate further in the proceeding in the event the ADR fails. This precludes that person from being the

[53] CPSO May Responses p. 14

investigator, or being involved in the investigation, resulting in very significant duplication of effort;

(c) third, the fact that ADR is undertaken provides the CPSO with no relief from statutory timelines. The CPSO has significant difficulty in meeting these timelines in any event. A failed ADR effort would place the CPSO significantly offside its mandated timelines; and

(d) finally, as noted, ADR outcomes must be acceptable to the ICRC. The need for approval, creates an uncertainty for participants, decreasing the incentive for compromise.[54]

94. As a consequence, the ADR process simply is not used by the CPSO.

95. In response to this situation, since 2009, the CPSO has attempted to adapt its processes in order to adopt alternative means of resolving some types of cases in a more expeditious manner. One such means is the use of “abbreviated investigations”.

96. In abbreviated investigations, the investigator attempts to resolve the complaint by meeting with the complainant and the physician to discuss the issues. Investigators seek agreement from both the complainant and the physician that each is satisfied with the abbreviated investigation, and neither want further investigation or other action to be undertaken. The investigator then sends the abbreviated investigation to a three member ICRC panel called the Fast Track Panel. The panel reviews the case and

[54] CPSO February Responses, p. 2-3

makes a decision based on the investigator's information and wishes of the parties. The panel writes a short decision with reasons.[55]

97. Currently, approximately 200 cases are resolved on this basis per year. The CPSO is exploring means by which the use of this mechanism can be expanded.[56]

98. Because an abbreviated investigation is only used in cases where the complainant and the physician agree to the process and outcome, ICRC decisions arising from abbreviated investigations are very rarely subject to HPARB review. However, on the rare occasions when this has occurred, HPARB has expressed its dissatisfaction with the process on the basis that it constitutes an "inadequate investigation".[57]

99. In my view, while this abbreviated investigation process is of some value, and I do not suggest its elimination, steps need to be taken to set up a more vibrant dispute resolution process that is exercisable during the investigation stage. The *HPPC* should be amended to provide for such a process.

100. The process in place before 2009 demonstrates the positive results that can be achieved. What is now needed is a process that is not seen to have the disadvantages of the statutory ADR process introduced in 2007. It is important that it should also be a process that is guided by the importance of serving the public interest. The CPSO has that mandate. This, after all, is fundamental to the regulation of physicians. Transparency would be met by requiring the Registrar or his or her delegate to explain

[55] CPSO May Responses, p. 10
[56] CPSO May Responses p. 10
[57] CPSO May Responses, p. 13

why the proposed resolution is in the public interest and by requiring the ICRC to specifically address any disagreement the complainant may have with the proposed resolution. Thus, while the complainant's agreement to a resolution is desirable, it ought not be mandatory.

101. There is another aspect of the current ADR scheme that I believe needs to be addressed. The current statutory ADR process is protected by a full and complete cloak of confidentiality. Information obtained through the ADR process cannot be used for any purpose, either within the context of the current proceeding, or otherwise. I acknowledge that this may maximize encouragement for the physician to participate. However, this degree of confidentiality may present a significant practical problem if, during that process the CPSO investigator acquires evidence of new and unrelated misconduct. This problem appears to be one of the reasons that the current process is not utilized.

102. In order to alleviate this impediment, the new ADR process I propose should move away from full and complete confidentiality to some degree, without shedding confidentiality entirely. This would balance the desirability of encouraging physician participation with the public interest responsibility of the CPSO.

103. I therefore propose that all communications in the new ADR process concerning a complaint should be inadmissible in any proceeding concerning that complaint. This will free the physician to fully participate in the attempted resolution of that complaint. But if, in the course of the new ADR process, the CPSO acquires information relevant to a new or different complaint, it would be free to use that information in pursuing another

complaint, thus serving its public interest mandate. This addresses one of the impediments to the use of the current statutory ADR process.

104. I therefore recommend that this new alternative dispute resolution process contain the followings elements:

(a) it can be initiated by the CPSO investigator at any stage of the investigation;

(b) the process should be facilitated by an appropriately skilled neutral who can bring resolution, such as a member of the ICRC or an independent mediator, not a member of the CPSO staff;

(c) the CPSO investigator should play an active role in the process;

(d) all communications in the new ADR process concerning a complaint should be inadmissible in any proceeding concerning that complaint but information relevant to a new or different complaint may be used by the CPSO in pursuing another complaint;

(e) the complainant's agreement is not a pre-condition to resolution;

(f) in the event a resolution is achieved that resolution is subject to approval by the ICRC;

(g) when a proposed resolution is submitted to the ICRC, the Registrar or his or her delegate must identify in his or her conclusion that the resolution is in the public interest, and the basis for that conclusion;

(h) if the complainant does not agree to the proposed resolution, the complainant's position must be recorded and specifically addressed by the ICRC; and

(i) proposed resolutions should be presumed by the ICRC to be appropriate for approval in the absence of any identifiable reason to believe that the resolution is not in the public interest.

D. Registrar's Investigations

105. Registrar's Investigations are an entirely separate source of investigation work for the I and R Department. These investigations do not arise from a complaint filed by the public. Rather they are initiated by the CPSO itself, through the office of the Registrar, pursuant to s. 75 (1) (a) of the *HPPC.*

106. The Registrar does not control the number of situations that come to his or her attention that potentially warrant a s. 75 investigation. The Registrar's office is under a public interest duty to ensure that matters which come to its attention are properly evaluated and investigated.

107. As a matter of public policy, the importance of giving the Registrar to power to be able to initiate investigations is clear. The public interest in ensuring that physicians maintain proper standards of conduct and practice cannot rely solely on the vagaries of individuals choosing whether or not to complain. Moreover, circumstances warranting investigation may not necessarily be amenable to individual complaints.

108. There has been no material increase in the number of new Registrar's Investigations over the past 5 years (the annual numbers vary between 280 and 380 new Registrar's Investigations per year).[58] However, there appear to be more Registrar's Investigations than there were 10 years ago.

109. On average, Registrar's Investigations are much more time consuming to investigate than Public Complaints. For Registrar's Investigations which proceed to the ICRC, the median time to completion has been approximately 450 days.[59]

110. Registrar's Investigations are typically much more expensive to investigate than Public Complaints. On average, each Registrar's Investigation costs four times as much as an average Public Complaint.[60] Moreover, the CMPA is much more likely to be actively involved in a material way in a Registrar's Investigation than in an average Public Complaint.

111. Of the CPSO combined budget for Public Complaints and Registrar's Investigations, Public Complaints consume approximately two-thirds of the budget and Registrar's Investigations consume one-third.[61]

112. There are at least two reasons why Registrar's Investigations are more expensive, on average, than Public Complaint investigations:

[58] CPSO Investigations 2014 Annual Report p. 19
[59] CPSO Investigations 2014 Annual Report p. 19
[60] Note that there is a very large variance in the investigative costs between the simplest and most complex Public Complaint;
[61] December 2014 I and R Department Cost Summary.

