cpsa
COLLEGE OF PHYSICIANS
& SURGEONS OF ALBERTA

ADVICE TO THE PROFESSION

Responsibility for a Medical Practice

The College of Physicians & Surgeons of Alberta (CPSA) provides advice to the profession to support physicians in implementing the CPSA ***Standards of Practice.*** This advice does not define a standard of practice, nor should it be interpreted as legal advice.

Advice to the Profession documents are dynamic and may be edited or updated for clarity at any time. Please refer back to these articles regularly to ensure you are aware of the most recent advice. Major changes will be communicated to our members; however, minor edits may only be noted within the documents.

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CPSA's Advice to the Profession documents cannot capture every potential scenario a member may encounter. Regulated members are expected to consider standards of practice and advice documents in the context of individual patients in each care encounter. Regulated members are expected to do their best to meet the spirit and intent of the standards and advice, while focusing on providing the best quality care possible.

Note: Under the current *Physicians, Surgeons, Osteopaths and Physician Assistants Regulations*[1], physician assistants cannot be responsible for a medical practice; as such, the term "physician" is used throughout this document.

Purpose

The *Responsibility for a Medical Practice* standard of practice recognizes the full scope of medical practice extends beyond the provision of patient care to the professional and administrative activities, which support that care. While some responsibilities may be delegated to a non-physician, CPSA will always hold physicians ultimately accountable for all aspects of medical practice (except administrative responsibilities that clearly fall under the jurisdiction of Alberta Health Services (AHS) or the provincial or federal government).

The standard acknowledges that practice settings may influence how physician responsibilities are managed, and the purpose of this advice is to help physicians better understand how the standard applies in their particular circumstances.

Basic physician responsibilities

Physicians are authorized to provide services to the public through the legislative authority of the *Health Professions Act (HPA)*. Section 100(1) of the *HPA* holds physicians accountable for the care they provide to patients and their compliance with the laws, regulations and standards applicable to the practice of medicine, regardless of practice arrangement. Specifically, Section 100(1) states:

[1] *Physicians, Surgeons, Osteopaths and Physician Assistants Regulations*, Section 1(i) (Apr. 1, 2021).

Responsibility for a Medical Practice

> *"A regulated member is responsible, for the purposes of this Act, the code of ethics, the standards of practice and the bylaws, for how the member provides professional services and complies with this Act, the code of ethics, the standards of practice and the bylaws, and that responsibility is not affected, modified or diminished by the practice arrangements of the regulated member."*

Clause 1 of the *Responsibility for a Medical Practice* standard confirms these responsibilities and is applicable to **all** physicians in Alberta regardless of practice setting.

PRACTICE MANAGEMENT RESPONSIBILITIES

While clauses 1(a) and (b) are fundamental, they do not describe everything included in a medical practice. Staffing, advertising, billing and medical records are all components of a physician's medical practice, as outlined in clauses 2(a) through (h) of the standard.

It is also important to understand that "medical practice" is the exclusive domain of physicians and cannot be delegated to or owned by a non-physician person or business interest except as authorized by legislation, such as within an AHS or government facility.

'Responsibility' means where the ultimate accountability lies.

Many practice settings have a Medical Director who has a formal agreement with the facility owner or operator that includes most, or all, of the responsibilities identified in clause 2. This includes all accredited facilities, AHS facilities and some community practices.

CPSA will hold the Medical Director accountable for upholding their agreement as relevant to clause 2. All physicians in the practice should be clear on the Medical Director's responsibilities, as individual physicians will be held accountable for any part of clause 2 not included in the Medical Director's agreement with the facility.

Additionally, CPSA would expect physicians in the practice to come forward if concerned the Medical Director isn't meeting their clause 2 responsibilities as per their agreement. Depending on the type of practice, this could mean reporting to the appropriate authority in the facility or to CPSA directly under the *Duty to Report a Colleague* standard of practice.

