

The Ontario Physician Assistant Initiative

Roles and Responsibilities of Supervising Physicians

All Physician Assistants (PAs) participating in Ontario's Demonstration Projects must work under the direction and supervision of a registered physician. This document describes the role and responsibilities of physicians who provide supervision to PAs.

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Executive Summary

All PAs participating in Ontario PA demonstration projects will work under the direction and supervision of a registered physician.

The following are key concepts related to supervision of a Physician Assistant:

- A physician is responsible and accountable for the clinical work completed by a PA. Physicians should only assign work that the physician is competent to do him or herself and that the PA is competent to perform, that is appropriate to the practice setting and that is in the patients' best interests.
- PAs have varying competencies depending on their program of preparation and experience. Supervising physicians need to assess a PA's competencies prior to assigning tasks. A practice agreement¹ should be established to document the PA's competencies, the type of clinical work and methods of delegating that will be used in that practice setting.
- A PA is always under supervision of a physician who will provide direct or indirect supervision as they deem appropriate.
- All PA activity takes place within an established physician-patient relationship. The supervising physician is ultimately responsible for coordinating and managing the care of the patient.
- The assignment of clinical work to a PA must be in accordance with the regulatory framework in Ontario.
- When the clinical work assigned to a PA involves a controlled act², the process of delegation described in **The College of Physicians and Surgeons of Ontario's Policy on Delegation of Controlled Acts** must be followed. Physicians may use a direct order to authorize a PA to perform a specific controlled act for a specific patient when the patient is known to the physician. Physicians may also use a medical directive to authorize a PA to perform controlled acts under certain circumstances, and for a specified group of patients, in advance of the anticipated relationship between a patient and a physician.
- It is an ongoing responsibility of both the supervising physician and the PA to ensure that the clinical work assigned, the process for assigning or delegating work, and the supervision provided to the PA are appropriate. Communication, role clarity and mutual respect are essential for establishing

¹ A practice agreement details the types of clinical work that the PA can perform and how that work will be assigned and supervised. A practice agreement template is provided in the Toolkit on Delegation provided to demonstration project participants.

² Controlled Acts are specific acts or procedures that certain types of health professionals are authorized to provide under Ontario's *Regulated Health Professions Act (1991)*

and maintaining the unique working relationship between the physician and the PA.

In the Ontario PA Demonstration projects, one physician will be the **Primary Supervising Physician (PSP)** for each PA. The PSP will have clinical responsibilities that include orienting the PA, establishing the PA's competency and the role in that practice setting, developing the PA practice agreement and overseeing supervision of the PA by other physicians as appropriate. The PSP will also have administrative and project responsibilities, which will include overseeing PA scheduling to ensure adequate supervision, coordinating PA performance evaluation and participating in project evaluation.

Each PA may be supervised by multiple physicians in their clinical setting. Physician supervisors will liaise with the PSP regarding the clinical work of the PA, to ensure that they are aware of the practice agreement established in that clinical setting. Each physician is responsible for the clinical work they assign to the PA, and must follow the framework for supervision established by this project.

Each PA and PSP will be asked to sign a Supervisory Agreement indicating a mutual understanding of their relationship, roles and responsibilities. The employing organization should witness this Agreement. The organization may choose to have other physicians who supervise the PA sign the agreement to indicate their understanding of their role as supervisor.

Physicians who submit claims for their work through OHIP may submit a claim for the clinical work they have delegated to a PA only if the physician has participated actively in that work. If the PA provides the clinical activity without the active participation of the supervising physician, then the supervising physician is not able to bill for the activity.

1.0 Understanding the PA-Physician Relationship

A PA is a health care provider who “extends the hand” of a supervising physician in a variety of health care settings. PAs support physicians as the principle medical-decision maker. At all times, the supervising physician is responsible for the direction of the PA’s activities and holds overall responsibility for patient care.

The concepts of supervision and assignment of clinical work are fundamental to the PA-physician relationship.

Supervision

A PA requires ongoing supervision by a registered physician. The physician who assigns clinical work to a PA is responsible for ensuring adequate supervision while that work is being carried out. Supervision may be **direct** (i.e. visual observation of the PA when clinical work is being carried out) or **indirect** (i.e. direction and management of the clinical work of the PA without direct, visual observation). At all times, the supervising physician should be available to the PA, either in person, by phone or by electronic means.

The physician and the PA should determine the type of supervision (direct or indirect) that is required for the PA to effectively carry out the clinical work that has been assigned. This decision may be dependant on many factors, including:

- the characteristics of the patient being served
- the predictability and risk of the procedure or task that has been assigned
- the type of practice setting
- the clinical skills and experience of the PA
- the comfort level of the supervising physician, and
- the familiarity of the organization with the PA role

The supervising physician should then ensure that the agreed upon level of supervision is provided when the PA is performing the clinical work that has been assigned.

It should be noted that the type of supervision provided to a PA may vary over time. It is likely that much direct supervision may be required at the start of the PA-physician relationship due to the time needed to:

- establish a working relationship
- assess the competencies of the PA and establish the practice agreement in that setting
- establish medical directives
- adapt to and understand this new role in the Ontario health care context

Per the judgement of the supervising physician, the knowledge, skills and judgement of the PA, and pending the circumstances in a particular practice setting, the PA may perform clinical work with less direct supervision over time.

