



THE CANADIAN
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Physician personal health information:

Supporting public safety and individual privacy



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PURPOSE

Over the past several years, the Canadian Medical Protective Association (CMPA) has witnessed increasing efforts by regulatory authorities (Colleges), hospitals and other organizations to collect and use physicians' personal health information. The rationale often offered for this effort is that it supports safer medical care. This paper addresses the individual privacy and public safety issues concerning the collection, use and safeguarding of physicians' personal health information. It provides recommendations for policy makers, regulatory authorities, hospitals, medical organizations and physicians. The aim of these recommendations is to achieve an appropriate balance between respecting physicians' right to privacy and safeguarding public safety.

Underpinning any examination of the key issues is the fundamental need to establish evidence-based criteria that guide the collection, use and safeguarding of physicians' personal health information. This paper reviews important evidence and recommends approaches which should guide the development and adoption of measures proportionate to the risks posed to safe medical care. It also identifies the requirement for fair processes and procedures to deal with the information that should reasonably be collected. It argues that these processes should aim to respect the individual privacy rights of physicians while, at the same time, take reasonable precautions to protect public safety. The CMPA believes achieving an appropriate balance between often competing imperatives requires a coherent framework which is based on evidence and a rational weighing of the risks.

While written to address the issues of particular relevance to physicians, the approach being advanced in this paper may also be valuable to other health care providers. Colleges, hospitals, regional health authorities and governments should also find the recommendations in this paper useful in developing and adopting evidence-based measures and policies which protect and respect the individual personal health information of physicians while continuing to safeguard public safety.

BACKGROUND

Regulatory authorities, hospitals and regional health authorities have an important responsibility to protect the safety of the public. This responsibility includes ensuring that the personal health status of physicians and other health care providers does not pose an undue risk to the patients they treat. This responsibility must be executed effectively if the public is to have confidence in the safety of the care they receive.

The CMPA recognizes that Colleges, hospitals and other institutions are mandated, under certain circumstances, to collect personal health information from physicians. The medical profession is self-regulated and Colleges in each province/territory fulfill the regulatory requirements of licensing physicians.

The CMPA also recognizes that, during their professional careers, physicians may be afflicted by a medical condition that could, if not effectively treated, negatively impact their ability to practise. Such conditions may or may not be acquired through a physician's professional practice and could take several forms. All individuals, physicians included, are at risk of diseases and physical ailments (e.g., epilepsy), of experiencing mental health conditions (e.g., depression) and of experiencing substance use disorders/dependencies, any of which, if not effectively treated could hinder their ability to practise. In addition, physicians may be exposed to occupational hazards (e.g., infectious diseases such as tuberculosis or being infected with a blood-borne pathogen).

Each medical condition necessarily requires different responses, based on the availability and effectiveness of treatment and the risk to patient care. As this paper will argue, there is no one approach that can universally address all conditions, however there are key principles that, when properly applied, can guide physicians, Colleges and others in effectively and fairly addressing these situations.

The extent to which Colleges collect personal information concerning the health of member physicians varies by jurisdiction. A number of Colleges rely on a physician's ethical duty to report medical conditions where appropriate and to take necessary precautions to mitigate the risk to patient safety. However, some Colleges and an increasing number of hospitals have, under the auspices of protecting the public, introduced requirements for physicians to disclose their personal health information when they apply for, or renew, their licence or hospital privileges.

The specific wording in the renewal questionnaires varies by jurisdiction. In some jurisdictions, the questions asked are general in nature and seek to determine if a physician suffers from a condition that could limit his or her ability to practise medicine safely. In other cases, it appears the questions may be tangential to an individual's specific practice of medicine and it is not clear how the collection of such information would improve the safety of health care delivery.

The potential negative impact on a physician's self-worth and livelihood is so significant that a systematic approach is required.

The following are some examples of the ongoing collection effort within the Canadian regulatory domain; similar examples exist within a hospital setting:

- Licence renewal forms that ask physicians whether they have suffered from or been treated for substance abuse.
- One specifically asks whether a physician has ever suffered or been treated for a physical or mental condition, disorder or addiction to alcohol or drugs.
- One licence renewal form asks whether a physician has had his or her blood tested for hepatitis B virus (HBV), hepatitis C virus (HCV) or Human Immunodeficiency Virus (HIV) since April 1, 2003.
- Another renewal form asks all physicians, regardless of their practice or the risk of transmission resulting from that practice, to disclose whether they have ever tested positive for a blood-borne illness (such as HBV, HCV or HIV).

The consequences to a physician of not answering mandatory questions on his or her annual licence or privileges renewal form can be significant. Failure to properly respond to the health questions on licence renewal forms may result in suspension of the physician's certificate of registration and can include referral to a discipline committee for professional misconduct. However, some forms currently neither indicate the implications of not disclosing, nor provide adequate information on how the information will be used or safeguarded. Without having a clear understanding of how this information may be used, there may be a tendency for physicians with medical conditions to under-report or fail to report, for fear the information provided may negatively impact their ability to practise.

SYSTEMS VIEW

As a general principle, the CMPA believes that physicians should not be required to pro forma disclose information in the absence of appropriate justification to Colleges, hospitals and other institutions concerning the status of their personal health. While recognizing the perceived benefit to the protection of patient safety, mandatory disclosure should not be used to trump individual privacy rights. The potential negative impact on a physician's self-worth and livelihood is so significant that a systematic approach is required.

