ALBERTA, CANADA
RESTRICTED ACTIVITIES UNDER THE HEALTH PROTECTION ACT

1. The following, carried out in relation to or as part of providing a health service, are restricted activities:
   (a) to cut a body tissue, to administer anything by an invasive procedure on body tissue or to perform surgical or other invasive procedures on body tissue:
      (i) below the dermis or the mucous membrane or in or below the surface of the cornea;
      (ii) in or below the surface of teeth, including scaling of teeth;
   (b) to insert or remove instruments, devices, fingers or hands:
      (i) beyond the cartilaginous portion of the ear canal,
      (ii) beyond the point in the nasal passages where they normally narrow,
      (iii) beyond the pharynx,
      (iv) beyond the opening of the urethra,
      (v) beyond the labia majora,
      (vi) beyond the anal verge, or
      (vii) into an artificial opening into the body;
   (b.1) to insert into the ear canal:
      (i) under pressure, liquid, air or gas;
      (ii) a substance that subsequently solidifies;
   (c) to set or reset a fracture of a bone;
   (d) to reduce a dislocation of joint except for a partial dislocation of the joints of the fingers and toes;
   (e) to use a deliberate, brief, fast thrust to move the joints of the spine beyond the normal range but within the anatomical range of motion, which generally results in an audible click or pop;
   (f) to prescribe a Schedule 1 drug within the meaning of the Pharmaceutical Profession Act;
   (g) to dispense, compound, provide for selling or sell a Schedule 1 drug or Schedule 2 drug within the meaning of the Pharmaceutical Profession Act;
   (h) to prescribe, dispense, compound or administer a vaccine or parenteral nutrition;
   (i) to prescribe, compound or administer blood or blood products;
   (j) to prescribe or administer diagnostic imaging contrast agents;
   (k) to prescribe or administer anesthetic gases, including nitrous oxide, for the purposes of anesthesia or sedation;
   (l) to prescribe or administer radiopharmaceuticals, radiolabelled substances, radioactive gases or radioaerosols;
   (m) to order or apply any form of ionizing radiation in:
      (i) medical radiography,
      (ii) nuclear medicine, or
      (iii) radiation therapy;
   (n) to order or apply non-ionizing radiation in:
      (i) lithotripsy,
      (ii) magnetic resonance imaging, or
      (iii) ultrasound imaging, including any application of ultrasound to a fetus;
   (o) to prescribe or fit:
      (i) an orthodontic or periodontal appliance,
      (ii) a fixed or removable partial or complete denture, or
      (iii) an implant supported prosthesis;
   (p) to perform a psychosocial intervention with an expectation of treating a substantial disorder of thought, mood, perception, orientation or memory that grossly impairs:
      (i) judgment,
      (ii) behavior,
      (iii) capacity to recognize reality, or
      (iv) ability to meet the ordinary demands of life;
   (q) to manage labor or deliver a baby;
   (r) to prescribe or dispense corrective lenses.

2. Despite subsection (1), the following are not restricted activities:

   (a) activities of daily living, whether performed by the individual or by a surrogate on the individual's behalf,
   (b) giving information and providing advice with the intent of enhancing personal development, providing emotional support or promoting spiritual growth of individuals, couples, families and groups;
   (c) drawing venous blood.

The Act also requires each profession to regulate how its members supervise other people in the performance of a

restricted activity unless the other person is a regulated health professional entitled in their own regulation to perform the activity. Other people can include the physician's office employees, other health care workers and hospital and health authority personnel. Medical students and residents will also be recognized in the regulations. We already know that some physicians delegate drug and vaccine injection to nurses and imaging procedures to medical radiation technologists. We want to learn other restricted activities that physicians currently delegate to non-physicians in their offices. This information will help us write the regulations for the medical profession.

Please write to us and provide the following:

1. the name or description of the medical procedure delegated to a non-physician in your office, and
2. the qualifications of the person to whom the procedure is delegated.

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BRITISH COLUMBIA, CANADA
FROM THE ETHICAL STANDARDS AND CONDUCT REVIEW COMMITTEE

Judging by the number of telephone calls to the Ethics Department of the College from patients wanting their records transferred to a new doctor, there is an increasing problem out there. The problem is two-fold.

First, the doctor who retires or leaves a practice without making arrangements for storage and distribution of patient files, or notifying the College of their whereabouts, creates problems for patients and physicians who take over their care. In doing so, the physician is also in violation of Rule 14(a) of the Rules made under the Medical Practitioners Act. Similarly, as happened with three physicians this year, sudden death can leave a distraught spouse with the problem and no direction or resources to handle it.

It should be part of your office management plan to have an arrangement for the care of your patient files if or when you are no longer around to look after them yourself.