It is the responsibility of both the supervising physician and the PA to ensure that the type of clinical work assigned to the PA, the process used to assign clinical work, and the type of supervision provided while the work is being carried out is appropriate. Each PA and physician will establish a unique working relationship within the parameters of this supervisory framework. Communication, role clarity and mutual respect will be essential in establishing and maintaining this working relationship.

Assignment of Clinical Work

Clinical work that is normally within the supervising physician's scope of practice may be assigned to a PA. Whenever clinical work is assigned to a PA, the work remains the responsibility of the physician that assigned it. Prior to assigning clinical work physicians must consider the following:

- the best interest of the patient
- the competence of the PA to safely complete the task
- the amount of supervision the PA should have in completing the task, and how that supervision will be provided
- the organization's policies and procedures

Each PA and their supervising physician(s) will establish a practice agreement that documents the types of clinical work the PA will perform in that practice setting, how that work will be assigned and the type of supervision they will receive when performing that work. Clinical work assigned to PAs will vary, but will typically include things like:

- conducting patient interviews and taking medical histories
- performing physical examinations
- providing counselling on preventive health care
- performing certain controlled acts delegated by a physician
- performing other tasks within the supervising physician's scope of practice that the physician deems the PA qualified to complete.

Clinical work assigned to a PA may include acts that are controlled³ under the ***Regulated Health Professions Act (RHPA)*** in Ontario. While PAs are not independently authorized to perform controlled acts under the ***RHPA***, physicians

³ Controlled Acts are specific acts or procedures that certain types of health professionals are authorized to provide under Ontario's *Regulated Health Professions Act (1991)*

are⁴ and may choose to delegate the authority to perform these acts to a PA⁵. In order to do so, physicians must follow the process of delegation described in ***The College of Physicians and Surgeons of Ontario's Policy on Delegation of Controlled Acts***⁶.

CPSO's Policy allows for controlled acts to be delegated in one of two ways:

- **Through a direct order.** A direct order provides instructions from an individual physician to the PA (and/or others), relating to a specific patient. It takes place after the physician and patient have established a relationship. The order indicates a specific procedure or treatment to be delivered at a specific time for that patient. The direct order may be verbal (over the telephone or in person) or written.
- **Through a medical directive.** A medical directive is an advance instruction from a physician, or group of physicians, to the PA (and/or other providers). It pertains to any patient who meets the criteria set out in the medical directive. The medical directive contains the delegation and provides the authority for the PA to carry out the treatments, interventions or procedures that are specified in the directive, providing that certain conditions and circumstances exist. The directive can authorize the PA to act before the actual physician-patient relationship has been established. However, a relationship between the patient and physician must be established before the end of that encounter.

2.0 Role and Responsibilities of the Supervising Physician

A PA requires the direction and supervision of clinical work by a registered physician. Any physician who assigns and supervises the clinical work of a PA must:

- understand the PA-physician relationship, and
- be willing to work with the PA in a manner that supports the PA-physician relationship.

In some practice settings, a PA may receive supervision from multiple physicians. It may be that the best model for PA practice involves the PA working with multiple physicians during one shift, multiple physicians on various shifts, or multiple physicians over time. Some physicians may provide more

⁴ Physicians are authorized to perform 12 of the 13 controlled acts set out in the *Regulated Health Professions Act*

⁵ Under appropriate circumstances, physicians may delegate the controlled acts which they have authority to perform to other individuals, who may or may not be members of a regulated health profession

⁶ This policy is appended to this document.

supervision to the PA than others. However, no matter what the model of supervision in that clinical setting, each supervising physician is responsible for the clinical work that they assign to the PA.

Any physician who supervises a PA will:

- ensure that they assign clinical work and provide supervision to the PA in a manner that is consistent with the PA-Physician relationship and supervisory framework
- ensure that they assign clinical work and provide supervision to the PA in a manner that is consistent with the practice agreement established for the PA in that clinical setting
- provide feedback on the PA's clinical performance for purposes of competency evaluation, performance management and the development of authorizing mechanisms (e.g. medical directives)
- provide feedback and/or data on the PA role for project evaluation purposes
- stay informed about the Ontario PA Demonstration Projects

In order to fulfill these obligations, it is imperative that supervising physicians understand:

- the PA role, responsibilities and competencies
- the framework defining the relationship between the PA and the supervising physician
- the regulatory framework for delegation of controlled acts, including the CPSO's Policy on Delegation of Controlled Acts
- the specific competencies of the PA to whom they are assigning work, and the role established for that PA in that particular practice setting
- the OHIP billing rules as they relate to the supervision of a PA
- who to go to if they have questions or concerns about working with the PA

3.0 Role and Responsibilities of the Primary Supervising Physician

No matter how many physicians provide supervision to a PA within a practice setting, the Ontario Demonstration Project requires that one physician is identified as the Primary Supervising Physician for each PA.

The Primary Supervising Physician (PSP) is the physician that a PA is “assigned to” for the duration of the demonstration project. The PSP will oversee and coordinate the clinical and project activities of the PA, and ensure that another physician provides clinical supervision to the PA when the PSP is not able to do so. The PSP may or may not provide the majority of clinical supervision to the PA.

In addition to the responsibilities of any physician who assigns clinical work to a PA, the PSP will have additional clinical, administrative and project responsibilities.