(a) there are far fewer Registrar's Investigations that are meritless (i.e. cases which can be resolved in a simpler and faster investigation). Over the period of 2010-2014 74% of all Public Complaints were closed on a "No Action" basis, whereas only 28% of Registrar's Investigations were closed on a similar basis. Put another way, 72% of all Registrar's Investigations result in "some action" (whether referral to discipline or otherwise), whereas only 26% of Public Complaints result in "some action";[62] and

(b) Public Complaints tend to be investigations into discrete events. On the other hand, Registrar's Investigations very often involve a systematic assessment of an aspect of a physician's practice. The latter tend, as a result, to be more intensive and time consuming exercises.

113. Aside from the identity of the person that initiates the investigation, there are a number of other differences between Public Complaint investigations and Registrar's Investigations.

114. First, unlike Public Complaints, s. 75(1)(a) of the *HPPC* requires the Registrar to have "reasonable and probable grounds" ("RPG") that a the member "has committed an act of professional misconduct, or is incompetent" in order to commence a Registrar's Investigation. For Registrar's Investigations the ICRC must approve the appointment of the investigator.

115. Matters which may become the subject of a Registrar's Investigation come to the attention of the CPSO in a variety of different ways, including: mandatory reports to the

[62] 2014 Annual Report pp. 22, 24

CPSO that various agencies are required to make under various regulatory schemes; media reports; and concerns raised by either the public or other physicians which are not in the form of a "complaint" under the *HPPC.*

116. In order for the Registrar to be in a position to form the RPG necessary to commence a formal investigation, some preliminary inquiries into the matter are almost always necessary. These are undertaken by CPSO investigators.

117. Second, once the appointment of an investigator has been approved by the ICRC, that investigator is granted a series of intrusive legal powers to facilitate the investigation, including:

(a) the power to enter the place of practice of the physician;

(b) the power to examine things found at that place of practice;

(c) the power to require the member to cooperate with the investigation;

(d) the prohibition on any obstruction, withholding, concealment or destruction; and

(e) the power to seek, without notice, a warrant of search and seizure from a justice of the peace.[63]

118. Third, Registrar's Investigations are typically less concerned with discrete actions of a physician and more concerned with systemic issues related to the physician's standard of practice.

[63] *HPPC,* s. 76,77

119. Fourth, because these investigations are initiated by the CPSO itself, and because of the RPG threshold, the probability that they will be wholly without merit is much lower than in the case of an average Public Complaint. As a result, the prospect that the investigation will be curtailed at an early stage is low. As well, there is a higher probability of adverse consequences to the physician, up to and including referral to discipline.

120. Consequently, there is a higher probability that a physician will be represented through a Registrar's Investigation by legal counsel arranged through the CMPA. Counsel are retained by the CMPA in a high percentage of Registrar's Investigations.[64] This has a direct impact on the costs expended by the CMPA.

121. In my view, there are two significant opportunities to improve the efficiency and therefore the cost effectiveness of Registrar's Investigations at the investigation stage.

122. First, in cases where there is a question regarding a physician's quality of care, the CPSO investigates the matter through a chart review conducted by an external assessor. This is common in Registrar's Investigations. Historically, the CPSO has had the assessor review a sample consisting of an average of 25 charts. The time and expense associated with this exercise is directly related to the number of charts subject to review. Since 2012 the CPSO has been undertaking a research project to determine whether this number can and should be reduced, potentially to as few as ten charts.

[64] The CMPA has observed an increase in the breadth of scope and comprehensiveness of Registrar's Investigations in recent years. This has led to an increased use of legal counsel by physicians. Over the period of 2010-14 there has been a 33% increase in the use of legal counsel in Registrar's Investigations. (CMPA May 7 Submission, p. 7).

This review is scheduled to be completed in 2015.[65] The CMPA is strongly of the view that the number of charts being reviewed can be significantly decreased. The CPSO's review to date appears to support this view.

123. I recommend that this review be completed as quickly as possible and that there should be a presumption that a maximum of ten charts be reviewed in a Registrar's Investigation. It seems to me that, if there is a problem with a physician's standards in a particular aspect of his or her practice, a skilled reviewer will very likely be able to identify that concern on a sample of this size. Obviously, in the event an assessor has reasonable cause for doing so, the assessor should be able to expand the number of charts subject to review, but this presumption is as good as any, and allows for immediate implementation rather than awaiting results or further study.

124. The second aspect of Registrar's Investigations that offers an opportunity for greater efficiency is in the extent or breadth of such an investigation, when seen in the context of the RPG requirement.

125. For a number of years, the CMPA has been concerned with what it perceives to be the unfocussed and unconstrained scope of Registrar's Investigations. It complains that (at least historically) the Registrar is authorized by the ICRC to investigate entirely unparticularized allegations of professional misconduct. Investigators are then granted coercive powers to engage in a "fishing expedition" into the entirety of a physician's practice.

[65] CPSO 2013 Annual Report p. 9-10

126. The Ontario Court of Appeal addressed and clarified the obligations of, and limitations on, the CPSO in this area in the *Sazant* case in 2012.[66] The court concluded that when acting pursuant to s. 75(1)(a), the Registrar should provide a brief description of the act or acts of the professional misconduct that he or she believes, on reasonable and probable grounds, constitute misconduct. This description limits the scope of the information which is "seizeable" under s. 77 because the scope of the information which is subject to summons is that which is relevant to the authorized investigation.[67]

127. If an investigator finds something during the course of the investigation that is indicative of misconduct different from that authorized to be investigated, the investigator then would be required to go back to the Registrar and seek a new appointment under s. 75(1)(a), to investigate the newly defined area of alleged misconduct.

128. The CMPA acknowledges that, since the *Sazant* decision, there has been a greater degree of particularity in the scope of authorized Registrar's Investigations. However, in its view, the authorizations remain too open-ended and the investigations are still too broad ranging, and too intrusive. The CPSO disagrees with this perception.

129. It is not possible for me to determine whether the appropriate balance has been achieved in limiting the scope of these investigations. Nevertheless, I have considerable sympathy for the CMPA's position on this matter, if only because the more tightly focussed investigations are, the more likely they are to be undertaken and completed more quickly, and with less expense, for both the CPSO and the CMPA.

[66] *Sazant v. College of Physicians and Surgeons of Ontario,* 2012 ONCA 727 (CanLII)
[67] *supra,* para. 160, 162.

Moreover, the clearer the definition of the scope of the investigation, the fewer disputes there can be about its scope.

130. When the Registrar is in the position to form RPG that a physician has committed an act of professional misconduct, the Registrar will have a reasonably well defined idea as to exactly what the physician has done, or failed to do, that constitutes professional misconduct. Precisely specifying that conduct is very likely to narrow the scope of relevance for the investigation. This will provide important guidance to the investigator, and provide the physician with some comfort that he or she is not being subject to a complete practice audit. Put another way, loose or imprecise specification runs the risk of scope creep in the investigation.

131. Of course nothing herein would limit the ability of the Registrar to seek a broader or different authorization, in the event that evidence of additional acts of misconduct is unearthed during the course of the investigation. While there may be incremental costs incurred in obtaining a fresh authorization, this is a better approach, both from a farness and efficiency perspective.