Second, the College receives many calls from patients who are angry because they have to pay a fee to have their records transferred to a new doctor, particularly if that transfer is not of their own volition, but rather because the physician has retired or has left the practice. Patients do not like to receive bills in what they believe is a free publicly funded system. They do not know which services are uninsured. It does prevent upset if information about record transfer and the associated fees is posted in your office and printed in patient practice information leaflets.

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ONTARIO, CANADA
MAINTAINING BOUNDARIES WITH PATIENTS

Do you think a lot about a particular patient? Do you share your personal problems with your patients? Be careful. You may be allowing your professional boundaries to become blurred.

A recently qualified family physician moves to a new town and sets up a practice. One of her patients, a middle-aged man, has a long history of panic attacks and depression following the death of his wife. At several appointments, the patient talked at great length about the loss of his wife. The patient sent the physician some flowers with a note thanking her for taking the time and being sensitive. The physician thought this was a nice gesture and didn't really think anything of it. More flowers came and then small gifts. At this point, the physician had an uneasy feeling but decided that if she ignored it, the patient would get the message and stop. A short time later, the patient called to ask some questions about medications – this conversation rapidly turned to his asking questions about her hobbies, relationships and where she lived. The physician was working one night, when the patient called requesting a home visit. He described feeling breathless, sweaty and nauseous. She was concerned that he might be faking a panic attack to get her alone, so she told him that a house call would not be necessary and suggested that he use some of the anxiety reduction techniques they had talked about. The patient eventually staggered to a neighbor's house and an ambulance was called immediately. He was having a myocardial infarction and later made a complaint about the physician.

This example illustrates what can occur when physicians allow the boundaries with patients to become blurred. Medical care can be compromised because objectivity

diminishes to the same degree that feelings – both positive and negative – develop between a patient and a doctor.

To help doctors in this regard, the College of Physicians and Surgeons of Ontario (College) has developed a self-assessment tool physicians can use to assess their awareness of boundaries and identify the early warning signs of boundary crossings and violations. The tool focuses on those areas most vulnerable to boundary blurring, i.e., gift giving, physician's self disclosure, physical contact and dual relationships.

Dr. John Lamont, chair of the Patient Relations Committee — the College committee that developed the self-assessment tool — says the tool was designed to be informative and educational for physicians, with the hope that it will sensitize doctors to the issue of boundaries.

"We don't want people to perceive this tool as a test or as the College making a judgment," says Dr. Lamont. "This is simply a tool intended for a physician's private use so that he or she can reflect on these issues and be alert to identifying them when they arise in practice."

According to Dr. Lamont, it is a given that boundary crossings will arise. "They are unavoidable," says Dr. Lamont. "They happen to all doctors. Patients will cross boundaries, whether on purpose or by mistake. It happens. Physicians need to know when they are happening, so they can protect both themselves and their patients."

Some may argue that in the example used earlier, the patient was inappropriate and that the physician was just trying to be polite. However, the nature of the physician-patient relationship is such that the physician must take the responsibility for maintaining boundaries. Within this fiduciary relationship, there is an inherent power imbalance. Since a patient believes the physician knows more about the matter in question than he or she does, the patient tends to defer to the physician's judgment. It is this tendency that puts the professional in a "one up" power position relative to the patient.

Examples of Possible Boundary Crossings:

- Attend/frequent the same places
- Sharing mutual friends or people in common
- Self-disclosure
- Establishing dual relationships (professional/social relationships)
- Hugs/touching

Examples of Boundary Violations

- Giving or receiving inappropriate gifts*
- Ignoring established conventions by making exceptions for certain patients: for example, providing care in social rather than professional settings, not charging for services rendered where you would usually do so, scheduling treatments outside office hours, providing or using alcohol during treatment
- Assuming a patient's values are the same as your own
- Excessive self-disclosure or self-disclosure that is not for the purpose of helping the patient
- Intruding verbally on your patient's personal space. This may include breaching patient confidentiality, making value judgments about your client's body or lifestyle, probing for inappropriate personal information, using intimate words (such as dear or darling) or allowing their use by your patient
- Inappropriate touching

In understanding boundaries, it is important to differentiate a boundary crossing from a violation. A boundary can be crossed without necessarily being violated, Dr. Lamont explains. In fact, many crossings are quite benign. "For example, you may get a box of cookies from a sweet old lady whom you have been taking care of for years. This is how she expresses her gratitude. You don't need to reject the gift, but you need to be aware and alert to the fact that it is a crossing," he said.

If a physician is made uneasy in being given, for example, a box of chocolates by a particular patient, he or she can defuse the situation by keeping the gift in the clinic and treating it as if it were intended for the whole staff, said Dr. Lamont. If the gift giving continues, the physician will need to document the crossings in the patient's chart and let the patient know that it is inappropriate for physicians to be accepting presents for providing medical services.