Additional clinical responsibilities of the PSP include:

- receiving the PA at the start of the contract and ensuring that the PA is oriented to the clinical setting
- coordinating activities to help integrate the PA role into the existing clinical team (for example, a team meeting to introduce the PA and discuss roles)
- providing clinical supervision to the PA at the start of the PA's contract, and for the duration of the probationary period
- coordinating the development of the clinical practice agreement for the PA⁷
- coordinating the development and approval of authorizing mechanisms required for the PA to practice within the department (for example, medical directives)
- co-ordinating the clinical supervision of the PA by other physicians in the department as appropriate. This includes determining when the PA is ready to be supervised by other physicians, and ensuring that other physicians are aware of their responsibilities as a PA supervisor.
- providing ongoing supervision, oversight and coordination for the clinical activity of the PA for the duration of the contract

Additional administrative responsibilities of the PSP include:

- ensuring the PA has completed any orientation, training or skills development necessary for practice in that clinical setting
- overseeing the scheduling of the PA's clinical activities, ensuring that appropriate supervision for the PA is available during all scheduled work hours
- understanding the OHIP billing rules as they relate to supervision of a PA
- ensuring the PA is submitting project data as required
- co-ordinating evaluation of the PA's performance. This may include collecting input from other physicians and team members for purposes of competency evaluation, development of authorizing mechanisms, and performance management.

⁷ The practice agreement documents the types of clinical work the PA will perform in that practice setting, and the amount and type of supervision they will receive when performing that work. A toolkit on delegation will be provided to each PA demonstration site. This toolkit will contain information about establishing a practice agreement and creating other authorizing mechanisms for PA practice, including medical directives.

- acting as a resource for the PA and team should any clinical conflicts or questions arise
- facilitating decision making among supervising physicians regarding sharing of the stipend for PA supervision, and reporting this decision to the administrative lead who manages the stipend

Project Responsibilities of the PSP include:

- liaising with the site lead for the PA project to ensure that project requirements are being fulfilled
- participating in project meetings or information sessions to stay informed about the Ontario PA Demonstration project
- acting as the primary clinical contact for project evaluation. This may include collecting data and/or providing feedback to the project to support the evaluation of the PA role, and/or ensuring a process is in place to collect feedback or information from other physicians that supervise the PA.
- reporting of any problems or concerns to the site lead for the PA project as they arise
- signing the Supervisory Agreement to demonstrate agreement to act as the PSP
- appointing another physician to fulfill PSP obligations if the PSP will be absent or unavailable for a period of time, and ensuring that the alternate PSP also signs the Supervisory Agreement

4.0 The Supervisory Agreement

It is a project requirement that a Supervisory Agreement be established for each PA in Ontario's demonstration projects. A template agreement that will be useful in your practice setting will be provided by the project.

Signing of the Supervisory Agreement indicates that there is a common understanding of the supervisory relationship between physicians and the PA, and a mutual understanding of respective roles and responsibilities. Both the PA and the Primary Supervising Physician are required to sign the Supervisory Agreement.

The agreement should also be signed by an administrator from the employing organization to indicate their understanding of the relationship.

One way to ensure that all physicians who provide supervision to the PA have an understanding of their responsibilities is to have them sign the Supervisory Agreement. Organizations may choose to do this. However, it is not a project requirement to have physicians other than the Primary Supervising Physician sign the document.

Evidence of a signed supervisory agreement is required to begin the flow of the stipend to the PSP at the demonstration site.

5.0 OHIP Billing Rules for PA Practice

The Schedule of Benefits for Physician Services ("Schedule") defines the requirements when a delegated procedure may be claimed to OHIP by physicians who are compensated by fee-for-service.

The general rule is that physicians cannot bill for the work of Physician Assistants unless the circumstances requires the active participation of the physician in the clinical activity of the PA. Thus,

- if a supervising physician participates actively in the clinical activity of a Physician Assistant for a patient, then the physician may bill for that clinical activity for that patient
- if the clinical activity is provided without the active participation of the supervising physician, then the supervising physician would not be able to bill for the activity

In defining active participation, the rules state that "it would be inappropriate for the physician to submit a claim to OHIP for simply greeting the patient" -- a reasonable contribution to the clinical encounter is required. The rules specify that the physician must engage in the history, performance of any "necessary" (further) physical examination and communication of a diagnosis and/or treatment plan.

This does not mean that the physician must duplicate the service to bill for their role in review and oversight. In a circumstance where the PA has rendered a service, but the physician meets with the patient, the physician may bill a partial or complete assessment or consultation so long as they review the history, confirm findings on physical examination where appropriate, and confirm the diagnosis and/or treatment plan. This may be a fairly brief encounter depending on the nature of the service provided and the skills and experience of the PA. The fee code claimed should be consistent with the service performed by the physician.