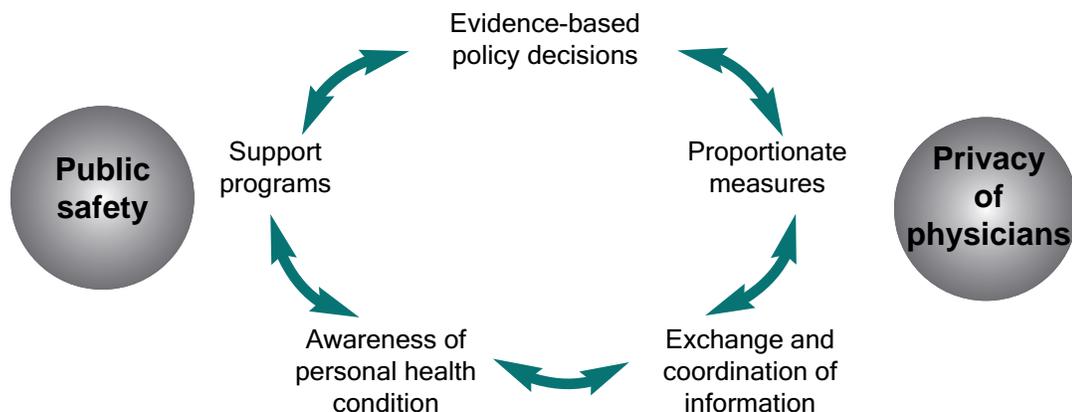
Mandatory disclosure and punitive approaches to identifying physicians' personal health issues are not likely to promote patient safety. They may actually serve as an impetus for physicians to hide their condition if they feel that the repercussions of reporting will affect their long-term professional career and personal livelihood. This result would hinder rather than support patient safety. A non-judgmental system which promotes self-reporting and encourages physicians to seek appropriate treatment would be a more beneficial alternative.

The CMPA supports a systematic approach in which policy makers, regulatory authorities, hospitals, health authorities, medical associations, and physicians recognize their respective obligations towards public safety and the personal privacy rights of physicians. In order to promote understanding of

this systematic approach, it is useful to illustrate the interdependencies and obligations of each contributor. When working in tandem, each element contributes to a balanced approach upon which the imperatives of public safety and a physician's right to personal privacy can be achieved.

System contributors: obligations and accountabilities

- *Policy makers:* advance evidence-based policy decisions in support of public safety and physician personal privacy.
- *Regulatory authorities:* implement proportionate measures to protect public safety and respect the personal privacy rights of physicians.
- *Hospitals and health authorities/regions:* coordinate the reasonable exchange of privileges information with regulatory authorities.



- *Medical professional associations:* establish or sustain physicians' support programs.
- *Physicians:* aware of personal health conditions.

Evidence-based approach

Achieving the balance between a contribution to safe health care and the rights of the individual (physicians and other health care providers) to privacy and confidentiality should underlie the approaches taken. The mandatory questions posed by regulatory authorities, hospitals and other institutions should reflect this balance. In determining a reasonable response to public safety imperatives, the risk of harm is a fundamental consideration. Whether regarding a physician's serologic status, addiction, mental health or other medical conditions, the CMPA understands the dilemma that these conditions present to those entrusted with protecting the safety of the public. These difficult decisions demand the greatest possible use of evidence-based criteria and an understanding of recent advances in the identification and treatment of various medical conditions.

The CMPA asserts that the perceived risk to patient safety posed by physicians with a medical condition does not justify the intrusive response of requiring all physicians to disclose the presence of a medical condition, the status of any addictions, or a positive serologic test. The effort associated with this widespread information collection might be more effective if applied to those situations where there may be a genuine risk to patient safety.

In examining the criteria to be used, authorities

should fully consider the progress made in treating various medical conditions and how effective treatment mitigates the risk to patient care. The following examples illustrate this progress:

- A study of Ontario physicians enrolled in a substance dependence program revealed that 85% successfully completed the program, indicating their likely suitability to fully practise in their specific area of medicine.¹
- Similar results were identified in a study of American physicians treated for substance abuse, with 78.7% of the participants in a substance abuse program retaining their licences five years after enrollment.²
- Improvements in anti-viral therapy have resulted in the majority of HBV and HIV infected patients undergoing therapy having plasma viral loads below the level of detection.³
- It is anticipated that the HCV infection can be cured in approximately 55% of patients with the current therapy, and this is expected to increase to 70% in the next few years.⁴

Studies also abound that highlight the increasing ability to address other medical diseases (e.g., diabetes, epilepsy), either through cure or through control of those conditions that might negatively impact a physician's ability to practise.

It is also important to recognize the advances made in the procedural responses to medical conditions that further mitigate the risk. For example, since guidelines for the prevention of transmission of blood-borne pathogens to patients were first created

¹ Brewster, J.M., Kaufman, M., Hutchison, S., MacWilliam, C. (2008). Characteristics and outcomes of doctors in a substance dependence monitoring programme in Canada: prospective descriptive study. *British Medical Journal*, 337:a2098.

² McLellan, A.T., Skipper, G.S., Campbell, M., DuPont, R.L. (2008). Five year outcomes in a cohort study of physicians treated for substance use disorders in the United States. *British Medical Journal*, 337:a2038.

³ Shafran, S.D., Angel, J.B., Coffin, C.S., Grant, D.R., Jaeschke, R. Wong, D.K. (2010). The physician with blood-borne viral infection: what are the risks to patients and what is an appropriate approach to physicians?

