COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

POLICY STATEMENT #8-05

Confidentiality of Personal Health Information

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REFERENCE MATERIALS:	*A Medico-Legal Handbook for Canadian Physicians* (1997, Canadian Medical Protective Association); *Office Practice Guidelines for the Care of Adolescents* (1994, Canadian Paediatric Society)
COLLEGE CONTACT:	Physician Advisory Service

Confidentiality of Personal Health Information

PURPOSE

This policy is designed to help physicians understand their legal and professional obligations to maintain patient confidentiality. It is intended to provide a general overview of the confidentiality requirements set out under the *Personal Health Information Protection Act, 2004 (PHIPA)*[1] and to outline other professional obligations related to patient confidentiality and the practice of medicine. It is not meant to be construed as legal advice, nor does it address all matters pertaining to the confidentiality of patient information.

Given the complexities of the legal requirements, physicians are reminded that whenever there is uncertainty, they are advised to contact the Physician Advisory Service at the College, their legal counsel, the Canadian Medical Protective Association (CMPA)[2] or the Information and Privacy Commissioner of Ontario for further direction.

DEFINITIONS

The terms noted below will appear throughout this policy and have the following legal definitions under section 4 of *PHIPA*:

"**personal health information**," subject to certain exceptions,[3] means identifying information about an individual in oral or recorded form, if the information,

a) relates to the physical or mental health of the individual, including information that consists of the health history of the individual's family,

b) relates to the providing of health care to the individual, including the identification of a person as a provider of health care to the individual,

c) is a plan of service within the meaning of the *Long-Term Care Act, 1994* for the individual,

d) relates to payments or eligibility for health care in respect of the individual,

e) relates to the donation by the individual of any body part or bodily substance,

f) is the individual's health number, or

g) identifies an individual's substitute decision-maker.

"**identifying information**" means information that identifies an individual or for which it is reasonably foreseeable in the circumstances that it could be utilized, either alone or with other information, to identify an individual.

PRINCIPLES

1. Physicians must act in accordance with all of their professional and legal obligations.
2. To establish and preserve trust in the physician-patient relationship, patients must be confident that their personal health information will remain confidential.
3. Maintaining confidentiality is fundamental to providing the highest standard of patient care. Patients who understand that their information will remain confidential are more likely to provide the physician with complete and accurate health information, which in turn, leads to better treatment advice from the physician.

POLICY

The College expects physicians to follow the regulations under the *Medicine Act, 1991;*[4] and the rules under *PHIPA* when collecting, using or disclosing personal health information.[5]

While *PHIPA* establishes rules in relation to the "collection," "use" and "disclosure" of personal health information, this policy will focus only on those pertaining to the "disclosure" of such information.

Disclosure of personal health information

A physician can only disclose his or her patient's personal health information:

1 S.O. 2004, c. 3 Sched. A. In force as of November 1, 2004.

2 The majority of physicians in Ontario have liability coverage with the CMPA. Any physician with liability coverage from another provider is advised to contact that provider if uncertainty arises regarding the confidentiality of patient information.

3 Please refer to section 4 of *PHIPA*, which sets out the exceptions to "personal health information."

4 Refer to section heading 'Professional Misconduct' for direction.

5 In this policy, the provisions in *PHIPA* should be considered as they apply to physicians.

- when he or she has the patient's or substitute decision-maker's consent and it is necessary for a lawful purpose;
- where it is permitted under legislation, without the patient's or substitute decision-maker's consent; or
- where it is required by law.

Consent

Generally, physicians need **express** or **implied** consent before disclosing personal health information.[6]

Physicians, however, are entitled to assume that they have the patient's **implied** consent for the purposes of providing or assisting in providing health care, unless the physician disclosing the information is aware that the patient has expressly withheld or withdrawn consent.[7] This means that, without reason to believe otherwise, physicians can share information with others involved within the patient's circle of care[8] without asking for the patient's consent.

The patient's **express** consent is required for providing his or her personal health information outside of the circle of care, except where otherwise directed by statute.

"Lock boxes"

The term "lock box" applies to situations where the patient has expressly restricted his or her physician from disclosing specific personal health information to others — even to others involved in the patient's circle of care.

Where in the course of treatment, a physician is not able to disclose to another physician or health care provider all of the information reasonably necessary for providing care, the physician must notify the recipient of that fact. Physicians are advised to discuss with patients the potential health risks associated with creating a lock box. These discussions and the patient's decision should be well documented in the patient's medical record.

Alternatively, if the lock box creates a situation where the physician feels the patient's safety is at risk, the physician can refuse to provide treatment when it is not an emergency situation. The physician should explain the reasons for his or her decision not to treat the patient and note all relevant discussions in the patient's health record.

It is to be noted that patients may not prevent the physician from disclosing personal health information permitted or required by law.[9]

Permitted disclosure under *PHIPA*

PHIPA allows the disclosure of personal health information without patient consent under certain circumstances. Physicians, however, are not prohibited from seeking the patient's consent. For this reason, the College advises physicians that, whenever possible, they should make every reasonable effort to obtain the patient's consent before disclosing his or her information.

The following sections address a limited number of situations where disclosure of personal health information is permitted without consent under *PHIPA*.[10]

Disclosure for the provision of health care under exceptional circumstances

If the disclosure of personal health information is reasonably necessary for the provision of health care and it is not reasonably possible to obtain the patient's consent in a timely manner, a physician may disclose the relevant information, unless the patient has expressly instructed the physician otherwise.

For example, this type of disclosure allows the physician to perform necessary medical services during emergency situations.

Disclosure related to risks

A physician may disclose personal health information

6 Under *PHIPA*, whether explicit or implicit, consent must: (i) be that of the individual; (ii) be knowledgeable; (iii) relate to the information at issue; and (iv) not be obtained through deception or coercion. Where applicable, the substitute decision-maker or authorized representative may provide consent on behalf of the individual.

7 The patient is not able to withhold or withdraw his or her consent when the disclosure of personal health information is required by law (see section on 'Required Disclosure').