There is good reason not to take a crossing too lightly. A pattern of crossings could be the first step in the slippery slope toward boundary violations. And, violations should be of concern to physicians, in that most cases of sexual abuse of patients by health professionals are preceded by boundary violations. Between January 1998 and July 2002, the College referred 84 cases with allegations of sexual misconduct or related allegations to the Discipline Committee. Allegations were proven in the majority of cases and the penalty applied in 30 out of the 49 cases was revocation of the physician's certificate of registration. The prevention of sexual contact starts with the careful atten-

tion to boundary crossings that may escalate into sexualized behavior.

Dr. Lamont acknowledges the situation becomes more complicated for rural and geographically isolated physicians who may have no choice but to develop friendships and socialize with people who also happen to be their patients. "The way rural or isolated physicians differ is that they have to accept the fact there will be more boundary crossings in their environment. There should not, however, be more boundary violations. Going curling with your patient is no excuse for boundary violations."

What should you do if you are concerned that you may be at risk?

- Document any inappropriate behavior on the part of the patient.
- Focus objectively on the patient's needs and best interests.
- Establish and maintain appropriate boundaries; look at the relationship from three perspectives – the physician's, the patient's and the neutral observer's:
  - The physician's: Be clear about your own needs and experiences in the relationship.
  - The patient's: Try to understand how the patient is experiencing your behavior. Empathize with what she or he is experiencing.
  - The neutral observer's: Step outside the relationship. Try to understand what an outsider would see when observing your relationship. Strive for objectivity and fair solutions to problems in the patient's best interests.
- Treat all patients equally. Function compassionately and free of preferences for some patients.
- Encourage patients to take responsibility for their own health. Don't impose your knowledge and authority.
- Do not accept inappropriate gifts from patients. Patients who offer gifts of great value should receive a sensitive explanation as to why the gift cannot be accepted. The frequency of gifts given by the patient, regardless of their value, should also be considered.
- Do not imply that patients are obligated in some way. Do not expect patients to return kindnesses or to be thankful.
- Ask yourself why you are acting in a particular way, i.e., stress, burnout, failed relationship, depression, etc.
- Discuss the situation with a colleague (of course, adhering to patient confidentiality) and document the discussion in the patient's chart.

If you have concerns and wish confidential advice, please call (416) 967-2600, extension 629, to speak to the intake coordinator or when more information is needed, call the Physician Advisory Service at extension 606. For your information, the College offers a course on boundary issues called "Understanding Boundary Issues and Managing the Risks Inherent in the Doctor-Patient Relationship." Information on the course can be obtained by calling (416) 967-2600, extension 346.

*"While small gifts such as cookies ... may represent benign boundary crossings rather than serious violations ... more significant and expensive gifts may be problematic from two standpoints. First, gift giving may be a conscious or unconscious bribe by the patient ... Second, there is often a secret or even explicit expectation of some reward or acknowledgment involved in performing services or bestowing a gift. The same can apply to the doctor who gives patients gifts or refrains from charging a fee for a particular patient." From "Boundaries in the Doctor-Patient Relationship," *Theoretical Medicine and Bioethics*, 2002;23(3): 191-201. C. Nadelson; M. Notman.

Reprinted from the online version of *Members' Dialogue*, published on the College of Physicians and Surgeons of Ontario website.

LONDON, ENGLAND
STRIKING A BALANCE IN HEALTH CARE DEBATE

Patient and public involvement in regulation will be a major theme for the General Medical Council (GMC) in 2005. According to Sir Graeme Catto, GMC president, getting public involvement is crucial to the success of independent regulation. "I do not believe in self-regulating professions," he says, "but I do believe very strongly in professionally led regulation. Regulation that protects patients by fostering professionalism in doctors and by involving patients and the public."

Sir Graeme argues that at the heart of such regulation is the setting of standards, which should be determined independently of government, the National Health Service (NHS) or any of the other health care providers and employers. "Of course, there needs to be substantial public involvement in the development of those standards, but ownership of the standards by doctors is absolutely essential. The model that can best achieve that aim is 'professionally led' or 'independent' regulation in

partnership with the public," says Sir Graeme.

Sir Graeme makes these points in a new report published by the Social Market Foundation. The GMC wants to stimulate a public debate on what constitutes best practices in health care regulation. Ultimately it would like to see a greater degree of patient-centeredness across health care regulation as a whole. In the GMC we have already done much to ensure the public plays a crucial role, for example:

- 40 percent of Council members are lay people.
- A patient and public reference group scrutinizes the GMC's work and has made important contributions to its revalidation plans.
- The GMC consults widely with the public and the profession on all major policy decisions, such as revalidation and its complaints procedures.