132. Thus to guard against “scope creep”, I recommend that when a Registrar’s Investigation is commenced, the Registrar should be precise about the acts that he or she has concluded, on reasonable and probable grounds, constitute misconduct, and the basis for that conclusion. In my opinion, that is something that the physician is entitled to know. This will, I think, help to keep Registrar’s Investigations properly focussed, and both fairness and efficiency will be served.

PART VI. IMPROVING THE EFFICIENCY AND COST EFFECTIVENESS OF THE ICRC STAGE

133. Having examined the investigation stage of the physician complaint process, I now turn to the next stage, where the ICRC considers the case. This will include those Registrar's Investigations that the Registrar seeks to proceed with, and all Public Complaints.[68]

134. The number of members of the ICRC has increased from 35 in 2010 to 57 in 2014.[69] The CPSO has also created specialized ICRC panels to improve timelines and the quality of decision-making.

135. Membership on the ICRC is a part-time commitment. Typically, the members have other jobs. The CPSO has faced ongoing issues with respect to its ability to assemble ICRC panels in a consistently timely fashion. For urgent matters it must put together ad hoc panels on short notice. Part of this problem arises from the difficulties in aligning the competing schedules of busy professionals. Part arises from the shortage of public member appointees to the Council, since each panel must have a public member.[70]

136. Investigations are streamed according to the issue and the subject physician's area of practice. For this purpose, the ICRC has various types of panels:

[68] Pursuant to s. 25 of the *HPPC* all Public Complaints must be considered by and determined by the ICRC in order to be resolved. The Registrar has no authority to close a Public Complaint file.
[69] CPSO February Responses, p. 6
[70] *HPPC* s. 25(2)

(a) a four to five member "general" panel;

(b) a four to five member "specialty" panel;

(c) an internal medicine panel;

(d) a four to five member incapacity panel;

(e) a three member panel designated as "medium track" for low risk matters, straightforward complaints, and frivolous and vexatious matters;

(f) a three member panel designated as "fast track" for abbreviated investigations;

(g) weekly teleconferences for urgent matters or approval of appointments for registrars' investigations.[71]

137. In recent years the ICRC (in its various panels) has met 77 days per year.[72]

138. Investigators do not make recommendations to the ICRC regarding potential outcomes. However, I was advised that in some cases, experienced investigators will advise subject physicians or their counsel of what the investigator believes the ICRC would consider to be a satisfactory outcome of the case. This may include an undertaking, or a suggestion that the physician take a course. If an undertaking is canvassed in this way before the matter goes before the ICRC, and the physician is willing to agree to certain terms, the ICRC may dispose of the matter by “directing” an undertaking.

[71] CPSO May Responses, p. 11
[72] 2014 I and R Annual Report, p. 5

139. The ICRC may consider a variety of factors when reviewing a particular investigation, including:

(a) the facts of the case;

(b) the number and seriousness of care and/or conduct concerns at issue;

(c) the standard of care expected for practitioners;

(d) the whether the physician is practicing within his or her area of expertise;

(e) the physician's response to the investigation;

(f) the physician's insight and self identification of areas for improvement and changes to practice;

(g) the physician's apparent capacity for remediation;

(h) the physician's investigative and disciplinary history;

(i) the expert opinions obtained in the course of investigation; and

(j) other documentary or witness information.[73]

140. The ICRC renders a written decision. Copies are provided to the complainant and to the physician. They are not made public.

141. By definition, all dispositions by the ICRC other than referral to discipline are non-disciplinary in nature, since only the Discipline Committee can impose discipline, and

[73] 2014 I and R Annual Report, p. 1

only after a finding of misconduct. However, even non-disciplinary outcomes can have potential negative implications for physicians, and are perceived that way by physicians.

142. It is therefore useful to review the various possible outcomes at the ICRC stage, short of referral to discipline.

143. A very substantial proportion of Public Complaints are closed by the ICRC on a "No Action" basis. From 2010-2014 between 60-83% of all Public Complaints were closed by the ICRC on a No Action basis.[74]

144. Over the period 2010 to 2014 between 17-36% of Registrar's Investigations were disposed of on a No Action basis.[75]

145. However, not all No Action outcomes result in literally "no action". In 5-10% of Public Complaint cases and in roughly 10-20% of Registrar's Investigations the matters were disposed of as No Action on the basis that the ICRC would issue a "Statement of Expectations"[76] to the physician.

146. Commencing in 2012, the ICRC introduced a new outcome called "Advice" which is applicable to both Public Complaints and Registrar's Investigations. This outcome replaced outcomes previously considered to be forms of No Action called "reminders" and "counsels". From that time, the percentage of Public Complaint cases disposed of by the ICRC on a No Action basis declined from more than 80% to around 60%. Approximately 20% of these cases are now disposed of by way of Advice. The

[74] CPSO Investigations 2014 Annual Report p. 22-23;
[75] CPSO Investigations 2014 Annual Report p. 24
[76] This is an indication to the physician of the expectations that are applicable to all physicians in that situation. CPSO Investigations 2014 Annual Report p. 23-25

combination of No Action plus Advice has remained constant at approximately 80% of dispositions by the ICRC.[77]

147. In terms of severity, Advice is the least negative outcome to a physician, after No Action. It is an educational outcome given in cases where the care or other concerns are of a low risk nature.[78]

148. The Caution in Person outcome was used in 3-5% of total Public Complaints cases and 4-7% of Registrar's Investigation cases over the period of 2010-2014.[79] It is a more serious outcome for a physician that Advice.

149. The Undertaking outcome was used in less than 1% of total Public Complaints cases and between 20-35% of Registrar's Investigation cases over the period of 2010-2014.[80] Depending on the terms of the Undertaking, this outcome can have a very serious impact on the practice of the physician. They include undertakings to resign from the profession.

150. Another possible outcome is Referral to Incapacity. In theory, this outcome would transfer a potential disciplinary matter to an incapacity hearing. In practice the ICRC rarely does so.[81]

151. Another possible outcome is Notification of the Director of OHIP. These are cases involving suspected OHIP billing irregularities. This disposition may be used in

[77] CPSO Investigations 2014 Annual Report p. 22-23
[78] CPSO May Responses, p. 22
[79] 2014 Annual Report p. 22, 24
[80] 2014 Annual Report p. 22
[81] 2014 Annual Report p. 22

combination with others as above. In the latter category, there has been only one such referral in Public Complaints files during the 2010-14 period, and in only two cases in Registrar's Investigations over the same period.[82]

152. The Caution in Writing outcome was used in 8-9% of total Public Complaints cases and in 6-12% of Registrar's Investigation cases over the period of 2010-2014.[83] Of the non-disciplinary outcomes, only a Caution in Person and certain specific undertakings are more serious for the physician.

153. The ICRC can also dispose of a case by using an outcome referred to as Specified Continuing Education or Remediation Program ("SCERP"). Over the period of 2010-2014 this outcome was used in 2-3% of total Public Complaints cases, and in 7-19% of Registrar's Investigations.[84] This outcome results in a referral to a mandatory education plan, designed to address some deficiency in the physician's knowledge or skills, and are intended to have a remediative effect.

154. The final possibility is Directing a Letter from the Registrar. There has been one such disposition in Registrar's Investigation cases during the 2010-14 period.