8 *PHIPA* does not define "circle of care," however, the term refers to those in the health care team who are involved in the care or treatment of a particular patient. For example, it describes health care practitioners, public or private hospitals, pharmacies, laboratories, ambulance services, community care access corporations. This definition of "circle of care" is supported by the: Ontario Hospital Association, Ontario Hospital eHealth Council, Ontario Medical Association, and the Office of the Information and Privacy Commissioner of Ontario.

9 This statement refers to the provisions in *PHIPA* where a physician is permitted or required to disclose personal health information without the patient's consent.

10 This list is not exhaustive. For a complete list of permissible disclosures of personal health information, please refer to sections 38 – 50 of *PHIPA*.

about an individual if the physician believes, on reasonable grounds, that the disclosure is necessary to eliminate or reduce a significant risk of serious bodily harm to a person or group of persons. The disclosure may be made to police, and in some instances, to the intended victim(s).

Physicians are expected to use their best judgment in these situations; however, physicians are advised to contact the College's Physician Advisory Service, their lawyer, the CMPA, or the Information and Privacy Commissioner of Ontario whenever they are uncertain whether the disclosure is appropriate. Physicians should also document all activities in the patient's medical record, and when appropriate, advise the patient of their decision to disclose the relevant information.

Disclosure for the purpose of regulating the medical profession

Disclosure of personal health information to the College is permitted for the purposes of administering and enforcing the *Regulated Health Professions Act, 1991 (RHPA)*. This includes disclosing personal health information for the purpose of carrying out the regulatory duties in the *RHPA* (i.e., Registrar's Investigations and Quality Assurance peer assessments).

Required disclosure

Physicians may be required by law, in a variety of circumstances, to disclose personal health information without the consent of the patient.

Mandatory reports

Certain statutes have reporting provisions that may require the physician to provide information about a patient. Examples of legislation requiring mandatory reports include the *Regulated Health Professions Act, 1991*; the *Highway Traffic Act*; the *Child and Family Services Act*; the *Health Protection and Promotion Act*; the *Aeronautics Act*; the *Coroners Act;* and the *Health Professions Procedural Code* (see College policy on Mandatory Reporting).

Monitoring of claims for payment

In circumstances where the Ministry of Health and Long-Term Care is monitoring or verifying claims for payment for health care, or for goods used for health care that are funded wholly or in part by the Ministry, the physician must provide the patient's personal health information to the Minister, upon his or her request.

Summonses, subpoenas and court orders

In the course of litigation, physicians may be required by a summons, subpoena or a court order to disclose a patient's personal health information and patient records. The physician should read the summons, subpoena or court order carefully and not do more than it requires. For example, a summons may require a physician to attend a court at a particular time and to take a specific patient chart. The summons does not authorize the physician to discuss the patient's care with, or show the record to, anyone in advance of the court appearance.

Reports under the *Workplace Safety and Insurance Act*

Under the *Workplace Safety and Insurance Act*, a physician who is providing health care to a worker claiming benefits under the workplace's insurance plan must promptly give the Workplace Safety and Insurance Board (WSIB) the relevant personal health information that the WSIB may require or that the patient requests that the physician provide to the WSIB. *PHIPA* permits the physician to report the required information to the WSIB and/or the employer, without the patient's consent.[11] If, however, the physician takes the position that the patient ought to be aware that his or her personal health information is being provided to the WSIB and/or the employer, the physician ought to notify his or her patient of that fact.

Professional expectations regarding disclosure

Physicians are expected to act in accordance with all legal requirements, but must also use their best judgment to practise medicine in a safe and humane manner.

[11] Under section 43(1)(h), *PHIPA*, whereby a physician can disclose personal health information where permitted or required by law.

Disclosure with respect to incapacity

When physicians have reasonable grounds to believe that another physician or health care professional is incapacitated,[12] the College expects physicians to behave ethically and in the public interest by taking appropriate action.

Appropriate action may include, depending on the circumstances, contacting the Physician Health Program at the Ontario Medical Association, the Registrar of the CPSO or other relevant regulatory college, or the individual's friends and family. Since this action will likely require physicians to disclose the individual's personal health information, physicians are advised to exercise caution and ensure that they uphold their obligations under *PHIPA*.

Where disclosures are necessary to reduce or eliminate a significant risk of serious bodily harm to a person or a group of persons, or for the provision of care, physicians may be able to disclose the individual's personal health information without contravening *PHIPA*. In addition, physicians may be permitted to disclose information to relatives or friends of the incapacitated individual in order to obtain consent for treatment.[13]

Physicians carry this ethical obligation to take action irrespective of whether there is a physician-patient relationship with the incapacitated physician or health care professional. Physicians may wish to contact their legal counsel or the CMPA for guidance in these situations.

Disclosure to a family member or friend

Situations may arise where physicians are asked by a family member or friend about the condition of a patient. Patients are permitted to restrict the disclosure of such information. For this reason, physicians will be required to obtain express consent from the patient before they are able to disclose the patient's personal health information. Where the patient is not capable to provide the required consent, physicians must seek consent from the patient's substitute decision-maker.

The College, however, recognizes that there may be situations where it will not be possible to obtain consent from the patient or the substitute decision-maker. In this situation, the College advises physicians to exercise caution and to use their best judgment when providing information. Discussions with friends and family ought to be limited to basic information about the patient's general state of health.

Other topics related to disclosure

Disclosure to custodial and/or access parents

There may be instances when a physician receives a request to disclose personal health information to a patient's parents or a third party where the parents have separated or divorced. If the child-patient has the capacity to provide consent, the physician must first seek the consent of the patient before any disclosure is made.

In dealing with requests from parents to disclose information to the parent or a third party, physicians should be aware that, under provincial legislation, there are different rights for the custodial parent and the non-custodial/access parent. The law, a court order or the terms of a separation agreement may prevent one of the parents from making decisions with respect to the personal health information about their child. Physicians are advised to act with sensitivity and request a copy of the applicable separation agreement or court order prior to releasing any information.

When releasing a child's medical record or disclosing the information in the record, physicians should exclude any reference or information pertaining to other family members and/or third parties. In addition, physicians are encouraged to keep copies of relevant agreements or court orders in the patient's medical record.