Appendix A

Practical Guidelines for PA – Physician Practice

The following guidelines have been adapted from the *American Medical Association's Guidelines for PA-Physician Practice* (adopted by the AMA House of Delegates, June 1995) for the Ontario PA demonstration:

1. Health care services delivered by physicians and PA must be within the scope of the supervising physician's authorized practice.
2. The supervising physician is ultimately responsible for coordinating and managing the care of patients and, with the appropriate input of the PA, ensuring the quality of health care provided to patients.
3. The physician is responsible for supervising the PA (directly or indirectly) who performs health care tasks that he/she has assigned.
4. The role of the PA in the delivery of care should be defined through mutually agreed upon guidelines that are developed by the physician and the PA. These should be documented in a practice agreement in each setting.
5. The supervising physician must be available for consultation with the PA at all times either in person or through telecommunication systems or other means. Supervising physicians should provide direct and/or on-site supervision until the PA has demonstrated competency in all tasks that will be assigned or delegated.
6. The extent of the involvement by the PA in the assessment and implementation of treatment will depend on the complexity and acuity of the patient's condition, and the training, experience and preparation of the PA as adjudged by the physician.
7. Patients should be made clearly aware at all times whether they are being cared for by a physician or a PA.
8. The physician and PA together should review all assigned patient services on a regular basis, as well as the mutually agreed upon guidelines for practice relating to delegated acts.
9. The physician is responsible for clarifying and familiarizing the PA with his/her supervision style.

The primary supervising physician and the PA should clarify the roles and responsibilities of the various physician supervisors that the PA may have, as well as the administrative lead for the site. Clear expectations, lines of

responsibility and processes for resolving any potential conflicts should be established.

Appendix B

Questions and Answers on Supervision

Q1. How much, and what kind of, supervision is the supervising physician required to provide?

Physicians supervise all clinical activity assigned to the PA at all times, however, this supervision may be direct or indirect.

There are several models of supervision that may apply:

Direct supervision of the PA: This occurs when the PA and supervising physician work side by side in the same physical location. The physician can observe the PA while interacting with patients. This type of supervision will be *required* during the initial period of all PA employment to allow for the assessment of PA competencies and development of the PA role and responsibilities in that practice setting. In this circumstance, the physician will assign clinical work to the PA verbally and sign any related orders. All delegation of Controlled Acts will be within the physician-patient relationship (i.e. the patient is known to the physician) and should be done using direct orders (either verbal or written).

Mixed direct/ indirect supervision of the PA: This occurs when the PA and supervising physician usually, but not always, work side by side. Some patient care is provided with direct supervision as above, but the PA may also see patients without direct supervision from the physician. Through verbal or written orders, the PA would complete clinical work, and report back to the supervising physician with an assessment and plan for ongoing intervention as appropriate. The supervising physician would then provide further direction to the PA. The PA may also perform clinical work under an approved medical directive, wherein the PA can implement treatments, interventions or procedures for a patient without the physician's direct supervision. Under certain conditions, medical directives will allow the PA to see a patient before the patient is known to the physician, however, a supervising physician must establish a relationship with the patient before the patient encounter can be completed.

Indirect supervision of the PA: This occurs when the PA and the supervising physician do not work together in the same physical location. In this model, the supervising physician is always available to advise the PA as required. This may involve phone or electronic contact if physical supervision is not possible and requires that appropriate medical directives have been put in place. This allows the PA to initiate or provide treatment either within an established physician-

patient relationship or before the anticipated physician-patient relationship has been established. However, if the PA's work involves controlled acts before a physician-patient relationship has been established, the supervising physician must establish a relationship with the patient before the patient encounter can be completed.

The nature and frequency of supervision required by a PA will likely vary from the beginning of the demonstration project to the end of the demonstration project for each PA. And, depending on the PA role, there may or may not be a need to progress through the full continuum of supervision in each practice setting. For example, a PA working in an urgent care clinic will usually work along side the supervising physician, and assignment of clinical work or delegation through verbal orders would be sufficient. However, it may be more efficient for a PA working in a well baby clinic to initiate an assessment on routine cases before the physician sees the patient, and thus a medical directive would need to be in place to authorize the controlled portions of the assessment.

The supervisory requirements of the PA practicing in that setting should be considered when scheduling hours of work for the PA at that site, to ensure that an appropriate level of physician supervision is available at all times.

Q2. Can one physician supervise more than one PA?

The Ontario PA Demonstration project does not allow for a physician to be the Primary Supervising Physician for more than one PA. However, there may be circumstances where one physician works with (and thus supervises) more than one PA in a site that employs multiple PAs. This physician could be the Primary Supervising Physician for one PA, and could be a supervising physician for any number of the other PAs as appropriate. However, that physician cannot be the Primary Supervising Physician for more than one PA.

Q3. How does a supervising physician ensure that the PA's competency has been established and that proper processes for the delegation of Controlled Acts have been implemented?

The *CPSO's Policy on Delegation of Controlled Acts* requires that, among other things, physicians have ensured the competency of the person to whom they delegate. To ensure that proper processes for delegation have been followed, a Toolkit on Delegation has been established for the project. This toolkit will help sites, physicians and team members walk through the steps required to ensure that competency has been established and documented, and that appropriate authorizing processes are being used.

Q4. How should orders implemented by a PA be documented?

Supervising physicians and PAs will need to ensure that they are complying with CPSO guidelines and other legislative and organizational guidelines for documentation. More details on required documentation are available in the Toolkit on Delegation that will be provided by the Demonstration Project.

Typically, any order, requisition or prescription implemented by the PA under a direct order will require the physician's signature. Orders, requisitions or prescriptions implemented by the PA under a medical directive will not require the physician's signature, as the physician will have signed the directive.

In order to signify to those needing to act on an order or prescription that the PA has been properly authorized to implement that order, any order or prescription implemented by a PA pursuant to a medical directive should specifically identify:

- The medical directive (name and number)
- The PA responsible for implementing the directive (name, signature, designation and contact information)
- The name and contact information of the authorizing physician.