155. Neither the *RHPA* nor the *HPPC* explicitly impose a standard to be applied by the ICRC in determining whether a case should be referred to discipline. The most common articulation of the standard that has been developed is: "the allegation ought to

[82] 2014 Annual Report p. 22, 24
[83] 2014 Annual Report p. 22, 24
[84] 2014 Annual Report p. 22

be referred to a discipline hearing only where the allegations warrant a referral, and there is a reasonable prospect of a finding being made against a member".[85]

156. The "warrants a hearing" aspect of this standard involves a consideration of the seriousness of the allegations, whether the allegations appear to reflect an isolated event or a pattern of conduct, the motivation of the member, the past record of the member, the need for general deterrence in relation to such conduct, the manner in which the member has responded to the investigation, and whether something short of the imposition of discipline can appropriately address the issue.[86]

157. The "reasonable prospect of a finding" aspect of the standard involves an assessment of the evidence to determine whether it is capable of supporting a finding of misconduct. Although the ICRC does not make findings of fact, it is entitled to take a critical look at the facts.[87]

158. Between 2010 and 2014, an average of 72 cases were referred to discipline each year. On average, 60% (i.e. 43) of cases originated from Public Complaints, and 40% (i.e. 29) originated from Registrar's Investigations.[88]

159. The referral rate to discipline for Registrar's Investigations is significantly higher than that for Public Complaints (13.6% vs. 1.9%, on average over 2010-2014).[89]

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[85] R. Steinecke, *A Complete Guide to the Regulated Health Professions Act,* (Thomson Reuters, 2015) at p. 5-52
[86] *Ibid.*
[87] *Ibid*
[88] 2014 Annual Report p. 22, 24
[89] 2014 Annual Report p. 22, 24

160. The CMPA advises that, from its experience, the proportion of cases referred to discipline is in excess of other Canadian jurisdictions.

161. This does not appear to be because unmeritorious cases are referred to discipline. A very high percentage of cases referred to discipline result in (a) findings of misconduct after a fully contested hearing; (b) a resolution approved by the Discipline Committee, with or without findings of misconduct; or (c) a withdrawal of all of the charges by the ICRC in exchange for undertakings which result in serious consequences to the physician, including restrictions on practice or resignations.[90]

162. However, as I have discussed, the ICRC has a variety of dispositions to select from short of referral to discipline. These dispositions range in gravity from No Action to SCERPs, Cautions in Person and Undertakings.

163. There is, no doubt, a difference of view between the CMPA and the CPSO about whether the disposition choices made by the ICRC in seeking to act in the public interest puts too little emphasis on remediation of the physician and too much emphasis on punitive sanctions.

164. Apart from the two observations I make below, I view this difference as outside my mandate. The choice of disposition seems to me to be a matter of substance, not a matter of process that can be analysed through the lens of efficiency and cost effectiveness.

[90] Memo from CPSO to S. Goudge dated March 2, 2015

165. I do think, however, that sound public policy and proper protection of the public interest require that the ICRC take care to fairly balance these two considerations in coming to its dispositions in each case. Beyond this reality, however, the perception held by physicians of the fairness of that balance will undoubtedly significantly influence the costs they and the CMPA incur in defending against complaints both at the investigation stage and the ICRC stage.

166. There is, however, an additional way that the ICRC does not now use, but could use, to dispose of cases that would, in my view, advance efficiency and cost effectiveness. In the appropriate case, the ICRC could make a referral to discipline subject to conditions which, if met, would result in the ICRC considering the case resolved.

167. The efficiency and cost savings created by this disposition compared to a full discipline hearing is obvious. It is consistent with the two part standard that the ICRC uses to refer cases to discipline, because implicit in that standard is the conclusion that while the conduct in question might constitute professional misconduct, a disciplinary sanction may not be required to ensure that the public interest is protected.

168. This proposal is different from the Undertaking disposition because an undertaking is not imposed by the ICRC. It is offered by the physician, and if it is accepted by the ICRC, it is a binding promise by the physician to do, or not do, certain things. Undertakings are an important non-disciplinary outcome. Undertakings can be a flexible tool. They can be tailored to specific circumstances. They can also cause

significant modification in behavior to eliminate undesirable conduct. This proposal is designed to broaden their use.

169. Where the ICRC reaches a conclusion that, in the event the physician were prepared to give an appropriately framed undertaking, a referral of the matter to discipline would not be in the public interest, but the physician does not offer the undertaking, the efficient solution is not available. This proposal would cure that shortcoming.

170. Therefore, I recommend that the ICRC should have the power to seek appropriate undertakings by physicians. Specifically, the ICRC should, in proper cases, make "conditional" referrals to discipline. The ICRC should advise the physician that the case will be resolved without referral to discipline, but only on the condition of the physician successfully undertaking a prescribed alternative. This would allow the ICRC to assist with resolutions in the proper case and provide an added incentive for the physician to give the requested undertaking. Once the undertaking is given there would be no referral to discipline, leaving the complainant's appeal rights unimpaired.

171. I recognize that the statutory prohibition on the use of ADR in sexual abuse cases may mean that this proposal cannot be used in those cases. However, I think its availability will advance efficiency and therefore cost effectiveness, while preserving fairness.

PART VII. IMPROVING THE EFFEICIENCY AND COST EFFECTIVENESS OF REVIEW BY HPARB

172. There is a statutory right to seek a review by HPARB of decisions of the ICRC apart from a decision to refer to incapacity proceedings. This right of review is applicable to all *RHPA* regulated professions.[91]

173. In recent years, between 60-70% of all applications for review made to HPARB originate from decisions of the ICRC at the CPSO.[92]

174. This right of review is available to both complainants and physicians. The Registrar does not have a right of review.[93]

175. In fact, virtually all (approximately 95%) HPARB reviews originate from complainants.[94]

176. There are only two considerations that HPARB can apply when reviewing an ICRC decision: (a) was the investigation inadequate; or (b) was the decision unreasonable?[95]

177. A noteworthy fact is that there are a significant volume of HPARB reviews, but a very low success rate. Over the period 2010-2014, on average annually:

(a) 2226 reviewable decisions were issued by the ICRC;

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[91] *HPPC,* s. 29

[92] HPARB Annual Report, 2012-13, p. 9

[93] *HPPC,* s. 29 (2). Note that it is theoretically possible for a physician to seek judicial review of a decision of the ICRC referring a matter to a discipline hearing, but such judicial reviews are almost always premature, pending the determination of the matter by a discipline panel.

[94] Information from CPSO

[95] *HPPC* s. 33(1)

(b) 398 HPARB reviews or 18% were actually commenced;

(c) 352 decisions were upheld;

(d) 46 of these reviews or 11.5% were allowed and referred back to the ICRC;

(e) this represents a 2% reversal rate relative to the number of reviewable decisions rendered;

(f) approximately 60% of reversals were based on "inadequate investigation" and 40% were based on "unreasonable decision"; and

(g) only about 55% of the cases returned to the ICRC result in a substantively different decision.

178. As a result, the HPARB process only results in substantively different outcomes to about 1.1% of decisions rendered by the ICRC.[96]

179. HPARB reviews are time consuming. Over the period 2010-2014, the average time from the commencement of an HPARB review to a decision being rendered was 547 days. Obviously, in the event a review is successful, further time will be required for the ICRC to implement HPARB's decision by reconsidering the matter.