⁴ Ibid.

in 1991,⁵ the implementation of universal precautions has substantially reduced the risk of transmission from blood-borne pathogens to and from health care providers by reducing exposures to patient blood and body fluids.⁶

Recognizing the progress made in treatment and in order to gain a more fulsome understanding of the risks of transmission of blood-borne pathogens from health care providers to patients, the CMPA commissioned an independent expert panel⁷ to review the body of scientific research and to find a constructive, evidence-based approach to this issue. “The Physician with Blood-Borne Viral Infection: What are the Risks to Patients and What is an Appropriate Approach to the Physicians” is available via the CMPA’s website (www.cmpa-acpm.ca).

Among its 11 recommendations (these recommendations can be found in full in Appendix A of this paper), the expert panel reached the following conclusions:

- The policies governing physician screening for blood-borne pathogens and the management of infected physicians should be evidence-based.
- The available evidence does not support mandatory testing for blood-borne pathogens for physicians who do not perform exposure prone procedures.
- Current data does not support mandatory HIV testing of physicians who perform exposure prone procedures.

- Current data support mandatory HBV testing of physicians who perform exposure prone procedures.
- Current data are inconclusive to make a recommendation regarding mandatory HCV testing of physicians who perform exposure prone procedures.

The low risk of transmission of a blood-borne pathogen from an infected health provider to a patient⁸ does not warrant the *pro forma* disclosure of physicians’ personal health information to Colleges, hospitals and other institutions.

In determining a reasonable response to public safety imperatives, the risk of harm is a fundamental consideration. As demonstrated by the scientific review, patients are at a relatively low risk of harm from a physician infected with a blood-borne pathogen. Similarly, the prevailing view is that physicians being treated or having successfully completed treatment for a drug or alcohol addiction also pose a minimal risk to patient safety.

This suggests a review of the current criteria used to assess the practice suitability of a physician who suffers from a medical condition may be warranted. The criteria should reflect the evidence, and those empowered to establish the criteria and the associated thresholds should take into account the risks involved. In so doing, these authorities must weigh many considerations and the decision-making should include a dispassionate examination of the facts involved.

Patients are at a relatively low risk of harm from a physician infected with a blood-borne pathogen.

⁵ Centers for Disease Control and Prevention (1991). Recommendations for preventing transmission of human immunodeficiency virus and hepatitis B virus to patients during exposure-prone invasive procedures. *Morbidity and Mortality Weekly Report*, 40(RR08): 1–9.

⁶ Shafran et al., 2010.

⁷ The expert panel consisted of: Drs Stephen D. Shafran, Jonathan B. Angel, Carla S. Coffin, David R. Grant, Roman Jaeschke, and David K. Wong.

⁸ The Public Health Agency of Canada (PHAC) quotes mathematical models that put the chance of transmission of hepatitis B at between 24-2,400 transmissions per million procedures; of hepatitis C at 50-500 transmissions per million procedures; and of HIV at 2.4-24 transmissions per million procedures. Oswald, T. (2007). Healthcare workers infected with blood-borne illnesses in Canada. *Healthcare Quarterly*, 10(4), p. 65.

Balancing physician privacy with patient safety

All individuals have fundamental human rights, including the right to privacy, personal autonomy and access to treatment without discrimination – irrespective of their health condition. While no right is absolute, in appropriate conditions, any right may be infringed. The extent, however, to which a fundamental human right can be justifiably infringed upon depends on the specific circumstances, including the level of risk.⁹

According to the Canadian Human Rights Commission, “When considering the impact of an accommodation on health and safety, look at the extent of the risk and identify anyone who would bear that risk. However, balance this risk against the right of employees to participate fully in the workplace. The goal is not absolute safety, but reasonable safety.”¹⁰

Regardless of their personal health, physicians – like patients – have the right to privacy, irrespective of their medical condition. Privacy should only be violated if it is determined that the condition poses an unacceptable risk to patients. Making disclosure of personal health information a mandatory condition of licence application or renewal is a disproportionate measure which can have serious deleterious effects on a physician’s self-worth, career and livelihood. This is particularly true in circumstances where an absence of policies or procedures creates additional uncertainty in how to proceed.

Physicians’ expectations of privacy do not, however, absolve them of their responsibilities to consider the interests of their patients. Canadian physicians are ethically bound to be aware of their serologic status and to take appropriate steps where

necessary to decrease the risk of transmission to patients. Physicians have a moral duty not to subject their patients and other health care providers to undue risk of harm.

Building on physicians’ ethical obligations, some Colleges employ a self-reporting model that places the onus on physicians to identify conditions that may impair their ability to safely deliver care in their specific type of practice. To date, there is no evidence that indicates the current system of self-reporting is deficient in identifying physicians whose medical condition may negatively impact the quality or safety of care provided.

Certain questions asked on licence renewal forms and applications do not appear to be limited to conditions or health issues that may affect patient safety. For example, questions on licence renewal forms that ask applicants to disclose if they have ever had any alcohol or drug “problems,” regardless of whether or when this may have been diagnosed or treated, do not advance patient safety. The CMPA believes that questions of this nature should only be directed to those physicians who have been diagnosed with a drug or alcohol problem and who have indicated they are not yet responding to treatment or have voluntarily ceased treatment. Such questions may also be relevant for those suffering from chronic, relapsing conditions.

Accordingly, rather than imposing a “one size fits all” mandatory reporting system that is likely to be viewed as threatening to both physicians with medical conditions and the great majority without, there are steps that Colleges can take to encourage physicians to fulfill their ethical obligations, adopt preventive measures, and to self-report in cases where patient safety may be at risk.