In other practice arrangements, responsibilities may be managed as follows:

- In a Primary Care Network (PCN) without a Medical Director, the PCN board may assume responsibility for specific components of clause 2 (e.g., hiring and supervision of non-AHS, non-medical staff) and may hire an Executive Director to carry out these functions. Unless there is evidence AHS or Alberta Health (AH) accepts direct responsibility for these staff (e.g., they are employees of AHS), CPSA has no recourse but to look to individual physicians for accountability – either the physicians on the PCN board or the physician members of the PCN, according to the agreement between these parties.
- In a community-based practice without a Medical Director and not part of a PCN (or where the PCN board has not assumed any clause 2 responsibilities), physicians are individually responsible. In a multi-physician setting, the physicians may select a medical lead to assume responsibility for some or all of clauses 2(a) through (h).
- In a hospital or facility operated by the provincial or federal government or provincial health authority, the organization itself assumes these responsibilities. For the purposes of this standard, this includes any organization authorized by legislation to deliver health services, including AHS, AHS-contracted providers (e.g., long-term care), First Nations and Inuit Health Branch settings and services, Workers' Compensation Board (WCB) facilities, etc. Many of these settings will also have a Medical Director.

All physicians in the practice should be clear on the Medical Director's responsibilities as the CPSA will hold individual physicians accountable for any part of clause 2 not included in the Medical Director's agreement with the facility.

Clauses 2(a), (b), (c), (e), (g) and (h) are discussed below. Refer to the *Advertising*, *Patient Record Content* and *Patient Record Retention* standards of practice for detailed information on professional expectations regarding these aspects of medical practice.

Non-regulated and regulated staff

A physician's responsibility for staff depends on whether the staff is a non-regulated or regulated member of a health profession under the *HPA*. As noted above, a PCN board with physician representation may assume responsibility for hiring non-AHS staff (regulated and non-regulated)

through an Executive Director. In this scenario, the board's physician members remain accountable for the Executive Director's actions, approving appropriate processes and procedures to meet the standard.

For non-regulated staff: Physicians are responsible for supervising any person who assists them with duties related to the physician-patient relationship (e.g., receptionist, medical office assistant, billing clerk, etc.). Duties might include booking appointments, following up with patients on the phone, or interacting with patient records as they relate to physician-patient encounters and billing for medical services.

Responsibility for supervising non-regulated staff with no involvement in patient-related duties (e.g., after-hours cleaning staff) belongs to the employer. If the physician hired the staff, the physician is responsible. If an organization hired the staff (e.g., social agency, university, PCN, etc.), the organization is responsible.

For regulated staff: Physicians are not responsible for supervising the activities of other regulated health professionals or the unregulated staff assisting them. However, they are responsible for ensuring the regulated health professionals working in the practice are in good standing with their regulatory body and for enabling their participation in patient care teams within their scope of practice.

Billing

Recent amendments to the *Alberta Health Care Insurance Act* (AHCIA) allow for third parties to enter into an agreement or arrangement with the Minister of Health to submit claims and receive payments for benefits for insured services provided by a physician (AHCIA, Section 20.1).

Physicians are responsible for ensuring they do not duplicate the claims for the services they provide that are submitted by the third party. Physicians are also responsible for providing the third party with the information required for the purposes of making the claim (AHCIA, Section 28(1)) and ensuring that submissions are congruent to the Schedule of Medical Benefits and the Medical Governing Rules List. As well, physicians continue to have a duty to report inappropriate billing.

Quality assurance and quality improvement

Government, the public and other stakeholders increasingly expect physicians to participate in quality assurance and continuing quality improvement to support optimal practice. Many physicians have embraced a commitment to quality and are actively engaged in these activities. Refer to the *Continuing Competence* standard of practice for detailed information on professional expectations regarding these aspects of medical practice.