Disclosure to police

It is not mandatory for physicians to provide confidential material to the police in the absence of a legal

[12] 'Incapacitated' as defined in section 1(1) of the *Health Professions Procedural Code*, Schedule 2 of the *RHPA*, S.O. 1991, c. 18 means that the member is suffering from a physical or mental condition or disorder that makes it desirable in the interest of the public that the member no longer be permitted to practise or that the member's practice be restricted.

[13] Further details of these permitted disclosures can be obtained by consulting *PHIPA* directly.

obligation. At these times, the general rules regarding consent and disclosure apply, meaning that express consent, either from the patient directly, or the substitute decision-maker, will be required before the police are provided with personal health information.

When personal health information is disclosed to the police, physicians are encouraged to record the officer's name and badge number, the request for information, the information provided, and the authority for the disclosure (e.g., consent, reporting obligation, search warrant or summons). A photocopy of any search warrant or summons should be included in the patient's medical record. The police or Crown attorney will usually take the originals but leave the physician with copies of the record so that ongoing care can be given.

Proper information practices

Physicians have always been obligated to keep their patients' personal health information confidential, however, the introduction of *PHIPA* has also imposed a legal obligation on physicians to maintain and comply with information practices that, among other things, keep their patients' personal health information:

- accurate, current and complete; and
- protected against theft, loss or unauthorized use or disclosure.

If personal health information is stolen, lost or accessed by, or disclosed to an unauthorized person, patients must, subject to specific exceptions,[14] be notified at the first reasonable opportunity.

Conversations with, or about, patients in the health care setting

As a matter of practising medicine, physicians are required to ask many questions and/or discuss personal health matters with patients, other physicians/health care professionals and/or office/hospital staff. For this reason, it is essential that physicians and all staff take every precaution to ensure that conversations regarding patient information are not inadvertently overheard by others. Extra sensitivity is required by physicians and staff when discussing patient matters, either on the telephone or in person within hearing distance of others. For example, physicians should be cautious if discussing matters of personal health with patients in emergency room areas, or if a conversation is taking place with staff close to a reception area.

Technology

Technology has provided physicians and patients alike with a more efficient way of maintaining and communicating personal health information. There are, however, several ways in which a physician using modern technology may inadvertently breach patient confidentiality, for example: wireless network connections can pose security problems; e-mails can be inadvertently sent to the wrong recipient; inappropriate readers may access computer files; and erased hard drives may contain private information. The College encourages physicians to capitalize on the advantages that electronic record keeping and other technological advances have to offer, however, it is always the responsibility of the physician to ensure that appropriate security provisions have been made.

The College strongly advises that physicians obtain patient consent to use electronic means for communicating personal health information. As part of obtaining consent, physicians must explain to patients the inherent risks of using this form of communication. As a way of recording the patient's express consent, the CMPA has provided a written consent form that can be used whenever possible. Completed consent forms should be included in the patient's medical record.

Voice messaging

Physicians may sometimes wish to communicate with patients by telephone, and should confirm and obtain

[14] Exceptions include if the information is being held for research purposes as permitted under *PHIPA* or other prescribed exceptions under the *Act*.

consent to use this method of communication with patients.

On certain occasions, it may be necessary to leave a voice message on a machine or with a third party. Physicians should be aware that when leaving voice messages for patients, more than one person in a home or an office may access messages. For this reason, physicians are advised to exercise caution regarding the content of any messages left for patients. While it is acceptable for messages to contain the name and contact information of the physician or the physician's office, the College advises that messages should not contain any personal health information of the patient, such as details about the patient's medical condition, test results or other personal matters.

PROFESSIONAL MISCONDUCT

Under the regulations to the *Medicine Act, 1991*, it is an act of professional misconduct for a physician to:

> *"[give] 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."*[15]

[15] Ontario Regulation 856/93, as amended (made under the *Medicine Act, 1991*) s. 1(1) paragraph 10.

Virtues-Based Advice for Beginning Medical Students

John H. Coverdale, M.D., M.Ed., F.R.A.N.Z.C.P.

Objective: *The goals of this article are to present a framework, based on John Gregory's (1724–1773) concept of professionalism, for advising beginning medical students about what is important to training and to the practice of medicine.*

Method: *The author presents Gregory's concept of professionalism with an emphasis on the related virtues. Members of the editorial board of* Academic Psychiatry *were also surveyed for their advice for beginning students.*

Results: *There are four fundamental virtues that originated from Greogory's concept of professionalism: integrity, compassion, self-effacement, and self-sacrifice. Medical students should actively cultivate these virtues in order to promote excellence in every clinical encounter.*

Conclusions: *These four fundamental virtues together obligate medical students to learn and practice in accordance with the principles of evidence-based medicine and to protect and promote the interests of patients.*

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The first day of medical school is one of the most exciting in a medical career. It is both a celebration of earlier achievements and a new start with unimaginable adventures and fun ahead. What should beginning medical students know or be advised about how to approach the training ahead?

MEDLINE searching with terms such as "advice to medical students" or "convocation lecture" provided limited guidance (1, 2). I was aware, however, of a collection of thoughts for beginning medical students by Richard Smith, the immediate past editor of the British Medical Journal (3). Smith began with reference to D. W. Winnicott's concept of the "good enough mother" (4) to argue that students should appreciate that there is only one who is best, that we cannot all be the best, and that being good enough as a physician is a worthy goal. Students should accept their own limitations and liberally use the "three most important words": "I don't know." He also advised that students and physicians not conform to pressures to become a stereotypical doctor or to spend their lifetime becoming something they are not.

Smith had asked members of his own editorial board for advice about what to say. Because any advice I might give to students would be meager, I chose to adopt this method by writing to members of the editorial board of *Academic Psychiatry* for their advice. I asked, for example, what would they have wanted to know that they didn't know as a beginning medical student. I received an enthusiastic response that included some speeches, pearls of wisdom, favored articles (5–7), and a book recommendation (8).