⁹ Canadian Medical Association (2010). *Blood-borne pathogens in the health care workplace*. Ottawa, ON, p. 2.

¹⁰ Canadian Human Rights Commission (2005). Preventing discrimination. Retrieved from: http://www.chrcccdp.ca/preventing_discrimination/page3-en.asp?lang=en&url=%2Fpreventing_discrimination%2Fpage3en.asp

Supporting patient safety

The CMPA is fully supportive of efforts to improve patient safety and devotes considerable resources to this objective. Occasionally, however, the mantra of “patient safety” may sometimes be inappropriately used to violate the privacy requirements of physicians. Authorities should only collect information essential for the protection of patient safety and relevant to the specific area of medicine. For example, questions concerning blood-borne pathogens should be limited to those practitioners who are deemed to be at an increased risk of transmission. There is no need for, or benefit to, questions about the serologic status of physicians who do not perform high-risk or exposure-prone procedures. At this time, it is not clear how mandatory reporting would promote patient safety. In fact, it may well encourage physicians and other health care providers to under-report their medical condition, thereby increasing the risk to the safety of care. There is evidence to suggest that fears about the loss of privacy are a factor in physicians’ decisions to delay seeking appropriate treatment, particularly for mental health issues.¹¹

The same concerns apply to the adoption of “zero risk” thresholds that have significant consequences for physicians. Such an approach may lead a medically afflicted physician to hide a condition for fear of losing his or her ability to practise or having that practice restricted. Rather than promoting

patient safety, it is likely to have the opposite effect. A proportionate approach to risk, as determined by the available evidence, is more likely to encourage physicians to seek treatment, to report their condition and to enter into physician health programs providing a wide range of services (such as case management and monitoring) that support their full or partial re-integration into practice. This approach also respects the interests of physicians, patients and, by returning critically short resources to the health care system, all Canadians.

Personal health information: collection, safeguarding and use

Collection of information

As noted earlier, the current policies of some Colleges, hospitals and institutions appear to be based on the *pro forma* disclosure of physicians’ personal health information, rather than on evidence-based criteria that assess the risks involved. This “one size fits all” approach is unnecessary, unfair to those involved and unlikely to be effective. While *pro forma* disclosure may be a simple measure, it is an inappropriate and ineffective means of achieving the common goal of protecting the public.

Authorities should place a greater emphasis on the identification of the information that is required and of the circumstances under which collection would be appropriate. This identification should be based on an examination of the evidence and a coherent risk assessment. Simply put, physicians’ personal health information should not be collected until the following questions have been fully answered: “why is this information needed?”, “how will it be protected from inappropriate use?” and “how will it be used to advance patient safety?”

Strong safeguards for the protection of physicians’ personal health information should be in place before collection takes place.

¹¹ Schwenk, T.L., Gorenflo, D.W., Leja, L.M. (2008). A survey on the impact of being depressed on the professional status and mental health care of physicians. *Journal of Clinical Psychiatry*; 69(4):617-620.

Safeguarding information

Having determined that certain elements of personal health information are required, the collecting organization has a responsibility to ensure it is effectively safeguarded, be it from inappropriate use or inadvertent release. Any personal health information collected needs to be treated with the utmost sensitivity and confidentiality.

Before authorities collect physicians' personal health information, reasonable procedures and processes must be in place to address privacy concerns. If not already in place, privacy policies and procedures should be established to ensure the confidential collection, use and safeguarding of all personal health information, and these procedures must be followed. Notwithstanding the evidence, physicians with blood-borne pathogens, addictions or other medical conditions may be susceptible to suffering stigma from peers and prejudice and discrimination from patients in the event that their health status is disclosed. Any information collected regarding a physician's personal health should never be publicly disclosed under any circumstances. Although it may be appropriate in certain circumstances to disclose information to patients who have been exposed to blood-borne pathogens following a clinical incident, the focus should be on testing and treating the exposed patient. It is generally unnecessary and of no tangible benefit to publicly identify the infected health care provider.

Strong safeguards for the protection of physicians' personal health information should be in place before collection takes place. It is inadequate to consider information protection after collection has begun and information has been gathered; this after-the-fact approach is fraught with risk. It appears, in certain organizations, collection may be taking place without those fundamental protections being in place.

Use of personal health information

As described previously, the authorities seeking to collect physicians' personal health information should fully understand its intended use before they begin collecting this information. If there are no justifiable uses, then collection should not occur.

There are circumstances where a physician's medical condition may well create a potential risk to the safety of his or her patients. The expert panel's report authored by Shafran et al. identifies some of these circumstances within a blood-borne pathogen context. There are similar studies that examine the impact of various medical conditions on a physician's ability to practise his or her specific type of medicine. In such instances, properly executed information collection and management is appropriate. The onus then falls on the respective authorities to ensure the information is used appropriately, respecting procedural fairness and privacy requirements.

A decision regarding the collection of personal health information should, wherever possible, use evidence-based criteria to decide what impact, if any, a physician's medical condition should have on his or her practice. The consequences of a decision to restrict or limit a practice on both the physician and his or her patients demand the application of carefully considered objective criteria.

For example, and within the context of blood-borne pathogens, the CMPA recommends and has encouraged Colleges to consider adopting a blind procedure whereby an expert panel would anonymously review the physician's health condition and practice standards. The expert panel would recommend practice requirements and periodic assessments based on the level of risk determined by the latest peer-reviewed scientific evidence. The member's identity would not be known to the panel,

thereby protecting the privacy of the physician. In the realm of mental health and addiction, such expert panels may best reside in physician health programs who would only release identifiable information to the College in accordance with pre-established protocols.