Appendix C

The College of Physicians and Surgeons of Ontario's Policy on Delegation of Controlled Acts

This section is provided for reference. It presents the CPSO Guidelines on Delegation as they appear on the CPSO web site.

Delegation of Controlled Acts

Policy #4-03

Approved by Council: September 1999

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Publication Date: March/April 2004

To be Reviewed by: November 2008

Key Words: Delegation, Controlled acts, Medical directives

Related Topics: Medical Directives

Legislative References: *Regulated Health Professions Act*, 1991, sections 27, 28, 29, 30, *Ambulance Act Regulations*, section 1

College Contact: Physician Advisory Service

Purpose

Under Ontario law, certain acts (more fully described below) may only be performed by certain health care professionals. However, under appropriate circumstances, these acts may be delegated to others. The purpose of this policy is to assist physicians to understand when and how they may delegate controlled acts. Since delegation sometimes takes place by way of a medical directive, the policy also offers guidelines for the use of medical directives.

Scope

This policy applies to all physicians, regardless of practice setting or type.

Controlled Acts

The *Regulated Health Professions Act*, which has governed the medical profession since 1993, sets out a number of "controlled acts" which may only be performed by certain of the regulated health professionals. Of the 13 controlled acts, physicians are entitled to perform 12 and may, in appropriate circumstances, delegate the performance of those acts to other individuals who may or may not be members of a regulated health profession.

The controlled acts set out in the *Regulated Health Professions Act* (RHPA) are:

1. Communicating to the individual or his or her personal representative a diagnosis identifying a disease or disorder as the cause of the symptoms of the individual in circumstances in which it is reasonably foreseeable that the individual or his or her personal representative will rely on the diagnosis.
2. Performing a procedure on tissue below the dermis, below the surface of a mucous membrane, in or below the surface of the cornea, or in or below the surfaces of the teeth, including the scaling of teeth.
3. Setting or casting a fracture of a bone or a dislocation of a joint.
4. Moving the joints of the spine beyond the individual's usual physiological range of motion using a fast, low amplitude thrust.
5. Administering a substance by injection or inhalation.
6. Putting an instrument, hand or finger,
 - i. beyond the external ear canal,
 - ii. beyond the point in the nasal passages where they normally narrow,
 - iii. beyond the larynx,
 - iv. beyond the opening of the urethra,
 - v. beyond the labia majora,
 - vi. beyond the anal verge,
 - vii. or into an artificial opening in the body.
7. Applying or ordering the application of a form of energy prescribed by the regulations under the RHPA.
8. Prescribing, dispensing, selling or compounding a drug as defined in clause 117(1) of the *Drug and Pharmacies Regulation Act*, or supervising the part of a pharmacy where such drugs are kept.
9. Prescribing or dispensing, for vision or eye problems, subnormal vision devices, contact lenses or eye glasses other than simple magnifiers.
10. Prescribing a hearing aid for a hearing impaired person.
11. Fitting or dispensing a dental prosthesis, orthodontic or periodontal appliance or device used inside the mouth to prevent the teeth from abnormal functioning.¹
12. Managing labour or conducting the delivery of a baby.
13. Allergy challenge testing of a kind in which a positive result of the test is a significant allergic response.

Emergency Situations

Although the *RHPA* prohibits performance of controlled acts by those not specifically authorized to perform them, it does not apply if the person performing the act is doing so to render first aid or temporary assistance in an emergency.² For example, if a passer-by sees someone in cardiac arrest in an airport and uses an automatic external defibrillator to assist him or her, there is no breach of the *RHPA*. Although applying a form of energy prescribed in the regulations is a controlled act under the *RHPA*, when it is done in an emergency it is not prohibited.

Principles of Delegation

The vision of the College is to ensure the best quality care for the people of Ontario by the doctors of Ontario. In order to most effectively meet patient needs, health care is often delivered by multidisciplinary teams. When controlled acts are delegated in appropriate circumstances, this process can result in more timely delivery of quality health care, and can make optimal use of health-care resources and personnel. In every instance of delegation, the primary consideration should be the best interests of the patient. Responsibility for the delegation of the controlled act always remains with the delegating physician.

Delegation may take place in one of two ways:

1. Direct Orders

The direct order provides instructions from an individual physician to another health care provider or a group of health care providers. The order relates to only one patient and initiates a specific intervention or treatment to be delivered at a specific time. It may be verbal³ (over the telephone or in person) or written.⁴ A direct order always takes place after a physician-patient relationship has been established.⁵

2. Medical Directives

Medical directives are blanket instructions by physicians (often more than one) to other health care providers. They pertain to any patient who meets the criteria set out in the medical directive. The medical directive contains the delegation and provides the authority to carry out the treatments, interventions or procedures that are specified in the directive, providing that certain conditions and circumstances exist.⁶ In most cases, medical directives are used to ensure that health care can be delivered without a physician's direct assessment of the patient or direct supervision. Their use is especially frequent in institutional settings.⁷

A medical directive must always be written and must comply with the principles set out in this policy. Guidelines about the use and development of medical directives are found in Appendix 1 to this policy. A prototype of a medical directive can be found at Appendix 2.