One goal for this article, therefore, is to present a definition of professionalism with an emphasis on the concept of fiduciary and on the virtues that follow (9). This will serve as a framework for advising medical students about what is important to training in particular and to their future medical practice. A second goal is to convey the advice provided by members of the editorial board of *Academic Psychiatry* to beginning medical students. Their comments are separated from the main text and italicized as exampled by the three introductory comments below. As Smith

noted (3), giving advice to medical students makes all of us think about what is important in what we do.

"Your path, medicine's path, and the path of others in your life will be nothing like what you expect."

"Conceivably, you could become a cardiac surgeon, a medical center administrator, a devoted teacher, a textbook author, an international public health worker, or a private practicing dermatologist."

"You cannot know how lucky you are to be embarking on the greatest career possible, to be entrusted with life and death matters, and the most intimate details of the lives of patients you will care for."

Gregory's Professionalism

The road ahead, while certainly exciting, is also undeniably challenging. Medical school is unlike college in that students' responsibility shifts towards taking care of patients, and learning occurs with that purpose in mind. Some patients evoke powerful and distressing emotions—dealing with death and disability is uncomfortable at best—and we risk unintentionally harming patients that we intend to benefit. Resolve and emotional fortitude will be tested. Complex ethical decisions include how to address potential conflicts of interest concerning payments or gifts and concerning relationships to the health care industry (10, 11), and between physicians' own interests and needs and those of patients.

The concept of professionalism (Appendix 1) and the related professional virtues are central to the disciplined practice of medicine in the face of these pressures. This concept, which did not originate from the Hippocratic Oath, was "invented" (9, 12) by John Gregory (1724–1773). John Gregory is a less well-appreciated figure in the history of medicine who heavily influenced Thomas Percival (1740–1804), who in turn was a major contributor to the Code of Ethics of the American Medical Association of 1847 (12). I am indebted to my colleague, Dr. Laurence McCullough, for the following account (9, 12, 13).

Gregory practiced in 18th century Scotland at a time when there was great competition in the marketplace between physicians, no uniform pathway to becoming a physician, and an unlimited number of concepts of health and disease. Some physicians put on "good manners" in order to pry their way into the houses of the rich, and to take advantage of the trust and confidences of the sick. Some also became sexual predators of the sick. Gregory was concerned with both a lack of scientific competence and rampant self-interest; physicians were not trusted to put the interests of the sick ahead of their own (9, 12, 13).

Gregory appealed to Francis Bacon (1561–1626) in addressing the problem of competence by calling on medicine to be based on experience or on the rigorously collected results of natural and designed experiments. This concept of reliance on evidence, now called evidence-based medicine, constitutes the first component of the concept of fiduciary. Physicians who practice in accordance with these standards enable patients to trust physicians intellectually. Gregory warned us against obstinate adherence to unsuccessful methods of treating disease "to which species of pride, a pride incompatible with true dignity and elevation of mind, have the lives of thousands been sacrificed" (9). Consequently, and given the context of the editorial board member's comment below, medical students need to learn how to stay current with scientific advances, to question, even to learn to doubt (3), and how to find the best answers.

"By the time you graduate from medical school, the knowledge you have learned will be dated."

The second and third components of Gregory's professionalism direct the physicians' attention away from oneself to the needs and interests of the patient (12). When physicians focus on the needs of patients and not on their own self-interest, patients can trust physicians morally. The virtues, as we shall see, give form to these two components of fiduciary and together provide a starting point for the moral or ethical practice of medicine.

Cultivating the Virtues

As is shown in Appendix 2, there are four fundamental virtues originating from John Gregory's concept of professionalism, the most important of which is integrity. Integrity commits physicians to a lifelong pursuit of excellence in the care of patients. Compassion, which follows Gregory and Hume's account of sympathy (13), moves physicians to protect and promote the interests of patients through identification with their suffering. Self-effacement reduces the potential that differences between the physician and patient in social class, appearance, ethnicity, religion, and beliefs will adversely affect the physician-patient relationship. Percival (12), for example, argued that patients from lower socioeconomic classes (the public patients of today) should not be treated as inferior but should be regarded as (especially) worthy. Self-sacrifice concerns the routine willingness of physicians to make sac-

rifices in their own lives in order to advance the interests of patients.

"Harness the power inherent from your position into interventions that will serve the patients' needs."

Cultivating the virtues is an active and daily process that requires thoughtful self-reflection and keen appreciation of motivation as a first step towards self-correction. It starts with medical students and physicians as individuals but also applies to wider medical organizations, which, unlike corporations, have fiduciary obligations to patients. As indicated by an editorial board member below, we should thus appreciate this history, and also promote the fiduciary responsibilities of the medical organizations to which we belong.

"It is very moving to remember you are entering an ancient fraternity of healing and not joining a new corporation."

Implications of the Virtues for Medical Training

How do the virtues apply to the challenge of managing potential adversities in training and practice? First, integrity obligates students to try to maximize educational opportunities in order to be better prepared to treat prospective patients. In addition, students are responsible to bring their best efforts to every patient encounter. Concomitantly, integrity obligates teachers to inform about evidence-based practices and to role model respect for patients and other professionals.

Second, integrity obligates medical students and physicians to promote the work of our colleagues and peers. Much of medicine is practiced in teams and high performance learning teams almost always outperform the best individual in the team (14). Therefore, optimizing team processes, such as collegiality, communication, leadership, and competition, supports excellence in the clinical practice of medicine.

"Learn the importance of working with teams and to respect all disciplines."

"Take a look at the person next to you. By graduation he or she will be your dearest friend."

Third, self-effacement and self-sacrifice in particular prevent the possibility that clinical judgment will become unhinged by the sometimes powerful feelings evoked by patients. Feelings of frustration, foreboding for concern that patients will place themselves at undue risk by their behaviors, displeasure, discomfort, or even sexual feelings (15) can result in a loss of focus. These feelings should at first be acknowledged when present (16) and, as indicated by an editorial board member's comment below, mentorship is one response that prevents these feelings from distorting clinical judgment. Recognizing bias in judgments supports principled action with compassion (7).

"Seek mentorship. Mentors can prevent students from getting mired in day-to-day frustrations, and can provide history, context, and perspective."