It is important that any process that is implemented offers the physician an opportunity to participate in the process, in a manner that first and foremost respects and maintains his or her privacy. Confidentiality concerns need not come at the expense of procedural fairness.

The chosen process must respect the sensitivity of the subject matter. A medically afflicted physician may suffer stigma not only from his or her peers, but possible prejudice and discrimination from patients in the event that his or her health status is disclosed. A physician not only must deal with the difficult reality and the physical impact of the illness, but also the stress of disclosing this information to family, friends and colleagues. Not surprisingly, most physicians in this circumstance are deeply concerned with confidentiality and the potential negative impact that disclosure will have on their future career and their ability to be licensed in their province or in any other Canadian jurisdiction.

It is instructive to consider the systems adopted by other regulatory authorities and professional organizations for assessing a physician's practice when that practice may be impacted by a medical

condition. Many entail the creation of a specially-appointed panel to anonymously and objectively review the physician's health condition and practice standards, as they might be appropriate to that condition. The member's identity is not known to the panel, thereby protecting his or her privacy. The information is funneled through an administrator who is one of few people with the ability to identify the member.

The College of Dental Surgeons of British Columbia, for example, adopted a similar process as part of its commitment to work closely with its serologically infected members on a case-by-case basis to ensure appropriate practice standards are maintained while allowing the member to continue practising without restrictions, where appropriate. Other regulators in Canada have adopted or are considering adopting variations of this system for assessing physicians who suffer from a medical condition that may impact their ability to practise in their specified area of medicine.

Within the context of seropositive health professionals, regulators and medical boards outside of Canada have also commented on the issue. For example, the American College of Surgeons encourages its members to know their serologic status. Seropositive physicians are advised to seek treatment and to consult with a physician. The Society for Health Care Epidemiologists of America states that infected health care providers should not be "excluded from any aspect of patient care unless epidemiologically incriminated in transmission despite precautions."¹² Authorities in the United Kingdom and Australia take similar approaches with determinations of a medically afflicted physician's ability to perform certain procedures made by an independent expert panel.

A medically afflicted physician may suffer stigma not only from his or her peers but possible prejudice and discrimination from patients in the event that his or her health status is disclosed.

¹² AIDS/TB Committee of the Society for Healthcare Epidemiology of America (1997). Management of healthcare workers infected with hepatitis B virus, hepatitis C virus, human immunodeficiency virus, or other bloodborne pathogens. *Infection Control and Hospital Epidemiology*, 18(5):349–363.

Optimizing system management

As noted above, there are many considerations associated with the effective and fair management of physicians with medical conditions. This not only includes determining what information should be appropriately collected, but also completing the collection, making decisions using evidence-based criteria, and monitoring the implementation of those decisions. All of these actions must take place while the highly sensitive information is appropriately safeguarded and the privacy of the individuals involved is respected. This is a potentially onerous task and one that is subject to system failure at several junctures. The risks associated with such failure, including the devastating impacts on the individuals involved, demand that attention be applied to minimizing those situations where information is inappropriately collected, incorrect decisions are made and information protections are ineffective.

Colleges are experienced in dealing with sensitive information concerning their physician members and, in every jurisdiction, they have generally transparent and publicly accountable processes through which to render decisions regarding a physician's professional conduct and competence. Accordingly, while additional processes, procedures and safeguards are required to deal with physician personal health information, the Colleges are relatively well positioned to undertake their mandated role in assessing the practice competence of physicians with medical conditions that may impair their ability to deliver care in their specific area of medicine. Colleges are also well positioned to adopt a constructive approach to returning physicians to full practice, when possible.

However, the same infrastructure, processes and procedures are much less evident at the hospital level in Canada. This is particularly true for smaller

institutions that may, due to resource constraints, be unable to implement the necessary information firewalls and blind procedures to make well informed decisions regarding physicians' medical conditions and the impact on their practice. Accordingly, the risks of system failure, be it inappropriate decisions concerning a physician's practice or the inadvertent release of highly sensitive personal information, may rise exponentially within a hospital setting. Given the role of Colleges in regulating the medical profession, the collection and use of physicians' personal health information by hospitals and others institutions represents an unnecessary and potentially harmful duplication of effort.

In view of this situation, there would be considerable merit in more clearly delineating the responsibilities related to physicians with medical conditions that may impair their ability to practise. Such a delineation should mirror the responsibilities related to a physician's professional competence and might logically comprise the following:

- Colleges undertake all responsibility for the collection, use and safeguarding of information related to physicians whose medical conditions might reasonably be expected to impair their ability to practise.
- In those instances where restrictions on a physician's practice are justified by the evidence, Colleges should identify those restrictions and communicate these to both the physician and the institutions in which the physician has privileges.
- Hospitals would no longer collect, use or have to safeguard physicians' personal health information. They would, however, have responsibility to appropriately support a physician to ensure that any restrictions placed on a physician's practice were adhered to.

By removing hospitals and other institutions from the need to collect physicians' personal health information, the risk of inadvertent release of this sensitive information would be greatly reduced. More importantly, the formalization of the decision-making process with greater application of evidence-based criteria, expert examination of the facts and processes based on procedural fairness will both support patient safety and respect the rights of those individuals involved.