But, as Sir Graeme says, there is more the GMC and other organizations within the health sector could do. The GMC has already begun talking to people with expertise in this area, including colleagues at the Departments of Health and patient groups, and is keen to hear from others about what else it could be doing. Public involvement will be a major theme for the GMC in 2005. All persons who would like to contribute to the debate should e-mail their views to patient.involvement@gmc-uk.org.

GETTING INVOLVED IN PATIENT SAFETY

Patient and public involvement in the National Health Service (NHS) has gotten a bad name during the past few years, mainly because of the government's disastrous and illogical insistence on abolishing Community Health Councils (CHCs) in England — no matter what patients and the public, or anyone else for that matter, had to say about it.

The problem has been compounded even more, recently, by the decision to abolish the Commission for Patient and Public Involvement in Health, just a year after it got going (again without any consultation) and the watering down and fragmentation of the role of patients' forums. These had been key components of the new system to replace CHCs, which had been secured only due to the huge controversy over the abolition of CHCs in the first place. It is easy to see why anyone might be a little cynical about the genuineness of government-led initiatives on patient and public involvement now. However, the need to involve patients in the planning and monitoring of health care is not about political fads. It is about bringing new perspectives, challenging the peceived wisdom of health professionals and institutions, and providing a dose of common sense from a consumer perspective. Fortunately, there is a lot of good work going on in this field, in spite of the mess left in the wake of CHCs. One area where Action against Medical Accidents (AvMA) hopes to make a significant contribution is in developing patient and public involvement in patient safety/clinical governance work. Preventing the same thing from happening to someone else is usually high on the list of priorities of people who contact us, having been affected by a medical accident. Opportunities to get involved, however, have been limited and largely uncoordinated up to now. Working with others, we hope to develop a program of induction training and support for people who want to make a contribution to the local work of clinical governance committees, for instance, or national programs, in conjunction with bodies such as the National Patient Safety Agency.

The views expressed in this article are those of the author and are not necessarily shared by the GMC.

DEVOLUTION PLEDGE

Devolution will see the U.K. countries take a diverse approach to health care and the General Medical Council (GMC) will respond accordingly, said GMC president Sir Graeme Catto at a dinner he hosted on the evening before the Northern Ireland conference. The conference on Nov. 9, 2004, in the Hilton Templepatrick Hotel near Antrim, gave the GMC an ideal opportunity to communicate some key messages about its reforms to the wider Northern Ireland community. Some 90 delegates – including Professor Rod Hay and GMC president Sir Graeme Catto, as well as doctors and patient and interest group representatives — attended the conference, which had the theme "Moving Forward." Dr. Joan Martin, the lay member of Council for Northern Ireland, chaired the conference. The GMC outlined the development of its Registration and Fitness to Practice reforms, as well as current GMC thinking on medical education and CPD. Other speakers included Dr. John Jenkins, the medical member for Northern Ireland, who set out his role leading the current review of *Good Medical Practice*, and Dr. Henrietta Campbell, chief medical officer for Northern Ireland. Delia van der Lenden, a former member of the

GMC's patient and public reference group, also gave a presentation. Dr. Henrietta Campbell said: "The GMC has a pivotal place in protecting, promoting and maintaining the health and safety of the public. The Reform Program, outlined by the GMC on November 9, will modernize professional regulation and promote high standards of care for patients."

THE MEMBERS' COLUMN

There are many opportunities for the General Medical Council (GMC) to engage with the medical profession, but we must get better at engaging with the public and patients. It is not that little happens at present. We have a strong lay membership, an active public and patient reference group and take every opportunity to work with a range of patient interest and consumer groups. But there are three areas where we can make significant improvements. These are:

- **Helping the public when things go wrong.** There is no doubt that when a patient is dissatisfied with their care, the current systems that come into operation are not centered on the patient. The Healthcare Commission is tackling this issue, but it is vital the GMC continues to clarify the options open to patients and explain its own role in the process.
- **Leading the debate on health and ethical issues.** The GMC needs to facilitate broad debate on key medical issues and stimulate the wider population into developing views on these important topics. The advent of new technology should allow people to participate in ways that have never been seen before.
- **Shaping the doctor-patient relationship.** We need to take what patients see as a good relationship our starting point and continue to update that relationship in line with societal changes. The GMC's Education Committee has launched a series of actions to help it build a picture of what will be required of doctors in the future, which involve everything from research projects through to essay competitions for schoolchildren.

Whatever improvements the GMC makes, it is vital we form our policies by consulting with specific patient interest and consumer groups, and with the public at large. It is also important we build a picture of an effective doctor that is driven not only by things that have gone wrong, but also by what is regarded by patients as the very best of what the profession can offer.

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LET US HEAR FROM YOU

Would you like for information from your board to be considered for publication in the *Journal*? If so, e-mail articles and news releases to Edward Pittman at epittman@fsmb.org or send via fax to (817) 868-4098.