180. The CPSO is not a formal party to HPARB reviews. Its role is limited to compiling and providing the record of the ICRC's decision, and making personnel available to HPARB as a resource regarding the record and its practices. As a result, HPARB reviews are not a material expense for the CPSO.

[96] CPSO Investigations 2014 Annual Report p. 27; CPSO May Responses, p. 33-34

181. However, the CMPA invariably provides legal counsel to physicians in HPARB reviews. Legal counsel are involved in these reviews up to and including appearances at the hearing before HPARB to make oral submissions. HPARB reviews comprise approximately 5% of the CMPA's overall Ontario legal expenditures.[97]

182. Both the CPSO and the CMPA question whether, in view of the very low success rate, the cost and effort associated with the processes currently used by HPARB are worthwhile.[98]

183. The CMPA notes, for example, that a significant proportion of HPARB reviews are dismissed simply on the basis that the party seeking review has not raised any issue within HPARB's jurisdiction.

184. Nonetheless, I do not think that HPARB reviews should be eliminated, even from the perspective of efficiency alone. Because ICRC decisions constitute a statutory power of decision, there must be some mechanism to review them. In the absence of a statutory alternative, a dissatisfied party could seek to invoke the supervisory jurisdiction of the superior courts, which could be even more costly and time consuming. So the wisdom of having a specialized, expert review body does not appear open to serious question. The issue is whether the HPARB review process could be made more efficient and cost effective.

185. Currently, HPARB has the ability to hear and determine a review application in writing, instead of by an oral hearing. However, HPARB uses this power infrequently.

[97] CMPA May Submission, p. 2
[98] CPSO February Submission, p. 11-12

In my view in-writing reviews should be the rule, not the exception. A fair process does not require an oral hearing, and certainly not in every case. I recommend that HPARB make reviews in writing the rule, not the exception.

186. Making this a presumptively written process will reduce overall costs, and eliminate the scheduling issues that can delay timely dispositions. The timelines for the filing of material and the consideration of the file by an HPARB panel can be prescribed, and should be made as short as reasonably possible. HPARB should, however, retain the power, in exceptional cases, to:

(a) extend timelines in the event a case is inordinately large or complex, or to relieve against hardship; and

(b) order an oral hearing, where there is good reason to do so.

187. The second aspect of the HPARB process that deserves attention relates to the adequacy of investigation standard it is directed to apply. In my view, it is important to recognize that in every case of a complainant seeking HPARB review, it is not just the CMPA that has concluded that the investigation was adequate. The CPSO, as a steward of the public interest has as well. This reality must be kept squarely in focus.

188. One example arises with abbreviated investigations. These are cases where the complainant had agreed that the investigation can be curtailed on the basis of an understanding acceptable to the physician, the complainant and the CPSO. The review arises from the complainant having resiled from his or her prior agreement to the resolution. In applying the adequacy of investigation standard to these cases, I

recommend that the review should be dismissed in the absence of compelling public policy justifications requiring further investigation.

189. With respect to the outcome of other investigations, I recommend that HPARB should assess the adequacy of an investigation being mindful of, *inter alia,* the nature of the interests at stake, the seriousness of the alleged misconduct (assuming misconduct was established), the evidence offered by the complainant to establish the complaint, the public interest in having complaints resolved in a fashion proportionate to the interests at stake, and the reality that both the CMPA and the CPSO view the investigation as adequate.

190. I do not think that either of these recommendations necessitates legislative change. Both can and, I would hope, will be accomplished by HPARB changing its practices accordingly.

PART VIII. IMPROVING THE EFFICIENCY AND COST EFFECTIVENESS OF THE DISCIPLINE HEARING STAGE

A. Disclosure

191. In preparation for a discipline hearing, the CPSO makes full disclosure of all relevant materials in its possession pursuant to the principles outlined in *R. v. Stinchcombe.*[99] This can be voluminous and time consuming.

192. The physician is not required to provide any disclosure to the CPSO, with the exception of reports of any expert witness that he or she intends to call at the hearing. Physicians' practices on voluntarily providing information to the CPSO before the hearing vary widely. Sometimes no information (witness lists, statement summaries, documentary production) is provided. Sometimes the physician will provide the CPSO with a significant piece of information right before or even during the hearing. In such cases, an adjournment may be required in order to deal with late disclosure.[100]

193. It appears that the approach to disclosure stems historically from a perception that CPSO disciplinary proceedings are quasi-criminal in nature, and as such, the member benefited from the right to remain silent. However, today the better view is that college disciplinary proceedings are not quasi-criminal but administrative in nature, and are designed to protect the public interest.[101] In my view, there is today no persuasive justification for exempting the physician from a disclosure obligation. At least one other

[99] 1991 3 SCR 326
[100] CPSO February Responses, p. 9
[101] *Sazant v. College of Physicians and Surgeons of Ontario*, 2012 ONCA 727 (CanLII)

regulated health profession has required a form of reciprocal disclosure for many years.[102]

194. In my view, in order to enhance the efficiency of the discipline hearing stage a disclosure obligation should be imposed on the physician. Because discipline proceedings are better seen as administrative, not quasi-criminal in nature, the disclosure requirements need not serve the right to silence paradigm.

195. I therefore recommend that the physician be required to disclose the documents he or she intends to rely upon, will-say statements from fact witnesses to be called and expert reports to be relied on. This obligation need not be concurrent with CPSO disclosure. However, it should be required at a reasonable point in time after the CPSO's disclosure in order to permit the physician to respond to it. To maximize the efficiency to be achieved, disclosure by the physician should precede any pre-hearing conference in the case. The Discipline Committee should however have discretion to admit previously undisclosed evidence on such terms as are just if, for example, that is due to oversight.

196. Requiring the member to provide disclosure will, in my view considerably assist the efficiency of the discipline hearing stage of the physician complaints process in a number of ways:

(a) it will give both the physician and the CPSO a much better sense of the strengths or weaknesses of the CPSO's case and will do so much earlier to the benefit of possible resolution;

[102] The Ontario College of Pharmacists.

(b) it will force both parties to be realistic as to the probable outcome of the a contested hearing, should one occur;

(c) it will allow both parties to obtain clearer instructions regarding resolution;

(d) it will provide the pre-hearing conference chair with more information on which to attempt to achieve a resolution; and

(e) it will enhance the possibility of the parties achieving agreements with respect to complete resolution, resolution of issues, agreed statements of facts, and/or dispensing with formal proof, all of which aid efficiency.

197. Critically, such disclosure will achieve these salutary effects at a relatively earlier stage in the process. It appears that too many settlements now occur very late in the proceeding, essentially on the eve of the commencement of a contested hearing. If the parties can be brought to the same realization about the realities of a probable outcome, at an earlier stage, significant efficiency can be achieved and significant costs and delay can be avoided.

198. I do not think that the change I propose requires legislative change. In my view, it should be effected by a CPSO Practice Direction, and I would hope that, for the reasons I have given, the parties would embrace it.

B. The Pre-hearing Conference

199. Pre-hearing conferences ("PHCs") are conducted by members of the Discipline Committee. The purpose is to determine if a full or partial settlement of the case is possible, and to streamline the case for hearing.