A more comprehensive guide and toolkit is posted on the Federation of Health Regulatory College of Ontario's (FHRCO) website at <http://www.medicaldirectives-delegation.com>. This guide was developed by a working group of FHRCO in 2006.

The toolkit provides templates for construction of Medical Directives, as well as explanations of how to establish the prerequisites. The templates will have the most direct application for large institutional settings, but anyone who wishes to establish a Directive (or to learn more about delegation) will find them helpful. Their use is not mandatory, but any physician who delegates a controlled act pursuant to a Medical Directive developed using these templates will be in compliance with the legislation and College policy and will be providing the very best quality of care to patients.

Guidelines for Delegation

1. Physician-Patient Relationship

The overriding principle of delegation is that it must **usually** occur in the context of a physician-patient relationship. In all instances where a controlled act is delegated, the act remains the responsibility of the physician who authorized it. In most cases, delegation will only occur after the physician has interviewed the patient, performed an assessment, made recommendations, obtained an informed consent to proceed, and instituted a course of therapy.

In some instances, the patient's interests will best be served by having the performance of the controlled act take place prior to assessment by the physician: in a hospital emergency room, for example, where it is commonplace for some tests to be ordered by a nurse before a physician has seen the patient. In such circumstances, the delegation may take place pursuant to a physician's direct order (where the physician has previously met the patient or engages in a consultation with the health care professional who will perform the delegated act) or a medical directive.⁸ When this happens, it is expected that a physician under whose authority the controlled act has been performed will meet and assess the patient as soon after it has been performed as possible.

The use of medical directives to authorize performance of a controlled act in advance of establishing a physician-patient relationship is intended to capture only those situations where it is in the patient's best interests to do so. It is not intended to capture situations where, for pecuniary or convenience reasons, a physician wishes to delegate a controlled act (for example, the delegation of Botox injections in the absence of a contemporaneous face to face assessment would not be endorsed by the College).

In very limited circumstances delegation may occur in the absence of a doctor-patient relationship. One example is the provision of care by paramedics under the direct control of base hospital physicians.⁹ Another example is in remote and isolated regions of the province where primary care is administered by registered nurses acting in expanded roles. Such programs have established protocols and quality assurance mechanisms that provide a proper basis upon which delegation may occur with good public protection even without a traditional physician-patient relationship.

2. Delegate only those acts that form part of your regular practice.

The RHPA requires the physician to confine medical practice to those areas of medicine in which he or she is suitably trained and experienced. A physician must not delegate the performance of an act he or she is not competent to perform personally, and which does not form part of his or her regular practice and daily competency.

3. Identify the individual performing the act and be aware of his or her skills.

i) Ensure the individual receiving the delegation has the appropriate knowledge, skill and judgement to perform the delegated act.

The physician should be satisfied that the individual to whom the act is being delegated has the appropriate knowledge, skill and judgement to perform the delegated act. A physician must not delegate an act where there is a question as to the knowledge, skill and judgement of the delegate.

The College recognizes that in some cases the physician may not personally know the individual to whom he or she is delegating. For example, in a public hospital setting, the hospital employs the delegates (nurses, respiratory technicians, etc.) and the medical staff are not involved in the hiring process. In this case, it is the institution's responsibility to ensure that its employees have the requisite knowledge, skill and judgement.

ii) Check with the relevant regulatory body of other health professionals where applicable.

Before delegating performance of any aspect of delivery of health care, the physician should first determine whether it is a controlled act. Where the individual to whom the act is being delegated is a member of a regulated health profession, the physician should ensure the delegation conforms to the regulations, policies and/or guidelines of that health profession. If it does not, the delegate will not be able to carry out the delegation. Where the physician knows that the delegate is not permitted to perform the controlled act, the physician must not delegate the act.

Because quality care is the primary concern physicians must not delegate the performance of a controlled act to a person whose certificate to practise any health profession is revoked or suspended by the governing body of his or her discipline at the time of the delegation.

Delegation of acts which are not controlled are not subject to concerns about regulations, policies and/or guidelines of other health professions. However, it would be inappropriate to delegate any act to a person whose certificate to practise has been revoked or suspended.

4. Establish a process for delegation, or ensure that there is one in place, that includes education, ensuring the maintenance of competence in the performance of the delegated act, and providing the appropriate supports.

i) The physician should satisfy him or herself that the delegation is in the best interests of the patient.

Patient care must not be compromised by the delegation.

ii) Identify the risk involved in delegating the act.

The physician must analyse the potential harm associated with the performance of the delegated act and be satisfied that delegating the act does not increase the risk to the patient. Some procedures in some circumstances carry such a high risk that only a physician should perform them. In such instances, the physician must not delegate.

iii) Quality assurance

If the particular act is routinely delegated (for example, in a hospital pursuant to a medical directive or in an office setting where staff roles include performance of medical acts), the physician must ensure there is ongoing monitoring and evaluation of the delegation. This would include ensuring the currency of the delegate's knowledge and skills and that there is an objective and regularly scheduled assessment of those skills. It would also include evaluating the delegation process itself to ensure that the process is safe and effective.¹⁰

iv) Ensure appropriate resources and equipment are available.

As part of the risk analysis undertaken to determine whether the act can be appropriately delegated, the physician will identify certain resources or equipment as necessary to reduce risk. The physician must ensure that such resources and equipment are available on site where the delegated procedure is being performed.

v) Develop written documentation about the delegation process.