Fourth, contributing to the advancement of knowledge provides one method for meeting our fiduciary obligations to patients. Learning to question and to develop and test hypotheses is integral to learning in medicine. Tremendous rewards follow from working a research question through to publication (17).

Fifth, the virtues blunt but do not eliminate self-interest. Physicians should ensure balance in their lives by appreciating that they have obligations not just to patients but to themselves, their families, and friends. Achieving an adequate balance is reinvigorating and promotes compassion.

"Take care of yourself; students should learn about making time for their families. Get enough sleep and do not drink in excess."

"At the end of the day it will be friendships, even more than the Kreb's Cycle, that will be remembered."

This focus on the virtues, as habits or traits of character (9, 12, 13), underscores the importance of personality in the practice of medicine.

"The most powerful tool you have is you."

How physicians care for patients in the level of personal support provided, and how they bear witness to patients' pain, could be as important as what physicians know (5). Patients, after all, may not remember what was done for them, nor what was said, but they do not forget how they were made to feel (18). Similarly, should physicians fail, it is less likely because of what they do not know, but more likely because of their personality, including their trustworthiness (19). Therefore, as formerly counseled (19), physicians should work conscientiously to improve their level of maturity and to cultivate the virtues.

Conclusions

As indicated below by the comments from the editorial board, there is reason for tremendous enthusiasm and optimism.

"Medicine will be completely different when you are in our shoes, except for the fundamentally wonderful awe-inspiring exchange between two people who are both changed by the encounter."

"The best part of being a doctor is the ability to listen to

what patients have to say, to understand it, and to offer relief through compassion, knowledge, and humanity."

As teachers, it is an honor and privilege indeed to play a small part in contributing to the education of medical students. We look to all students with enormous respect, hope and anticipation for the future. And, the more things change, the more they stay the same. Although knowledge and skill-based advances will allow for unforeseeable treatments in the future, the importance of every single interaction with patients will not be diminished. Cultivating the virtues, learning to listen to patients' stories, and appreciating the power of words and behavior in every encounter will endure as essential to the practice of medicine.

This article is based on the convocation lecture presented to the incoming medical students at Baylor College of Medicine on July 26, 2006. The author gratefully acknowledges the contributions of each of the members of Academic Psychiatry's editorial board of June 2006. The author also gratefully acknowledges the guidance of and contributions to this paper by Laurence McCullough, Ph.D.

Dr. Coverdale is Associate Editor of the Journal. Manuscripts that are authored by an Editor of Academic Psychiatry or a member of the Editorial Board undergo the same editorial review process applied to all manuscripts, including blinded peer review. Additionally, the Editor is recused from any editorial decision-making.

APPENDIX 1. John Gregory's Professionalism

1. Medicine should be based on the rigorously collected results of natural and designed experiments
2. Physicians should be primarily concerned with protecting and promoting the interests of the patient
3. Physicians should be concerned only secondarily with protecting their own interests

APPENDIX 2. The Four Fundamental Professional Virtues Originating From John Gregory's Concept of Professionalism

Integrity	The lifelong commitment to the practice of medicine in accord with the standards of intellectual and moral excellence
Compassion	The determination to promote patients' best interests, including relief of their pain and suffering through identification with their distress
Self-effacement	The putting aside of differences between physicians and patients that should not count as clinically relevant
Self-sacrifice	The routine willingness of physicians to take risks in their own lives in order to protect and promote the interests of patients

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COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

POLICY STATEMENT #1-12

Professional Responsibilities in Undergraduate Medical Education

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Professional Responsibilities in Undergraduate Medical Education

INTRODUCTION

The delivery of undergraduate medical education in Ontario has significantly evolved over time. Today education occurs in a variety of environments – teaching sites are not limited to traditional teaching hospitals but also extend to community settings such as community hospitals, interdisciplinary clinics, and physicians' private practices. Also, education relies on a team-based approach to care, involving the provision of comprehensive health services to patients by multiple health-care professionals. There are no longer exclusive domains of physician practice; rather, care is delivered through multidisciplinary teams. This collaborative, team-based approach promotes optimal health care for patients and learning opportunities for students.

As part of the training endeavour, medical students need to be given opportunities to observe and actively participate in clinical interactions in order to acquire the knowledge, skills, behaviours, attitudes and judgment required for future practice. This occurs through a process of graduated responsibility, whereby students are expected to assume increased responsibility as they acquire greater competence. For this to occur safely, supervisors must assess the competencies of the students they are supervising on an ongoing basis.

During the educational process, students will also gain an understanding of the values of the profession, as well as their individual duties to the patient, collective duties to the public, and duties to themselves and colleagues.[1] These are all essential components of medical professionalism. Students cultivate attitudes and behaviours about professionalism through observing their supervisors. Positive role-modeling is therefore of the utmost importance and supervisors are expected not only to demonstrate a model of compassionate and ethical care but also to interact with colleagues, patients, patients' families or their representatives, students, and other staff in a professional manner. This is consistent with the College's expectations of all physicians regardless of practice circumstances.

An understanding of the responsibilities and expectations placed on supervisors is essential for ensuring patient safety in this complex environment. Thus, while this policy focuses on professional responsibilities in the undergraduate environment, supervisors are expected to be familiar with other applicable College policies as well; these include, but are not limited to Delegation of Controlled Acts, Mandatory Reporting, Consent to Medical Treatment, Disclosure of Harm, and Medical Records.

Supervisors should also encourage medical students to become familiar with the above-named policies, this policy, as well as any applicable medical school policies, guidelines and statements relevant to undergraduate medical education.

PURPOSE

The purpose of this policy is to clarify the roles and responsibilities of most responsible physicians (MRPs) and supervisors of medical students, thereby optimizing the education of medical students and ensuring the safety and proper care of patients in educational settings. Ultimately, the goal is to ensure quality professionals and the best possible patient outcomes. This policy focuses on professional responsibilities related to the following aspects of undergraduate medical education:

1. Designation of Most Responsible Physician
2. Identification of Medical Students
3. Supervision and Education of Medical Students
4. Professional Relationships
5. Reporting Responsibilities
6. Patient Care in the Undergraduate Educational Environment

1. Supervisors should be aware of the MD program requirements set out in the "Standards for Accreditation of Medical Education Programs Leading to the M.D. Degree" prepared by the Liaison Committee on Medical Education, as well as university and hospital policies and procedures relating to professionalism, e.g., Codes of Conduct.