200. Both the CPSO and the CMPA raised concerns that this process is not as effective as it could or should be. It appears that the PHC is not used as effectively as it might be to seek a resolution of the case. For example, it seems that the PHC chair does not typically meet with the parties separately, using the form of shuttle diplomacy that is very effectively employed by successful mediators.

201. In order to make the PHC a more effective vehicle to resolve cases without the need for a hearing, I recommend that the following steps be taken:

(a) PHC chairs should be those members of the Discipline Committee who have the skills and disposition most likely to achieve an agreed upon resolution;

(b) Those PHC chairs should receive extensive independent training in the full range of mediation techniques, including meeting separately with the parties; and

(c) To deal with those cases where a physician PHC chair is not required, or where a non-physician PHC chair might be more effective (for example, where credibility is the issue), non-physicians with advanced dispute resolution skills should be appointed to the Discipline Committee to be available as PHC chairs for these cases.

202. Making the PHC as effective as possible must be a serious priority. Resolution at this stage avoids the need for a hearing. Coupled with the disclosure change I have proposed, it also addresses a problem that contributes to inefficiency, namely the

settlement of cases at the last minute, after the expense of full preparation on both sides.

C. The Discipline Hearing

203. Over the period 2010-2014 there was an average of 38.8 cases referred to discipline per year. During the same period there was an average of 31.4 cases completed per year. Of these, approximately three-quarters were one day cases and the balance was multiple day cases.

204. During the same period, all charges were withdrawn against the physician on average, 7.4 times per year.[103]

205. Over the period of 2010-2013 the Discipline Committee sat for an average of 101 days per year, with no upward trend.[104]

206. The year end unresolved caseload of the Discipline Committee over the period of 2010-2013 averaged 71.25 cases, with a downward trend.[105]

207. The distinction between single day and multiple day cases is an important one. A case that will be fully contested is never scheduled for a single day, on the theory that such a case can never be completed in a single day. The number of single day cases indicates the number of cases where a full or partial resolution has been achieved or is anticipated, for example, where the only evidence is by way of agreed statement of fact,

[103] CPSO May Responses, p. 53; 2014 Annual Report p. 32
[104] CPSO November 2014 Report of the Discipline Committee, p. 4
[105] CPSO November 2014 Report of the Discipline Committee, p. 4

or where liability is admitted and only penalty is contested. What remains contested, if anything, can most often be dealt with in a single day.

208. There is no doubt that there are cases that simply cannot be settled in full, or even in part, and that ultimately have to be fully litigated on the merits. But the statistics reveal that the number of such cases is actually quite small. Out of the approximately 2500 new complaints and Registrar's Investigations received or initiated annually, about eight (0.3%) result in fully contested hearings.

209. Whether a hearing is to be fully contested multiple day case or a single day case with limited issues to resolve, the efficiency with which the hearing is managed is worthy of attention.

210. For many years the Discipline Committee has appointed independent legal counsel ("ILC") pursuant to s. 44 of the *HPPC* to provide it with advice on legal issues. ILC has been very useful in this role over the years. ILC has also been able to assist with the way that hearings are run. However, the CPSO advised that it would like to have the ability, on a case-by-case basis, to assign a legally trained person, experienced in running hearings (such as a retired judge) to chair the hearing. The CPSO perceives that such a person would be able to exert superior hearing hearing management skills, resulting in more efficient proceedings. It would also incidentally avoid the need in those cases to have ILC to address legal issues.

211. I agree. I would thus recommend that several such persons be appointed to the Discipline Committee as public members, so that in appropriate cases they can chair hearing panels. I agree with the CMPA that care must be taken to select the

appropriate cases. For example, cases in which standard of practice issues are significant may not be appropriate. However, I have no doubt that there will be fully contested multiple day hearings or even single day hearings with limited issues where panel chairs with this experience will very likely be able to advance the efficiency of the hearing process itself without sacrificing fairness to the parties.

212. In addition, these appointments may also usefully be brought to bear in addressing another issue, namely the CPSO's view that some motions are brought that have little or no merit, although this is not a view shared by the CMPA. I am not in a position to express any opinion on this difference. However, I think that to have appointees with this kind of experience and skill will likely make for more efficient disposition of the motions that may have given rise to this difference of view.

213. I was advised that prior to my appointment the CPSO and the CMPA were engaged in discussions seeking to develop a protocol of agreed upon best practices for various discipline hearing related matters, but that these discussions were suspended pending my report.

214. I recommend that the parties resume and complete those discussions as quickly as possible. I am confident that the parties that labour day to day in this environment have the detailed knowledge and experience to reach agreement on procedural rules that will add to the efficiency of discipline hearings.

215. To assist attaining this objective I recommend that these discussions include the following in the protocol:

(a) Where there are competing experts (as is frequently the case where standard of practice is an issue) the experts should be required to meet beforehand to discuss and refine the differences between them. They should then testify on the same panel;

(b) Presumptively evidence in-chief should be tendered in writing;

(c) Presumptively cross-examination should be subject time to limits as agreed to by counsel or as determined by the hearing panel;

(d) Presumptively witnesses should be able to testify by videoconference in lieu of personal attendance;

(e) Presumptively, where authenticity is not in dispute, contemporaneous documentary evidence should be admitted for all purposes; and

(f) Relief from these presumptive provisions should require a showing that without relief a material unfairness will result.

216. I am confident in putting these suggestions forward for inclusion in the protocol because they are used by many administrative tribunals and inquiries. I can also say from experience that not only do they advance efficiency but can make the truth seeking process better, with no sacrifice of fairness.

217. I should note that I have not addressed the issue of costs. In my view, no change is required. The current legislative regime is reflective of the reality that just as these proceedings are not quasi-criminal in nature, they cannot be said to be civil in

nature, and that the CPSO is not a private litigant advancing its own private agenda, but is a regulator acting in the public interest.

PART IX. SUMMARY OF RECOMMENDATIONS AND CONCLUSION

PART V: Improving the Efficiency and Cost Effectiveness of the CPSO Investigation Stage

1. I recommend that the Registrar (or the Registrar's delegate under his or her oversight, or alternatively a newly created position of Complaints Director), like the Complaints Director in Alberta, be required to conduct an early review of Public Complaints and be given the power to:

(a) approve the withdrawal of a Public Complaint by the complainant; and

(b) dismiss a Public Complaint outright where satisfied that there is no reasonable prospect of an outcome from the ICRC other than No Action".[106]

(i) in such cases, brief written reasons will be provided to the complainant; and

(ii) an appeal from a dismissal will lie to the ICRC.

2. I recommend that the CPSO create a patient advocate position. Although this need not entail a new hire, the separate position and its title send an important signal. The patient advocate should be required to interact with the complainant immediately on filing to review and clarify the true substance of the complaint. For a significant number of complainants, who are simply not aware of the limits on the scope of the jurisdiction of the CPSO, a proper explanation from someone who is sympathetic to the patients'

[106] This provision would be similar to than in s. 55 (2) (f) of the Alberta *HPA*.

perspective may well satisfy them that their complaint can be withdrawn or does not fall within the jurisdiction of the ICRC, and that their remedy may lie elsewhere.