Supporting physicians

It is difficult to imagine the devastation that accompanies the news that you are afflicted with a serious medical condition, such as being infected with a blood-borne pathogen. Not only must the physician deal with the diagnosis and the physical impact of the illness, he or she often has to address disclosure issues with family and colleagues. The questions and decisions facing physicians in these circumstances are extremely stressful. Most physicians in this position are deeply concerned about issues of confidentiality, the expected course of the disease, and the potential impact on their career, including their ability to earn a living.

In each Canadian province, physician health programs exist to provide assistance to physicians who experience problems such as those related to stress, burnout, marital and family issues, conduct or behavioural problems, sexual and boundary issues,

gambling, mental health and psychiatric disorders, substance abuse and substance dependence. The confidentiality provisions associated with the physician health programs provide a safe haven for physicians to seek advice, assistance and, if necessary, treatment, in a manner that does not threaten their professional standing. Ongoing case coordination/management and monitoring programs support compliance and provide indications if treatment is not successful.

The physician health programs demonstrate success in returning physicians suffering from substance abuse disorders, mental health and psychiatric disorders to practise. In addition to providing physicians with advice and rapid access to treatment, they have a strong role to play in addressing the stress experienced by affected physicians. The physician health program model, with its non-judgmental and confidential approach, provides a useful model that could be expanded to deal with medical conditions beyond those currently addressed. However, for this approach to be successful, physicians should be encouraged to seek treatment for their medical condition, confident their privacy will be protected, and decisions made regarding their practice will rely on evidence-based criteria.

Notwithstanding the availability of treatment, there will be instances in which physicians will no longer be able to practise (or to continue their existing practice) as a result of a medical condition. Unless the physician in question has had the foresight to obtain comprehensive disability insurance, there are currently few avenues of support available. In this regard, the current approach appears at odds with how society responds to the needs of other crucial providers of critical societal needs (e.g., police, firefighters, etc.) who have been injured on the job or are unable to continue to perform their responsibilities as a result of a medical condition.

The physician health program model, with its non-judgmental approach, provides a useful model that could be expanded to deal with medical conditions beyond those currently addressed.

The CMPA is of the view that the physician community can do more to ensure that its members are educated about the risks that exist and understand the benefits associated with taking the necessary income replacement precautions, such as disability insurance. This, however, may not be sufficient.

The CMPA believes there is a role for governments to examine how they can more effectively support physicians whose ability to continue to provide care for their patients has been impaired by a medical condition resulting from their practice. This could and should include funding for training programs to enable physicians to either transition their professional practice to one that reflects a necessary limitation or pursue an alternative career path that leverages the individual's medical knowledge and experience. At the current time, the CMPA is not aware of any such funding, thereby leaving physicians to fend for themselves. This situation does not support a culture of self-reporting and may well contribute to the under-reporting of medical conditions.

Disclosure to patients

It is also necessary to address the issue of disclosure of physicians' personal health information to patients when obtaining informed consent to medical care. Indeed, the same principles apply when determining whether a physician's medical condition is a "material risk" that should be disclosed to the patient.

Physicians have a duty to disclose material risks associated with proposed medical care and to answer any specific questions posed by the patient. A risk that is a mere possibility does not ordinarily need to be disclosed, unless its occurrence carries serious consequences (e.g., paralysis or death). The test for determining whether a risk is material is

whether it is one that a reasonable person in the patient's position would want to know in making an informed decision.

It is not possible to make a definitive statement on whether a physician's medical condition should be disclosed to the patient. In addition to the "reasonable person's" desire to know the material risks associated with medical care, careful and equal consideration must also be given to balancing the competing privacy rights of the physician. It is reasonable to expect that as the risk to patient safety decreases, the weight that must be given to the physician's privacy increases proportionately. Accordingly, it may be acceptable not to disclose such information on the basis that the risk does not justify the intrusion on the physician's privacy.

The CMPA acknowledges this position does not fully align with that held by some organizations. However, judicial and legal opinion indicates that a disclosure determination should not be made without consideration of the physician's privacy. These opinions reinforce the CMPA's view that each situation must be examined on its own specifics.

RECOMMENDATIONS

As a national association providing medico-legal protection to more than 78,500 physicians across Canada, the CMPA is well positioned to develop recommendations to address the collection, use and safeguarding of physicians' personal health information. The Association's recommendations are built upon the principles of fairness, balance and patient safety. The practice of collecting a physician's personal health information should be grounded in scientific knowledge and evidence-based practices. Once collected, such information should only be used in a manner that accords the physician procedural fairness and which leads to decisions that are ethically and scientifically supportable. Finally, at all stages, any information collected must be safeguarded in a manner that reflects its sensitivity and respects the rights of the physicians involved.

Physicians and health care providers:

- Physicians and other health care providers have an ethical responsibility to know whether they have a medical condition that may negatively impact their ability to safely deliver care to their patients.
- They also have a responsibility to protect their patients and themselves and this should include taking the necessary precautions that reflect the nature of their medical condition and their specific practice.
- Physicians should disclose personal health information to Colleges in circumstances where it is required by law, or the physician consents to the disclosure because it is necessary to protect patient safety.
- Physicians should carefully consider the circumstances, if any, in which they might choose to disclose their medical condition to a patient. Such circumstances are inevitably complex and physicians should seek advice from the CMPA.
- All physicians, regardless of their type of practice, should consider the consequences of a medical condition that may impair their ability to continue in their practice and to the extent reasonable, put in place disability insurance and other arrangements to offset a possible loss of income. This consideration is particularly important for those whose practice may expose them to a higher risk of contracting an illness which leads to practice restriction or limitation.