Responsibility for a Medical Practice

The *Responsibility for a Medical Practice* standard recognizes that outside of legislation-authorized health facilities, these activities are part of medical practice and must therefore be overseen by a physician and not a non-physician with a limited understanding of medical practice.

Notifying CPSA about changes to practice

Providing CPSA with notice in advance of relocating a practice helps us keep public information current and proactively support patient safety. Thirty days' notice is the absolute minimum; ideally, CPSA should be notified at the same time as patients (at least 45 days ahead, as per the *Relocating a Medical Practice* standard, or 90 days ahead if closing or leaving a medical practice).

CPSA also needs to know at least 30 days before new services or procedures are introduced. It takes time to meet patient safety requirements, and advance notice helps avoid unnecessary delays. Some services can only be provided in accredited facilities. We also follow up with all clinics performing medical device reprocessing (learn more at Infection Prevention and Control).

Staff identification

Clear identification of staff reassures patients and prevents misunderstandings about the roles of individuals. It also supports accountability for the activities of staff and their interactions with patients. Posted credentials or nametags are acceptable, and both are the norm in many practices. Nametags do not require last names, only first names and professional designation/job titles.

Delegation of Responsibility

As noted above and mandated through the *HPA*, individual physicians will always be responsible for clauses 1(a) and (b) of the *Responsibility for a Medical Practice* standard, and CPSA will hold physicians accountable. This also applies when physicians are supervising staff to carry out restricted activities.

Similarly, physicians who delegate some aspects of practice management identified in clauses 2(a) through (h) to staff remain accountable for the work performed by these delegates.

The role of medical lead is different, in that physicians in a multi-physician setting with no Medical Director may choose one regulated member to accept overall responsibility for any or all of clauses 2(a) through (h) for a defined period of time. As defined in the *Responsibility for a Medical Practice* standard, a multi-physician setting is any practice arrangement between regulated members in which they share the use, benefits or costs associated with any of the following:

- advertising;

- office telephone number;
- medical records;
- clinical or administrative functions, including infection prevention and control, billing, etc.;
- premises, equipment, furnishings or other property; and/or
- staff.

The medical lead must be a regulated member of CPSA and may be selected by formal appointment or an informal arrangement. In a formal appointment, the medical lead signs a contract that includes a list of duties. In an informal arrangement, the physicians in the practice agree informally on who will act as medical lead. The role may rotate among all members of the practice, but at all times all parties must understand their respective roles and responsibilities.

Contact Person for CPSA Interactions

All physicians need to interact occasionally with CPSA, for example when renewing their practice permit or participating in a continuing competence process (i.e., Individual Practice Review or MSF+). CPSA also interacts with physicians involved in a complaint concerning professional conduct or care for a patient. All of these interactions relate directly to the individual physician responsibilities outlined in clause 1 of the standard: patient care and compliance with applicable laws, regulations and standards.

Other CPSA interactions focus on office processes, such as infection prevention and control assessments, Group Practice Reviews and new office assessments. For these interactions, CPSA requires one person who is a regulated member to be the contact for the practice.

Ideally, this is the Medical Director. In other practices, it is the medical lead. In a multi-physician practice with neither a Medical Director nor a medical lead, one physician must be designated the contact person for CPSA. In this circumstance, all physicians in the practice remain individually responsible for clauses 2(a) through (h).

Example Scenarios

The *Responsibility for a Medical Practice* standard of practice is always interpreted in context. The following are a few common scenarios to clarify how CPSA applies the standard.

Scenario 1

Dr. A practises exclusively in an intensive care unit at a tertiary care hospital operated by AHS. The physician is privileged by AHS. The care provided in the ICU is delivered by a multidisciplinary team consisting of a number of regulated health professionals and some non-regulated staff, for instance, the unit clerk who carries out some patient-related duties such as entering orders into the system.

All the non-regulated staff are employees of AHS and are supervised by AHS managers. The regulated professionals are a mix of AHS employees (nurses) and physicians with privileges. The ICU has a Medical Director hired by AHS who has a list of responsibilities, including quality improvement and quality assurance for the unit.