SCOPE

This policy applies to all physicians who supervise[2] undergraduate medical students for educational experiences that fall both within and outside of an Ontario undergraduate medical education program.

DEFINITIONS

Undergraduate medical students ("medical students") are students enrolled in an undergraduate medical education program in any jurisdiction. They are not members of the College of Physicians and Surgeons of Ontario.[3]

The **most responsible physician** ("MRP") is the physician who has final accountability for the medical care of the patient, whether or not a student is involved in the clinical encounter.

Supervisors are physicians who have taken on the responsibility to guide, observe, and assess the educational activities of medical students. The supervisor of a medical student involved in the care of a patient may or may not be the most responsible physician for that patient. Residents or fellows often serve in the role of supervisors but do not act as the most responsible physician for patient care.

PRINCIPLES

1. Safe, quality patient care must always take priority over the educational endeavour.
2. Proper education optimizes patient care, as well as the educational experience.
3. The autonomy and personal dignity of students and patients must be respected.
4. Allowing students to have insight into the decision-making process enables an optimal educational experience.
5. Professionalism, which includes demonstration of compassion, service, altruism, and trustworthiness, is essential in all interactions in the educational environment in order to provide the best quality care to patients.[4]

POLICY

1. Designation of Most Responsible Physician

As there are multiple health-care professionals involved in patient care, one physician must always be designated the most responsible physician for every patient to ensure continuity of care and appropriate monitoring. The MRP and/or the supervisor are responsible for ensuring that patients are given the name of the MRP, along with an explanation that the MRP is responsible for directing and managing their care.[5]

2. Identification of Medical Students

Medical students will be involved in observation and interaction with patients from the start of their undergraduate medical education. The supervisor and/or MRP are responsible for ensuring that the educational status of medical students and nature of their role are made clear to the patient, the patient's family, and members of the health-care team as early as possible during the educational process. Students must be introduced as medical students and it should be made clear to patients that they are not physicians. An explanation could be provided that the student is a member of the health/clinical care team and the experience forms an important part of their undergraduate medical education program. Where appropriate, medical students may introduce themselves to patients instead of relying on a supervisor and/or MRP to make a formal introduction.

2. Supervision may include, but is not limited to the guidance, teaching, observation, and assessment of undergraduate medical students.
3. Students are able to participate in the delivery of health care through a provision in the *Regulated Health Professions Act, 1991*, which permits them to carry out controlled acts "under the supervision or direction of a member of the profession," i.e., a clinical teacher or supervisor. Medical students are not independent practitioners or specialists. They are pursuing both program and individual objectives in a graded fashion under the supervision of the undergraduate medical education program. While some students hold "Affiliate Status" with the College, they are not licensed to practise medicine in Ontario, and are not members of the College.
4. For more information about professionalism and the key values of practice, please refer to The Practice Guide: Medical Professionalism and College Policies: http://www.cpso.on.ca/policies/guide/default.aspx?id=1696
5. The MRP is ultimately responsible for disclosure of harm to a patient or his or her substitute decision-maker, even if the harm is sustained as a result of an action or inaction on the part of the medical student.

Professional Responsibilities in Undergraduate Medical Education

3. Supervision and Education of Medical Students

The supervisor and/or MRP must provide appropriate supervision. This includes:

a) determining the medical student's willingness and competency or capacity to participate in the clinical care of patients, as a learning experience;

b) closely observing interactions between the medical student and the patient to assess:

i. the medical student's performance, capabilities and educational needs,

ii. whether the medical student has the requisite competence (knowledge, skill and judgment) to safely participate in a patient's care without compromising that care, and

iii. whether the medical student demonstrates the necessary competencies and expertise to interact with patients without the supervisor being present in the room;

c) meeting at appropriate intervals with the medical student to discuss their assessments;

d) ensuring that the medical student only engages in acts based on previously agreed-upon arrangements with the MRP;

e) reviewing, providing feedback and countersigning documentation by a medical student of a patient's history, physical examination, diagnosis, and progress notes as soon as possible;

f) managing and documenting patient care, regardless of the level of involvement of medical students; and

g) counter-signing all orders concerning investigation or treatment of a patient, written under the supervision or direction of a physician. Prescriptions, telephone or other transmitted orders may be transcribed by the medical student, but must be countersigned.

In addition, appropriate supervision and education requires clear communication between the MRP and supervisor in order to ensure the best possible care for the patient.

Supervision of Medical Students for Educational Experiences not Part of an Ontario Undergraduate Medical Education Program

Physicians are occasionally asked to supervise medical students who are either not on an approved rotation from an Ontario medical school[6] or are from another jurisdiction. In addition to fulfilling the obligations set out elsewhere in this policy, physicians who choose to supervise medical students for educational experiences not part of an Ontario undergraduate medical education program must also:

- be familiar with the Delegation of Controlled Acts policy;[7]
- obtain evidence that the student is enrolled in and in good standing at an undergraduate medical education program at an acceptable medical school;[8]
- ensure that the student has liability protection that provides coverage for the educational experience;
- ensure that the student has personal health coverage in Ontario;
- ensure that they have liability protection for that student to be in the office; and
- ensure that the student has up-to-date immunizations.[9]

In addition, physicians who do not have experience supervising medical students or are unable to fulfill the expectations outlined above should limit the activities of the med-

6. Ontario medical students sometimes seek rotations outside of their undergraduate medical education program for added educational experience.

7. The College's Delegation of Controlled Acts policy applies to any physician who supervises:

1) an Ontario medical student completing an extra rotation that is not part of their MD program, and

2) a student from outside Ontario completing an Ontario educational experience where the student will be performing controlled acts.

8. For the purposes of this policy, an "acceptable medical school" is a medical school that is accredited by the Committee on Accreditation of Canadian Medical Schools or by the Liaison Committee on Medical Education of the United States of America, or is listed in either the World Health Organization's Directory of Medical Schools: http://www.who.int/hrh/wdms/en/, or the Foundation of Advancement of International Medical Education and Research's (FAIMER's) International Medical Education Directory (IMED): https://imed.faimer.org/.