Regulatory authorities (Colleges):

- Colleges should develop clearly written policies for dealing with physician personal health issues that are, to the greatest extent possible, evidence-based and which reflect ongoing advances in the prevention and treatment of such medical conditions. These policies should recognize the difference between illness and

The practice of collecting a physician's personal health information should be grounded in scientific knowledge and evidence-based practices.

impairment. In so doing and while balancing the imperatives for patient safety, Colleges should consider the potential ramifications of practice restrictions on the physician.

- Colleges should encourage physicians to meet their professional and ethical obligations to self-report medical conditions that may impact their ability to practise.
- In the case of blood-borne pathogens, Colleges should seek to collect information from those practitioners deemed to be at an increased risk of transmission (that is, physicians performing exposure prone procedures).
- Before the collection of any physician personal health information, Colleges should establish and communicate the procedures and processes to be used to safeguard that information. These procedures must address the confidentiality requirements of this sensitive information.
- Any information obtained should be used only in limited and confidential settings. In employing personal health information to make decisions regarding a physician's practice, Colleges are encouraged to employ a blind procedure whereby an expert panel determines risk on an anonymous basis and recommends practice requirements and periodic assessments based on the level of risk. Consideration should also be given, particularly in instances of mental health and substance use disorders, to the use of expert panels within physician health programs and the limited transfer of identifiable information only under specific criteria.
- The physicians involved should be able to participate in the discussions regarding their practice and any health-related restrictions or limitations being considered. This should include the right to make submissions, to respond to

reports with expert opinion, and to appeal decisions.

- Any process implemented by the Colleges to subsequently assess and monitor physicians must respect the physician's privacy rights while at the same time, ensure reasonable procedural guarantees.

Hospitals and institutions:

- Hospitals and institutions have a responsibility to create a safe working environment for physicians and other health care providers that reduces occupational safety hazards.
- They should generally refrain from the collection of physician personal health information and rather, should rely on Colleges to make evidence-based decisions regarding a physician's practice.
- In those circumstances where information may be collected, hospitals and institutions should establish and communicate the procedures and processes to be used to safeguard any personal health information collected.
- Hospitals and institutions should employ appropriate procedures to ensure that any practice restrictions resulting from a physician's medical condition are appropriately supported and followed. To the greatest extent possible, such compliance mechanisms should respect the confidentiality of the information involved.
- Policies should seek to create a safe working environment for physicians and other health care providers that reduces the likelihood of exposure to and transmission of blood-borne illnesses. This would include mandating the requirement to employ universal precautions when appropriate, and to report occupational blood exposures to

and from patients without disclosing the physician's personal information.

Governments and regional health authorities:

- Physicians and other health care providers have the right to be protected and supported with the appropriate information, policies and procedures. Any process that collects the personal health information of health care providers must not be disclosed to the public under any circumstances and must respect the sensitivity and confidentiality of any and all information collected. Policies to safeguard the collection, storage and use of physicians' personal health information need to be created and mandated at the provincial/territorial level.
- Independent expert review committees that operate at arms-length from regulatory authorities should be established with consistent procedures and processes by provincial/territorial governments to ensure fair, consistent treatment of health care providers. In this regard, it should be remembered that a disability or other medical condition is only relevant if it significantly impairs or can reasonably be expected to significantly impair the provider's ability to perform the functions of a job or if it would create an undue risk to other health care providers or to the public.
- Consideration needs to be given to providing physicians with appropriate assistance, should their ability to practise be impaired by a medical condition incurred as a result of that practice. For example, those whose practices are adversely affected as a result of being infected by a patient should be eligible for financial assistance. Equally important, provisions should be available to transition a physician whose medical condition limits his or her practice to a meaningful role that draws the maximum benefit from their medical expertise.

- Recognizing the role of Colleges in regulating the medical profession, governments may consider limiting the role of collecting personal health information, when warranted, solely to regulatory authorities. This may require adjustments to the responsibilities currently assigned to hospitals and other institutions.
- Governments should promulgate clear guidelines on the protection of personal health information of all health care providers.

Medical professional associations:

- Medical organizations should continue to educate physicians as to the risks associated with their practice and encourage them to know their personal health status and, where appropriate, to seek confidential assistance through such venues as the physician health programs.
- Medical organizations should also consider how best to support those physicians whose practices have been appropriately restricted or limited by a medical condition incurred as a result of their practice. This should include managing government-funded training programs to assist the transition of physicians with medical conditions to meaningful employment that, to the greatest extent possible, leverages their medical expertise and experience.
- Medical organizations may wish to consider educating patients about the low risks of blood-borne pathogen transmission from physicians to patients, and to advance a shared understanding of the benefits of self-reporting.

CONCLUSION

Physicians have an ethical responsibility to protect the safety of their patients and this responsibility includes the requirement to report any medical condition that may adversely impact their ability to deliver care safely. In line with this responsibility is an obligation to seek treatment that might further reduce any risk to their patients.

Medical regulatory authorities have a responsibility to protect the public and this responsibility may include limiting or restricting the practice of physicians, when justified. However, such decisions should be made using evidence-based criteria that establish an acceptable level of risk. There should be clearly articulated and evidence-based procedures regarding the collection, storage and potential use of physicians' personal health information. Before collecting such information, regulatory authorities should have reasonable procedures in place that address privacy concerns.