Dr. A is compensated for his work through the Alberta Health Care Insurance Plan (AHCIP) and third-party payers as applicable (e.g., WCB, insurance companies, etc.). He bills AHCIP and other agencies for his services through his professional corporation and is paid directly by AH and third parties on a fee-for-service basis. The physician hires a part-time employee to do the billing on behalf of his corporation.

Dr. A is responsible for:

- the care he provides to patients and maintenance of his own competence;
- his own compliance with the *Code of Ethics & Professionalism*, CPSA *Standards of Practice*, CPSA Code of Conduct and CPSA and AHS bylaws; and
- the staff he hired to do his billing.

Dr. A is NOT responsible for:

- the care provided by other regulated health professionals or the actions of non-regulated AHS employees in the ICU;
- the custody of health information in AHS systems; or
- infection prevention and control or other clinical processes in the AHS facility.

Scenario 2

Dr. B works in a walk-in clinic operated by a non-physician. She works three shifts a week. There is no Medical Director or medical lead. The non-physician owner has hired several staff to support the physicians practising in the clinic:

- a receptionist who greets patients on arrival and collects information for the clinic EMR, such as a current address, phone number and so on. The receptionist also answers the phone and directs calls.
- a medical office assistant (MOA) who places patients in examination rooms, prepares them to see the doctor and assists Dr. B as required. The MOA also books investigations, facilitates referrals, calls patients on behalf of Dr. B and reprocesses medical devices.
- an RN who assists Dr. B and carries out duties such as medical device reprocessing (MDR), injections, ear syringing, etc.
- an office cleaner who comes in after hours. The cleaner is responsible only for general housekeeping, not medical device reprocessing.
- a billing clerk who submits billings to the AHCIP for all the physicians in the clinic.

Dr. B is responsible for:

- the care she provides to patients and maintenance of her own competence;
- her own compliance with the *Code of Ethics & Professionalism*, CPSA *Standards of Practice*, Code of Conduct and Bylaws;
- the clinic's compliance with the CPSA *Standards of Practice* (includes the responsibility to not sign a contract with the clinic that may interfere with her ability to comply with the standards);
- the actions of the receptionist, the MOA and the billing clerk in their duties related to the patients she provides care for;
- the proper custody, storage and security of the EMR, including the records she creates;
- security of medications and medical devices in the clinic;
- ensuring MDR and other clinical processes performed by the receptionist and MOA are conducted to the appropriate standard, even though working only 3 shifts a week and not the employer;
- quality assurance and quality improvement activities;
- clinic advertising;
- notification to CPSA if the clinic relocates; and
- in collaboration with her colleagues, selection of a regulated member to be a contact person for CPSA in the event of an interaction, for example an IPAC inspection.

Dr. B is NOT responsible for:

- supervision of the RN, who is responsible to the College of Registered Nurses of Alberta (CRNA); or

- supervision of the office cleaner, who has no patient involvement.

Scenario 3

Same as Scenario 2, except the non-physician clinic owner has hired a Medical Director.

Dr. B is responsible for:

- the care she provides to patients and maintenance of her own competence;
- her own compliance with the *Code of Ethics & Professionalism*, CPSA *Standards of Practice*, Code of Conduct and Bylaws;
- understanding the responsibilities of the Medical Director with respect to clauses 2(a) through (h), as outlined in their agreement with the facility;
- meeting all remaining responsibilities under clause 2; and
- in the event the Medical Director isn't upholding their agreement as relevant to clause 2, bringing this to the attention of the clinic owner and, if not resolved, CPSA.

Scenario 4

Drs. C, D and E work in their own clinic. They hire and oversee a receptionist, two MOAs, an RN and a billing clerk. The PCN provides a pharmacist and chronic disease nurse, both regulated professionals. The PCN also provides a non-regulated referral coordinator to help triage and facilitate referrals.