3. I recommend that there be a new alternative dispute resolution process containing the followings elements:

(a) it can be initiated by the CPSO investigator at any stage of the investigation;

(b) the process should be facilitated by an appropriately skilled neutral who can bring resolution, such as a member of the ICRC or an independent mediator, not a member of the CPSO staff;

(c) the CPSO investigator should play an active role in the process;

(d) all communications in the new ADR process concerning a complaint should be inadmissible in any proceeding concerning that complaint but information relevant to a new or different complaint may be used by the CPSO in pursuing another complaint;

(e) the complainant's agreement is not a pre-condition to resolution;

(f) in the event a resolution is achieved, that resolution is subject to approval by the ICRC;

(g) when a proposed resolution is submitted to the ICRC, the Registrar must identify his or her conclusion that the resolution is in the public interest, and the basis for that conclusion;

(h) if the complainant does not agree to the proposed resolution, the complainant's position must be recorded and specifically addressed by ICRC; and

(i) proposed resolutions should be presumed by the ICRC to be appropriate for approval in the absence of identifiable reasons to believe that resolution is not in the public interest.

4. I recommend that the CPSO's review of its chart review process be completed as quickly as possible and that there should be a presumption that a maximum of ten charts be reviewed in a Registrar's Investigation. It seems to me that, if there is a problem with a physician's standards in a particular aspect of his or her practice, a skilled reviewer will very likely be able to identify that concern on a sample of this size. Obviously, in the event an assessor has reasonable cause for doing so, the assessor should be able to expand the number of charts subject to review.

5. I recommend that when a Registrar's Investigation is commenced, the Registrar should be precise about the acts that he or she has concluded, on reasonable and probable grounds, constitute misconduct, and the basis for that conclusion. In my opinion, that is something that the physician is entitled to know. This will, I think, help to keep Registrar's Investigations properly focussed and less open to challenge, and both fairness and efficiency will be served.

PART VI: Improving the Efficiency and Cost Effectiveness of the ICRC Stage

6. I recommend that the ICRC should have the power to seek appropriate undertakings by physicians. Specifically, the ICRC should, in proper cases, make

"conditional" referrals to discipline. The ICRC should advise the physician that the case will be resolved without referral to discipline, but only on the condition of the physician successfully undertaking a prescribed alternative.

PART VII: Improving the Efficiency and Cost Effectiveness of Review by HPARB

7. I recommend that HPARB make reviews to it from decisions of the ICRC in writing the rule, not the exception. The timelines for the filing of material and the consideration of the file by an HPARB panel should be prescribed, and should be made as short as reasonably possible. HPARB should, however, retain the power, in exceptional cases, to:

(a) extend timelines in the event a case is inordinately large or complex, or to relieve against hardship; and

(b) order an oral hearing, where there is good reason to do so.

8. Where HPARB applies the adequacy of investigation standard in the context of ICRC decisions arising from CPSO abbreviated investigations, I recommend that the review should be dismissed in the absence of compelling public policy justifications requiring further investigation.

9. Where HPARB applies the adequacy of investigation standard in the context of ICRC decisions arising from other CPSO investigations, I recommend that HPARB should assess the adequacy of an investigation being mindful of, *inter alia,* the nature of the interests at stake, the seriousness of the alleged misconduct (assuming misconduct was established), the evidence offered by the complainant to establish the complaint,

the public interest in having complaints resolved in a fashion proportionate to the interests at stake, and the reality that both the CMPA and the CPSO view the investigation as adequate.

PART VIII: Improving the Efficiency and Cost Effectiveness of the Discipline Hearing Process

10. I recommend that the physician be required to disclose the documents he or she intends to rely upon, will-say statements from fact witnesses to be called, and expert reports to be relied on. This obligation need not be concurrent with CPSO disclosure. However, it should be required at a reasonable point in time after CPSO disclosure in order to permit the physician to respond to it. To maximize the efficiency to be achieved, disclosure by the physician should precede any pre-hearing conference in the case. The Discipline Committee should, however, have discretion to admit previously undisclosed evidence on such terms as are just.

11. In order to make the PHC a more effective vehicle to resolve cases without the need for a hearing, I recommend that the following steps be taken:

(a) PHC chairs should be those members of the Discipline Committee who have the skills and disposition most likely to achieve an agreed upon resolution;

(b) Those PHC chairs should receive extensive independent training in the full range of mediation techniques, including meeting separately with the parties;

(c) To deal with those cases where a physician PHC chair is not required, or where a non-physician PHC chair might be more effective (for example, where credibility is the issue), non-physicians with advanced dispute resolution skills should be appointed to the Discipline Committee to be available as PHC chairs for these cases.

12. I recommend that several legally trained persons, experienced in running the hearings (such as retired judges) be appointed to the Discipline Committee as public members, so that in appropriate cases they can chair hearing panels. I agree with the CMPA that care must be taken to select the appropriate cases. For example, cases in which standard of practice issues are significant may not be appropriate. However, I have no doubt that there will be fully contested multiple day hearings or even single day hearings with limited issues where panel chairs with this experience will very likely be able to advance the efficiency of the hearing process itself without sacrificing fairness to the parties.

13. I recommend that the CPSO and the CMPA resume and complete their discussions seeking to develop a protocol of agreed upon best practices for various discipline hearing related matters as quickly as possible. I am confident that the parties that labour day to day in this environment have the detailed knowledge and experience to reach agreement on procedural rules that will add to the efficiency of discipline hearings.

14. To assist attaining this objective I recommend that these discussions include the following in the protocol:

(a) Where there are competing experts (as is frequently the case where standard of practice is an issue) the experts should be required to meet beforehand to discuss and refine the differences between them. They should then testify on the same panel;

(b) Presumptively evidence in-chief should be tendered in writing;

(c) Presumptively cross-examination should be subject to time limits as agreed to by counsel or as determined by the hearing panel;

(d) Presumptively witnesses should be able to testify by videoconference in lieu of personal attendance;

(e) Presumptively, where authenticity is not in dispute, contemporaneous documentary evidence should be admitted for all purposes; and

(f) Relief from these presumptive provisions should require a showing that without relief a material unfairness will result.

Conclusion

15. In summary, I have concluded that these recommendations, if implemented, will streamline the physician complaints process in Ontario, while maintaining a fair process for patients, physicians and the public.

16. The changes will, I think, benefit all participants: complainants, physicians, CPSO, CMPA and the Ministry of Health. To attempt to track the extent of those efficiencies and their cost effectiveness it would be desirable that on implementation,

the institutional participants the CPSO, the CMPA and the Ministry of Health engage in discussions to ensure they have in place tools to do that. These would undoubtedly include measures of the timeliness for the various stages of the physician complaints process, the costs to the participants of those stages and the outcomes.

17. At this point, precisely what a quantification of these measures will yield remains for the future. What can be said with confidence is that these recommendations will increase the efficiency cost effectiveness of the physician complaints process. They will permit decisions to be made in a more timely and less onerous way, and as a result, costs will be saved by the CPSO, the CMPA and the Ministry of Health. Just as important, the fairness of the process for all participants will be maintained.