For their part, hospitals and institutions have a responsibility to ensure that any restrictions placed on a physician's practice as a result of a medical condition are reasonable and followed. These restrictions will assist in protecting the safety of the public while at the same time being respectful of the privacy rights of the individual.

However, such a system is, by itself, not sufficient. Greater attention must be paid to encouraging physicians to seek treatment for medical conditions, including mental health issues, substance abuse or infection from blood-borne pathogens. This effort can be best supported by effective physician health programs that provide non-judgmental support and assistance.

Notwithstanding the best efforts of all involved, there will inevitably be circumstances wherein a physician's medical condition requires significant restrictions or limitations to his or her practice, including in the worst case scenario, his or her full

preclusion from practice. In these relatively few but personally devastating circumstances, governments and others should provide retraining opportunities to enable the physician to either adapt his or her practice or to transition to another employment field, hopefully one that leverages his or her medical training and experience.

Achieving a balanced approach that protects public safety while respecting the privacy of physicians with medical conditions is a difficult task, and one that requires carefully considered decisions and weighing of the individual and collective consequences. However, all of those involved (governments, Colleges, hospitals and institutions, physicians and medical organizations) must strive to achieve the appropriate balance; to do otherwise would be to fail both physicians and the patients for whom they care.

APPENDIX A

The Physician with Blood-Borne Viral Infection: What are the Risks to Patients and What is an Appropriate Approach to the Physicians?

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RECOMMENDATIONS

Recommendation 1: The policies governing physician screening for blood-borne virus (BBV) and the management of BBV-infected physicians should be evidence-based.

Recommendation 2: Provincial Colleges should develop policies that encourage a safe working environment and maximize the use of measures to prevent BBV disease transmission. Some of these opportunities include but are not limited to 1) mandating professional obligations to always use universal precautions when appropriate and always report occupational blood exposures to and from patients; and 2) identifying additional financial resources to support BBV-infected physicians who face practice restrictions.

Recommendation 3: When a blood exposure occurs during an exposure prone procedure (EPP), the involved physician and patient should both be tested for BBVs. If a patient is exposed to blood from a BBV-infected physician, the patient should be told about the exposure as well as the specific BBV, and the estimated risk of transmission, but the patient should not be told the identity of the BBV-infected health care worker (HCW). Appropriate follow-up of the patient and the physician should be provided. Both the patient and the physician should be offered baseline and follow-up testing, and where appropriate, post-exposure prophylaxis at no cost to the patient or physician.

Recommendation 4: The available evidence does not support mandatory testing for BBVs for physicians who do not perform EPPs.

Recommendation 5: Current data support mandatory testing of physicians who perform EPPs for immunity to HBV (presence of anti-HBs).

Recommendation 6: Current data do not support mandatory HIV testing of physicians who perform EPPs.

Recommendation 7: Current data are inconclusive to make a recommendation regarding mandatory HCV testing of physicians who perform EPPs. If a decision to test is undertaken, HCV antibody negativity is sufficient to exclude HCV infection, but only HCV RNA positivity indicates infectivity. Decisions about the frequency of HCV testing will be arbitrary, as there is no available evidence on effectiveness to guide this recommendation.

Recommendation 8: For BBV-infected health care providers who do not perform EPPs, there are no grounds to restrict their practice on account of the BBV infection, provided that they adhere to universal precautions.

Recommendation 9: HIV-infected physicians should not perform EPPs, but can perform other medical duties until they are on antiretroviral therapy (ART) and their plasma HIV RNA is undetectable. Once documented to have undetectable plasma HIV RNA on ART, HIV-infected physicians should be permitted to perform EPPs using double gloves with the proviso that their personal physician provides regular (every 3 to 4 month) confirmation to an appropriate designated physician that his/her plasma HIV RNA is undetectable.

Recommendation 10: HBV-infected physicians with plasma HBV DNA over 2000 IU/mL should not perform EPPs, except on patients who are HBV immune (anti-HBs positive) or HBV infected (HBsAg positive), until or unless their infectivity status changes—whether by natural immunity or from antiviral therapy. HBV-infected physicians with plasma HBV DNA consistently below 2000 IU/mL should be permitted to perform EPPs using double gloves and universal precautions, regardless of their HBeAg status, with the proviso that their personal physician provides regular (every 3 to 4 month) confirmation that his/her plasma HBV DNA is suppressed below this level to an appropriate designated physician.

Recommendation 11: HCV-infected physicians (HCV RNA positive) should not perform EPPs, but they can perform other medical duties. They may resume EPPs while on anti-HCV therapy once HCV RNA is negative. Once anti-HCV therapy is completed, they should once again refrain from EPPs for at least 12 weeks following completion of antiviral therapy until a repeat HCV RNA test done at least 12 weeks after completion of treatment is confirmed to be negative, after which they can resume EPPs.



In keeping with its 2011-2015 Strategic Plan, the CMPA is committed, in collaboration with others, to encouraging and supporting the development of sound public policies.

As a national association providing medico-legal protection to more than 78,500 physicians across Canada, the CMPA is well positioned to identify medico-legal issues of importance to its members. In recent years, the Association has released several policy papers in support of collaborative care, wait times, disclosure of adverse events to patients, electronic health records and the reporting and learning from adverse events. These policy papers provide a medical liability perspective on issues of importance to the medical profession.

This policy paper builds on this approach and contributes an important medico-legal perspective on the issue of physician individual privacy and public safety.

All CMPA policy papers are available at cmpa-acpm.ca

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