The physician should ensure that there is appropriate documentation of all steps taken to meet the above guidelines. This documentation would be a key resource in answering any concerns or questions about the delegation process.

5. Ensure delegation occurs with the informed consent of the patient where feasible.

In instances where there is an established physician-patient relationship, physicians must ensure that patients provide informed consent¹¹ for performance of the act by a delegate, rather than the physician. In circumstances where the delegation takes place pursuant to a medical directive, the protocol for the directive must include obtaining the appropriate patient consent.

The patient's consent must be documented on the medical record.

6. Ensure proper supervision of the delegation.

It is important to remember that the accountability and responsibility for the act that has been delegated remain with the delegating physician. A physician delegating a controlled act must provide the appropriate level of supervision to ensure that the act is performed properly and safely. The nature of the supervision will vary according to the assessment of risk, taking into account the specific act being delegated, the circumstances under which the act will be performed and the qualifications and experience of the person performing it.

7. Consider any liability issues that may arise from delegation.

The physician might wish to be aware of whether or not the person to whom the controlled act is being delegated is appropriately covered by insurance or otherwise in a position to meet any liability which may arise from the performance of the delegated act. The Canadian Medical Protective Association can provide advice about a physician's own liability.

8. Consider any billing issues that may arise from delegation.

Physicians should be aware that the Schedule of Benefits of the Ontario Health Insurance Plan (OHIP) contains particular provisions as to the circumstances under which remuneration can be claimed from OHIP by physicians for the performance of acts that have been delegated to others. The Schedule of Benefits also indicates that applications for exceptions to these rules may be made upon the recommendation of the Ontario Medical Association (OMA) and the College. Physicians who bill OHIP and who are considering delegating performance of controlled acts to others should carefully review the provisions of the Schedule of Benefits. The OMA and the Provider Services Branch at OHIP are available to answer questions and give advice about such matters. Any request to have a procedure considered for exemption from the general requirements should be submitted directly to the Ministry of Health and Long-Term Care (MOHLTC). The College will respond to consultation requests from the MOHLTC only.

Exceptions for Programs Under Medical Officer of Health

In extremely limited circumstances, a controlled act may be delegated in the absence of a physician order and in the absence of the doctor-patient relationship. One example of such a circumstance is within programs operated under the authority of a Medical Officer of Health, such as influenza inoculation programs. In this example, the best interests of the patient is protected as long as the program operator adheres to the quality assurance protocols established by a Medical Officer of Health.

Appendix 1

Developing a Medical Directive

In many instances, medical directives are created by committees or groups of physicians who will ultimately sign and rely on the directive.¹² Whether the directive is developed personally by the physician who signs it and under whose authority it is used, or whether it is developed by hospital administration, any physician who signs a medical directive is ultimately responsible for a patient

who receives care pursuant to the medical directive. It is important to remember that the accountability and responsibility for the directive and for the delegation of any controlled acts it contains remain with the signing physician.

When developing the directive, consider each of the following issues and ensure that this consideration is reflected in the document:

1. Assess the risk.

- a. What is the procedure, treatment or intervention being ordered?
- b. How predictable are the outcomes?
- c. Does safe management of the possible outcomes require physician involvement or intervention?
- d. Are the appropriate resources available to intervene as required?
- e. Will delegation of the controlled act (if any) increase the risk to patients?

If the risk assessment results in the conclusion that patients' best interests would not be compromised by a medical directive, the following considerations should be taken into account.

2. Consider who should be involved in the development of a medical directive.

Although the directive is, strictly speaking, a physician's order, it has a significant impact on a number of other health care professionals who will be involved in the patient's care. Accordingly, the development of medical directives should be undertaken with a collaborative team approach. All of the health care professionals who may be affected by the medical directive should be involved in its development.

3. Determine the qualifications, skills or knowledge required to carry out the directive.

4. Ensure that the directive addresses the requirements of Consent to Medical Treatment.¹³

A medical directive cannot be implemented until the patient has provided informed consent (which may be in writing or verbal). In a medical directive, a physician proposes that a specific treatment (i.e., an x-ray) be performed for a range of patients who meet certain conditions. Instituting a medical directive raises the possibility that a physician may not be available to obtain the patient's informed consent to the proposed treatment. Under these circumstances, the physician is also assigning to another person the responsibility for obtaining the patient's informed consent for the proposed treatment, intervention or procedure. Obtaining informed consent includes the provision of information and the ability to answer questions about the material risks and benefits of the procedure, treatment or intervention proposed. If the individual who will be enacting the medical directive is unable to provide the information that a reasonable person would want to know in the circumstances, the implementation of the medical directive is inappropriate.

5. Consider who will sign the directive.

The overriding principle of delegation is that it must occur in the context of a physician-patient relationship. Accordingly, a physician who is ultimately responsible for the patient's care must sign the medical directive. At least one of the signatories to the medical directive must be available (on site or by phone) at the time it is implemented in case clarification or further intervention is required.

In some hospitals medical directives are created and approved by Committees and signed only by Chiefs of departments or divisions. In the College's view this arrangement is unlikely to meet the requirement that the physician signing the medical directive must have a physician-patient

relationship with the patient treated pursuant to the directive. Each physician responsible for the care of a patient who will receive the proposed treatment, intervention or procedure should sign the medical directive.