18. In short in the public interest will be properly served.

Schedule A

O. Reg 856/93 made under the *Medicine Act, 1991*

1. (1) The following are acts of professional misconduct for the purposes of clause 51 (1) (c) of the Health Professions Procedural Code:

1. Contravening a term, condition or limitation on the member's certificate of registration.

2. Failing to maintain the standard of practice of the profession.

3. Abusing a patient verbally or physically.

4. Practising the profession while the member's ability is impaired.

4.1 Practising the profession while the member knows that he or she has deficient clinical ability, as defined in section 26 of Ontario Regulation 114/94 (General) made under the Act.

4.2 Practising the profession during the period after the member is notified by the College that he or she has deficient clinical ability, as defined in section 26 of Ontario Regulation 114/94 (General) made under the Act, and before the member is notified by the College that he or she no longer has deficient clinical ability.

5. Having a conflict of interest.

6. Prescribing, dispensing or selling drugs for an improper purpose.

7. Discontinuing professional services that are needed unless,

i. the patient requests the discontinuation,

ii. alternative services are arranged, or

iii. the patient is given a reasonable opportunity to arrange alternative services.

8. Failing to fulfil the terms of an agreement for professional services.

9. Performing a professional service for which consent is required by law without consent.

10. Giving information concerning the condition of a patient or any services rendered to a patient to a person other than the patient or his or her authorized representative except with the consent of the patient or his or her authorized representative or as required by law.

11. Sharing fees with a person who has referred a patient or receiving fees from any person to whom a member has referred a patient or requesting or accepting a rebate or commission for the referral of a patient.

12. Failing to reveal the exact nature of a secret remedy or treatment used by the member following a proper request to do so.

13. Making a misrepresentation respecting a remedy, treatment or device.

14. Making a claim respecting the utility of a remedy, treatment, device or procedure other than a claim which can be supported as reasonable professional opinion.

15. Using a name other than the member's name as set out in the register in the course of providing or offering to provide services within the scope of practice of the profession.

15.1 Without restricting the generality of paragraph 27, using a term, title or designation relating to a specialty or subspecialty of the profession in contravention of section 9 of Ontario Regulation 114/94 (General) made under the Act.

15.2 Without restricting the generality of paragraph 27, failing to include, in a clear and prominent manner and unabbreviated form, specialist or subspecialist information or the fact that the member is a general practitioner in any material that advertises, promotes or relates to the provision of any professional services by a member in contravention of section 9 of Ontario Regulation 114/94 (General) made under the Act.

16. Falsifying a record relating to the member's practice.

17. Failing without reasonable cause to provide a report or certificate relating to an examination or treatment performed by the member to the patient or his or her authorized representative within a reasonable time after the patient or his or her authorized representative has requested such a report or certificate.

18. Signing or issuing, in the member's professional capacity, a document that the member knows or ought to know is false or misleading.

19. Refusing to perform a medically necessary service unless all or part of the fee is paid before the service is performed.

20. Charging a fee for services not performed, but a member may charge for the cancellation of an appointment less than twenty–four hours before the appointment time or, in psychotherapy practice, in accordance with any reasonable written agreement with the patient.

21. Charging a fee that is excessive in relation to the services performed.

22. Charging a fee for a service that exceeds the fee set out in the then current schedule of fees published by the Ontario Medical Association without informing the patient, before the service is performed, of the excess amount that will be charged.

23. Charging a block or annual fee, which is a fee charged for services that are not insured services as defined in section 1 of the Health Insurance Act and is a set fee regardless of how many services are rendered to a patient.

23.1 Charging a fee for an undertaking not to charge for a service or class of services.

23.2 Charging a fee for an undertaking to be available to provide services to a patient.

24. Failing to itemize an account for professional services,

> **i. if requested to do so by the patient or the person or agency who is to pay, in whole or in part, for the services, or**
>
> **ii. if the account includes a commercial laboratory fee.**

25. Failing to issue a statement or receipt when requested by a patient or his or her authorized representative.

26. Selling or assigning any debt owed to the member for professional services, but a member may accept a credit card to pay for professional services and may make a general assignment of debts as collateral for a loan to finance his or her medical practice.

26.1 Pledging, mortgaging or in any other way encumbering or granting security in the member's interest in a medical record required to be kept under the Act.

27. Contravening the Act, the Regulated Health Professions Act, 1991 or the regulations under either of those Acts.

27.1 Without restricting the generality of paragraph 27, failing, by act or omission, to comply with any duty or requirement under Part XI (Inspection of Premises where Certain Procedures are Performed) of Ontario Regulation 114/94 (General) made under the Act.

28. Contravening a federal, provincial or territorial law, a municipal by-law or a by-law or rule of a public hospital if,

> **i. the purpose of the law, by-law or rule is to protect public health, or**
>
> **ii. the contravention is relevant to the member's suitability to practise.**

29. Permitting, counselling or assisting a person who is not a member of the College to perform acts which should be performed by a member.

30. Failing to respond appropriately or within a reasonable time to a written inquiry from the College.

31. Influencing a patient to change his or her will or other testamentary instrument in favour of a member.

32. Being subjected to the withdrawal or restriction of rights or privileges under the Narcotic Control Act (Canada) or the Food and Drugs Act (Canada) or the regulations under either of those Acts, unless by the member's own request.

33. An act or omission relevant to the practice of medicine that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional.

34. Conduct unbecoming a physician. O. Reg. 856/93, s. 1 (1); O. Reg. 857/93, s. 1 (1); O. Reg. 115/94, s. 1; O. Reg. 53/95, s. 1; O. Reg. 450/10, s. 1.

(2) Despite paragraph 10 of subsection (1), it is not professional misconduct for a member to give information about a patient, including access to the patient's records,

(a) to a practitioner of a health profession for the purpose of providing care to the patient; or

(b) to a person for the purpose of research or health administration or planning if the member reasonably believes that the person will take reasonable steps to protect the identity of the patient. O. Reg. 856/93, s. 1 (2).

(2.1) Paragraphs 23, 23.1 and 23.2 of subsection (1) do not apply in a case where a member charges a fee to a third party for a third party service under the Health Insurance Act. O. Reg. 857/93, s. 1 (2).

(3) A member shall be deemed to have committed an act of professional misconduct if the governing body of a health profession in a jurisdiction other than Ontario has made a finding of incompetence or professional misconduct or a similar finding against the member, and the finding is based on facts which would, in the opinion of the College, be grounds for a finding of incompetence as defined in section 52 of the Code or would be an act of professional misconduct as defined in subsection (1). O. Reg. 856/93, s. 1 (3).

(4) A member shall be deemed to have committed an act of professional misconduct if,

(a) the governing body of a health profession in a jurisdiction other than Ontario has provided records to the College evidencing that an allegation of professional misconduct or incompetence or a similar allegation has been made against the member and he or she has entered into an agreement or compromise with the governing body in order to settle the matter without a finding of misconduct or incompetence or a similar finding being made;

(b) the College is satisfied that the records are authentic, accurate and complete; and

(c) the act or omission that is the subject of the allegation would, in the opinion of the College, be an act of professional misconduct as defined in subsection (1), or would constitute incompetence as defined in section 52 of the Code. O. Reg. 856/93, s. 1 (4)