9. Please refer to the Council of Ontario Faculties of Medicine's Immunization policy which is available on the websites of the Ontario medical schools, for more information.

ical student to the observation of clinical care only. While it is laudable for physicians to assist students in acquiring the experience they need for future practice, patient safety must prevail in all situations.

4. Professional Relationships

Physicians must demonstrate professional behaviour in their interactions with each other, as well as with students, patients, other trainees, colleagues from other health professions, and support staff. Displaying appropriate behaviour and providing an ethical and compassionate model of patient care is particularly important for the MRP and supervisor, as students often gain knowledge and develop attitudes about professionalism through role modeling. MRPs and supervisors have a duty to lead by example and to translate into action those principles of professionalism taught to students during the undergraduate didactic curriculum.

The MRP and supervisor must be mindful of the power differential in their relationship with the student. Also, they should not allow any personal relationships to interfere with the student's education, supervision, or evaluation. Any relationship which pre-dates or develops during the educational phase between the MRP or supervisor and the medical student (e.g., family, clinical care, dating, business, friendship, etc.), must be disclosed to the appropriate responsible member of faculty (such as the department or division head or undergraduate program director). The appropriate faculty member would need to decide whether alternate arrangements for supervision and evaluation of the student are warranted and, if necessary, make these arrangements.[10]

Moreover, the undergraduate medical education environment should be safe, and free of harassment, discrimination and intimidation. Any form of behaviour that interferes with, or is likely to interfere with, quality health care delivery or quality medical education is considered "disruptive behaviour." This includes the use of inappropriate words, actions, or inactions that interfere with a physician's ability to function well with others.[11] Failure to display professional behaviour may also interfere with students' education. Physicians, in any setting, are expected to display professional behaviour at all times.

5. Reporting Responsibilities

Physicians involved in the education of medical students are expected to report to the medical school and, if applicable, to the health-care institution when a medical student exhibits behaviours that would suggest incompetence, incapacity, or abuse of a patient; or when the student fails to behave professionally and ethically in interactions with patients, supervisors or colleagues; or otherwise engages in inappropriate behaviour.[12]

Similarly, educational institutions should provide a safe, supportive environment that allows medical students to make a report if they believe their supervisor and/or the MRP exhibits any behaviours that would suggest incompetence, incapacity, or abuse of a patient; or when the supervisor and/or MRP fails to behave professionally and ethically in interactions with patients, supervisors or colleagues; or otherwise engages in inappropriate behaviour. The College expects that students will not face intimidation or academic penalties for reporting such behaviours.

6. Consent and the Educational Nature of the Undergraduate Environment

The MRP and/or supervisor are responsible for communicating to patients that patient care in teaching hospitals and other affiliated sites where education occurs relies on a team-based approach, i.e., care is provided by multiple health-care professionals, including students.[13]

10. Physicians should also be aware of university policies and procedures on these issues.

11. For more information, please refer to the College policy on Physician Behaviour in the Professional Environment, as well as the Guidebook for Managing Disruptive Physician Behaviour.

12. This obligation equally extends to physicians who supervise medical students from other jurisdictions. They are required to report these behaviours to the medical student's school.

13. Typically, a hospital would have signage notifying patients that it is a teaching institution. However, physicians in private offices and clinics need to explicitly communicate this information.

Professional Responsibilities in Undergraduate Medical Education

Student involvement in patient care will vary according to the student's stage in the undergraduate medical education program as well as their individual level of competency. Student-patient interaction may be limited to observation alone, while students who develop and demonstrate competencies may be actively involved in patient care, including performance of procedures. While patient consent[14] is necessary for treatment in any setting, there are circumstances unique to the undergraduate environment, which require additional consideration:

a) Significant Component of Procedure Performed Independently by Student:

In the rare situation where a significant component, or all, of a medical procedure is to be performed by a student and the MRP and/or supervisor is not physically present in the room, the patient must be made aware of this fact and, where possible, express consent must be obtained. Express consent is directly given, either orally or in writing.

b) Investigations and Procedures Performed Solely for Educational Purposes:

An investigation or procedure is defined as solely "educational" when it is unrelated to or unnecessary for patient care or treatment. An explanation of the educational purpose behind the proposed investigation or procedure must be provided to the patient and his or her express consent must be obtained. This must occur whether or not the patient will be conscious during the examination. If express consent cannot be obtained, e.g., the patient is unconscious, then the examination cannot be performed. The most responsible physician and/or supervisor should be confident that the proposed examination or clinical demonstration will not be detrimental to the patient, either physically or psychologically.[15]

14. 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. For more information, please refer to the College policy on Consent to Medical Treatment and also, the *Health Care Consent Act, 1996*, S.O. 1996, c. 2, Sched. A.

15. For more information, please refer to the joint policy statement "Pelvic Examinations by Medical Students" dated September 2010 prepared by the Society of Obstetricians and Gynaecologists of Canada (SOGC) Ethics Committee and the Association of Professors of Obstetrics and Gynaecology of Canada (APOG).

Faculty of Medicine /Affiliated Institutions
Guidelines for Ethics & Professionalism In
Healthcare Professional Clinical Training and Teaching

Preamble
All affiliated institutions of the University of Toronto have in their mission statements the facilitating of education of healthcare professional trainees. Students, at all levels of experience, encounter learning opportunities in a wide variety of clinical settings. It is the aim of the University and its teaching institutions to provide healthcare professional trainees and clinical faculty or supervising clinicians with a welcoming learning environment and strong positive role models for professional behaviour and professional practice. In doing so, the following guidelines for the conduct of clinical teaching in the clinical environments are suggested for use across the affiliated teaching institutions. Teaching is not only defined as 'specific acts' but includes all activities when someone in training is providing care to patients on a day-to-day basis.

Purpose
This document is intended to provide guidance for all healthcare professional trainees and the clinical faculty or supervising clinicians in determining their rights and responsibilities when participating in clinical education.