Medical directives must be updated each time there is a medical staff change within the department or division to which the directive applies.¹⁴

6. Ensure that the directive will be practically applicable and that a copy of it will be available to those implementing it.

For instance, in an emergency department of a hospital, unless all physicians in the department are signatories to the directive, it will be administratively difficult to institute. Hospital staff should not be expected to determine whether the physician on call is or is not a signatory to a particular medical directive. If administrative simplicity is not possible, it is likely that the risk of relying on the medical directive is too high to justify its use.

7. Consider the communication path that will enable the individual implementing a directive to identify the physician responsible for the care of the patient to be able to contact him or her immediately if necessary.

8. Consider what documentation will be required when the directive is implemented.

The patient's record should reflect what actions were taken and that the actions were pursuant to a medical directive. It may be appropriate to place a copy of the directive in the patient's chart.

9. Consider tracking/monitoring methods to identify when medical directives are being implemented inappropriately or are resulting in unanticipated outcomes.

Contents of Medical Directives

The following information must always be included in a medical directive:

1. The name and a description of the procedure, treatment or intervention being ordered;
2. An itemized and detailed list of the specific clinical conditions that the patient must meet before the directive can be implemented;
3. An itemized and detailed list of any situational circumstances that must exist before the directive can be implemented;
4. A comprehensive list of contraindications to implementation of the directive;
5. Identification of the individuals authorized to implement the directive;
6. The name and signature of the physician(s) authorizing and responsible for the directive and the date it becomes effective; and
7. A list of the administrative approvals that were provided to the directive. The dates and each Committee (if any) should be specifically listed.

A more comprehensive guide and toolkit is posted on the Federation of Health Regulatory College of Ontario's (FHRCO) website at <http://www.medicaldirectives-delegation.com>. This guide was developed by a working group of FHRCO in 2006.

Appendix 2 - Medical Directive Prototype

MEDICAL DIRECTIVE

Management of Possible Ectopic Pregnancy

Background: This section may contain a description of why the medical directive has been created and/or how it best serves the patients' interests.

Authorizing Physician(s): all individual names of ER physicians should be listed

To:

- Emergency Room Nurses
- Medical Radiation Technologists

Clinical Conditions Required:

- Female patients
- Childbearing years
- Amenorrhea
- Vaginal "spotting"
- Abdominal/pelvic pain

Situational Conditions Required:

- Consent

Contraindications: Patient's vital signs must be stable. If they are, the following apply.

- Draw haemoglobin, blood for possible grouping and matching. B-HCG;
- If vital signs are abnormal, hold patient until assessed by E.R. physician;
- If vital signs are normal, send patient to Diagnostic Imaging, accompanied by RHA, for ultrasound of pelvis.

Physician's Order:

- Complete blood count and differential.
- Serum B HCG.
- Pelvic ultrasound.

Approvals:

- Emergency Department Committee - July/03
- Medical Advisory Committee - July/03

Signatures:

- All ER physicians (ensure dated once signed).

1. This is the only controlled act that physicians are not authorized to perform.

2. *RHPA*, section 29(1)(a)
3. Verbal orders should be noted in the patient's chart by the recipient of the order and must be renewed or confirmed in accordance with the policy of the institution in which they are used.
4. The order may rely on a protocol established by the physician or institution that describes the steps to be taken in delivering treatment. A protocol is a generic set of instructions about a specific health care scenario. The protocol itself is generic, but it is only used for a patient when it is called for by a direct order.
5. Orders given to paramedics by designated base hospital physicians are an exception to this expectation.
6. Not all medical directives contain delegation of controlled acts. Depending on the circumstances, medical orders may be required for controlled acts within the domain of the health care professional receiving the delegation. In such situations, the medical directive contains the order to perform the controlled act, but does not delegate it.
7. While it is not impossible to use a medical directive in a non-institutional setting, the College expects this would rarely arise. A medical directive should be used only when it is in the patient's best interests to do so. It is a fundamental principle of the practice of medicine that the patient's interests must come first. Where a medical directive is created primarily in order to serve the physician's best interests, the College would consider it inappropriate whether or not it actually jeopardized the patient's wellbeing.
8. A medical directive is a prescription for a drug, treatment, procedure or intervention that may be performed for a range of patients when specific conditions and circumstances exist. See below for further details.
9. This exception to the general principal that a doctor-patient relationship is required is established by the Regulations to the *Ambulance Act*. That legislation defines the term paramedic and stipulates that paramedics must be authorized by the medical director of a base hospital program to perform controlled acts.
10. As with the requirement to identify the individual receiving the delegation, the College recognizes that in some cases, usually in hospital settings, the physician will not bear the responsibility for the quality assurance of staff. In these circumstances, the physician will meet the College's expectations if he or she satisfies him or herself that an appropriate quality assurance process is in place in the institution.
11. See [Consent to Medical Treatment](#) Policy for detail.
12. This is not always the case – the same principles apply to private practice settings.
13. See the [Consent to Medical Treatment](#) Policy.
14. Where it is impractical for a hospital to have all new staff and locums sign a copy of each medical directive, it is acceptable if these individuals receive copies of each directive and sign one statement indicating that they have read and agreed with them.
15. See the [Medical Records](#) Policy.
16. The individuals need not be named but may be described by qualification or position in the workplace.
16. The individuals need not be named but may be described by qualification or position in the workplace.