The pharmacist, chronic disease nurse and referral coordinator were hired by the PCN. The PCN has an Executive Director (ED)[2], typically a non-physician, who reports to the PCN board[3].

Drs. C, D and E are responsible for:

- the care they provide to patients and maintenance of their own competence;
- their own compliance with the *Code of Ethics & Professionalism*, CPSA *Standards of Practice*, Code of Conduct and Bylaws;
- the staff they hire:

[2] The PCN Executive Director (ED) (and Medical Director [MD]) are accountable to the Physician Not for Profit Corporation (NPC) Board in Legal Model 1 and the Joint PCN Board in Legal Model 2.

[3] "Board" in Legal Model 1 PCNs refers to the NPC Board, and in Legal Model 2 PCN "board" refers to the Joint PCN Board.

  - ensuring appropriate roles, responsibilities, qualifications and performance of the receptionist, two MOAs and billing clerk (CPSA will hold physicians accountable for the actions of these staff); and
  - verifying the RN they hire is a regulated member in good standing with CRNA;
- compliance with clauses 2(c) through (h) of the *Responsibility for a Medical Practice* standard; and
- if there is **no** Medical Director, choosing one physician to represent the practice in interactions with CPSA, as per clause 3 of the standard.

Drs. C, D and E are NOT responsible for:

- Staff hired by the PCN board and Executive Director. Because CPSA has jurisdiction only over physicians, CPSA will hold the physicians on the PCN board[3] accountable for ensuring clauses 2(a) and (b) are met, unless these staff are hired and supervised by AHS.

Scenario 5

Dr. F is hired by WCB to provide services in a WCB rehabilitation centre. Dr. F sees WCB claimants in the facility one afternoon a week for disability assessments. Other employees in the facility include reception staff, a registered nurse and physiotherapists, all staff hired and supervised by the WCB. The physician is paid by WCB.

Dr. F is responsible only for clauses 1 (a) and (b), which includes:

- the care he provides to patients and maintenance of his own competence;
- his own compliance with the *Code of Ethics & Professionalism*, CPSA *Standards of Practice*, Code of Conduct and AHS Bylaws.

As WCB is authorized through a legislative act, CPSA considers the WCB rehabilitation centre a "government facility" for the purposes of this standard. WCB thereby assumes responsibility for clauses 2(a) through (h).

Scenario 6

Drs. G and H work in a PCN-owned clinic. The PCN hires and oversees all the regulated and unregulated staff. The PCN does not have a Medical Director.

Drs. G and H are responsible for:

- the care they provide to patients and maintenance of their own competence; and
- their own compliance with the *Code of Ethics*, CPSA *Standards of Practice*, Code of Conduct and AHS Bylaws.

Drs. G and H are NOT responsible for:

- staff hired by the PCN board[3] and Executive Director[2]: because CPSA has jurisdiction only over physicians, CPSA will hold the physicians on the PCN board accountable for ensuring clauses 2(a) and (b) of the *Responsibility for a Medical Practice* standard are met unless these staff are hired and supervised by AHS.

Resources

CPSA team members are available if you have questions or concerns. Please contact support@cpsa.ca or 1-800-561-3899.

RELATED STANDARDS OF PRACTICE

- *Responsibility for a Medical Practice*
- *Advertising*
- *Charging for Uninsured Professional Services*
- *Closing or Leaving a Medical Practice*
- *Patient Record Retention*
- *Re-Entering a Medical Practice or Changing Scope of Practice*
- *Referral Consultation*
- *Relocating a Medical Practice*
- *Supervision of Restricted Activities*

COMPANION RESOURCES

- Advice to the Profession:
  - Advertising
  - Charging for Uninsured Professional Services

  - Closing or Leaving a Medical Practice
  - Medical Practice Observation
  - Physicians as Custodians
  - Referral Consultation
  - Relocating a Medical Practice
- CMPA’s The Most Responsible Physician