University healthcare professional trainees and clinical faculty or supervising clinicians participating in clinical teaching at designated affiliated teaching locations (e.g. hospitals and community settings) must adhere to the Regulated Health Professions Act (RHPA) and the Health Care Consent Act (HCCA), the policies and procedures outlined by the host institutions and the policies and procedures of the University. In addition, each trainee and clinical faculty or supervising clinicians should make use of any ethical guidelines provided by their professional college or organization.

The University, the Affiliated Teaching Institutions, the Clinical faculty or supervising clinicians and the Healthcare Professional Trainees Are Committed To Their Roles in:

A. Teaching and Learning and :

1. To the education and training of all healthcare professional trainees.
2. To excellence in patient care, teaching and research.
3. Agree that clinical teaching is an essential component in the development of healthcare professional trainees.
4. Agree to attempt to clearly, effectively and appropriately communicate to patients that the affiliated teaching institution(s) is a learning environment(s) and therefore healthcare professional trainees are concurrently involved in both patient care and learning.
5. Agree that it is the responsibility of the clinical faculty or supervising clinician to provide not only instruction in clinical reasoning and technical skills, but also to exemplify ethical behaviour and to act as a role model to trainees for ethical practice. This includes maintaining confidentiality and affording patient dignity and respect, being open to questions trainees may have pertaining to what constitutes ethical practice and a commitment to the highest standards of ethical conduct in teaching activities, including integrity and honesty.

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B. Supervision and Communication:

1. Agree that the information regarding the role and training of healthcare professionals is a vital part of the mission of the affiliated teaching institutions and that this fact should be shared with patients by means of appropriate signage and by communication with professional healthcare providers and/or administrative staff. Patient consent for care and exchange of information should be sought at the first appropriate opportunity.
2. Agree that patient's consent to treatment in a clinical teaching setting should be obtained as soon as appropriately possible after an explanation of this setting and discussion of the patient's concerns have taken place. Patients must be informed as to who is responsible for their care. The patient's right to refuse treatment under such circumstances must be respected.
3. Agree that the responsibility for the supervision of healthcare professional trainees lies with the clinical faculty or supervising clinician. Details of the responsibility and dispute resolution procedures are to be found in the documents specific for each clinical group. Relevant documents are appended to these guidelines.
4. Agree that the clinical faculty or supervising clinician is responsible for the ongoing evaluation of the healthcare professional trainee's competence in order to determine the degree of supervision that the healthcare professional trainee requires and the degree of delegation of controlled acts that the healthcare professional trainee is able to accept.
5. Agree that regular and appropriate exchange of information between a healthcare professional trainee and clinical faculty or supervising clinician is essential for the healthcare professional trainee's learning experience and for the optimum care of the patient.
6. Agree that healthcare professional trainees are required to document patient care information and interventions and are required to notify the clinical faculty or supervising clinician of his/her actions in a timely fashion.
7. Agree that the clinical faculty or supervising clinician is responsible for receiving healthcare professional trainee's communications on patient care activities, validating the trainee's findings in an appropriate fashion.

C. Informed Consent:

1. Agree that patient information is invaluable for the education of healthcare professional trainees.
2. Agree that healthcare professional trainees will have access to patient information and that patients will be informed that trainees have access to the patient's information.
3. Agree that patient consent should be obtained for participation in teaching activities that are purely educational in nature (e.g. teaching sessions with healthcare professional trainees, bringing patients into seminars, lectures, etc.) and that patients have the right to refuse to participate in such activities.
4. Agree that patients have the right to refuse the use of their information for educational conferences and seminars when the identity of the patient is provided.
5. Agree to ensure that the relevant faculties, programs, teaching institutions and the relevant governing bodies will define the profession-specific invasive procedures that require a patient's written consent prior to a healthcare professional trainee's participation in the defined invasive

procedure.

D. Protecting Patient Confidentiality:

1. Agree that clinical faculty or supervising clinicians and healthcare professional trainees are required to maintain the confidentiality of patient information including written, verbal and electronic information at all times.

E. Managing Ethical Concerns:

1. Agree that the expectation is that most ethical or difficult situations in the teaching institutions will be discussed in a collegial atmosphere that normally exists in healthcare professional interactions and be satisfactorily resolved at the teaching or clinical interface.
2. Agree that the clinical faculty or supervising clinician must provide the healthcare professional trainee with an opportunity to discuss an ethical or difficult situation and that all health care professional trainees and the clinical faculty or supervising clinicians will have access to alternative avenues to resolve misunderstandings and differences of opinion.
3. Agree that a healthcare professional trainee has the right to refuse to participate in patient care or clinical teaching if the trainee has ethical concerns about the activities, is concerned regarding their own competency, lack of knowledge, lack of understanding of the duties/ tasks/ responsibilities or believes there is a lack of explanation or supervision.
4. Agree that the clinical faculty or supervising clinician is responsible to accept the trainee's refusal to participate in patient care activities or clinical teaching, for ethical reasons.
5. Agree that in situations when a healthcare professional trainee expresses concern about ethical issues, refuses to participate in patient care activities or clinical teaching based on reasonable ethical grounds, or seeks consultation on an ethical issue, there will be no repercussions to the trainee.
6. Agree that healthcare professional trainees and clinical faculty or supervising clinicians have the right to consultation with a bioethicist, clinical ethics consultant or other individuals specifically trained in the management of ethical issues. Each institution should have policies and procedures to facilitate these consultations.
7. Agree that procedures will be implemented for healthcare professional trainees and clinical faculty/ supervising clinicians to report ethical concerns. These procedures may proceed through usual academic or hospital service routes for dispute resolution or through the institutional committee (described in E8).
8. Agree that each affiliated institution will identify a committee to receive unresolved ethical issues, adjudicate them as necessary and report to all parties involved. Committees will consist of an institutional bioethicist or his/her delegate, and institutional VP Education or his/her delegate and at least one other member.
9. Agree that information will be available to ensure that healthcare professional trainees and clinical faculty or supervising clinicians are aware of the procedures available to them to address ethical concerns and/or other issues by performing periodic audits of ethical issues brought forward for dispute resolution as in E8.