Excerpt from *Physicians with Health Conditions: Law and Policy Reform to Protect the Public and Physician-Patients*

Tracey M Bailey and Cameron Jefferies

Preface

The following excerpt from the Health Law Institute Policy Paper, titled *Physicians with Health Conditions: Law and Policy Reform to Protect the Public and Physician-Patients*,[1] introduces the reader of this Special Edition of the Health Law Review to the issues, processes and outcomes (including recommendations) related to the Policy Paper, which was first distributed and made available on-line in the summer of 2012.

Serving as an introduction, we urge readers to refer to the report in its entirety to gain a complete picture of the research that went into completing this work. For example, the full report contains sections addressing, *inter alia*:

i. A description of the mandate, roles and responsibilities of the Alberta Medical Association (AMA) and the College of Physicians & Surgeons of Alberta (CPSA), and consideration of the processes and relationships between them as they then existed;
ii. Consideration of key components of physician health programs;
iii. Consideration of the principles that guided the HLI-coordinated Working Group throughout the process;
iv. A summary of notable points extracted from an extensive review of other jurisdictions, including the Canadian provinces of British Columbia and Ontario, and the approaches to physician health and wellness taken in the United Kingdom, Norway, the United States of America, Australia and New Zealand; and
v. Legal issues that informed the working group's recommendations, including those regarding physician's obligations.

We would once again like to thank the members of the HLI Working Group, namely Sister Elizabeth Davis, Dr. Philip Hébert and Professor William Lahey, and, of course, both the AMA and CPSA for their continued work on this important set of issues.

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I. Introduction/Background

A. Introduction

The impact of health issues on physicians' practices has recently garnered considerable media attention as one of the ways in which our health care system fails, in some instances, to protect patients from harm. At the outset, we acknowledge that there are a variety of issues that impact patient safety; it is beyond the scope of our research and this report to address all of these issues. However, this analysis focuses on the issue of health conditions of physicians that lead to a negative impact on practice. It examines how the medical profession can best ensure that the public is protected, while appropriately addressing the needs and rights of physicians as patients.

The issues addressed in this policy paper are much more than theory; they have real-life consequences and are of concern to patients and society at large. Recent reports illustrating this matter have received considerable attention in North America. It is appropriate to begin this discussion with a brief summary of a few examples.

The winter 2011 issue of International Anesthesiology Clinics (49:1), titled *Anesthesia and Addiction*, was dedicated exclusively to articles discussing the issue of addicted anesthesiologists. Dr. Ethan Bryson, associate professor at Mount Sinai School of Medicine (located in New York, New York), author or co-author of many of the articles in this special edition, and author of the forthcoming book titled *Addicted Healers: 5 Key Signs Your Healthcare Professional May Be Drug Impaired*, describes how addicted physicians will sustain their addictions by diverting drugs from patients. He states that anesthesiologists (who perform life-sustaining functions during surgical interventions) represent up to 30% of all addicted physicians in the United States.[2] Anesthesiologists continuing to practice while impacted by drug addictions may be extremely harmful for patients, potentially leading to injuries such as patient paralysis or irreversible brain damage.[3]

The second example is contained in an article published in the *Archives of Surgery* in February, 2012, which concludes that "[a]lcohol abuse and dependence is a significant problem in US surgeons."[4] This analysis based on existing data found that the percentage of US physicians suffering from a substance use disorder is between 10-15%.[5] Building from this understanding, the authors of this article surveyed American surgeons to determine the rate of alcohol misuse amongst this subset of physicians, and assessed whether or not this alcohol use was associated with incidents (defined as medical error and/or resulting medical malpractice lawsuits) based on self-reports in the survey.[6] The survey employed indicated that 15.4% of responding surgeons met diagnostic criteria for alcohol dependence or alcohol abuse.[7] Additionally, this cross-sectional study stated that "surgeons with alcohol abuse or dependency were substantially more likely to report a major medical error in the last three months, suggesting a potential relationship with quality of care."[8] The authors conclude that this "provides further evidence in support of a proactive approach to identify and treat a prevalent disorder that may affect the surgeon's ability to practice with skill and safety."[9] Finally, this article is of import as it pointed out the perceived stigma and shame that physicians (and surgeons in particular) associate with admitting to, or accepting treatment for, a chemical dependence. The authors conclude with the hope that increasing discussion will work to reduce such shame and stigma, and alter the culture, such that individuals will be less reluctant to seek the assistance they require.[10]

There are many conditions that can affect physicians besides addictions and substance use. An area of concern currently receiving considerable attention in Canada is mistakes made in pathology and diagnostic imaging. While such errors can occur as a result of a wide range of factors, some recent cases have indicated that errors have occurred, at least in part, as a result of physician impairment due to factors such as physical health conditions. These examples raise important questions not only about impairment, but also about how effective current medical regulatory schemes are at preventing medical mistakes, as well as overseeing and managing the repercussions of harm that do occur, regardless of whether the source of harm was physician impairment or other unrelated factors. Recently, concerns about mistakes or oversights in assessing diagnostic laboratory tests have become public in Ontario, New Brunswick and Alberta. One report alleges that a pathologist, serving at the Hospital of Miramichi in New Brunswick from 1993-2007, was operating with error rates up to 1000% higher than pathology standards.[11] A review of his practice by two physicians indicated that he suffered from a significant tremor and cataract-affected vision; it was on the basis of their review that the College of Physicians & Surgeons of New Brunswick suspended

his license to practice. This issue is currently before the courts in New Brunswick as a medical malpractice class action.[12] Similarly, alleged misdiagnosis based on pathology reports completed by one pathologist, serving three hospitals in Windsor, Ontario, resulted in a formal investigation as ordered by Ontario's Minister of Health and Long-Term Care.[13] The physician who made these alleged errors suffered from cataracts that affected his ability to properly assess pathology, yet he kept practicing. His colleagues, despite noticing errors in his reports, did not notify the College of Physicians & Surgeons of Ontario.[14] Alberta has initiated a review of pathology testing and diagnostic imaging in light of errors at three hospitals throughout the province (in Calgary, Edmonton, and Drumheller) in the last few months of 2011. While it is too soon to comment on whether the concerns, if substantiated, are related in part to issues of physician impairment, this review will be important to take into account if such factors are indicated.[15]

It is understandably quite disconcerting for the public to read about physicians affected by a condition that could jeopardize patient well-being. This is especially so if the appropriate mechanisms are not in place, and/or there is a perception that they may not be in place, to protect the public from the physician whose practice has been compromised.

It is understandably quite disconcerting for the public to read about physicians affected by a condition that could jeopardize patient well-being. This is especially so if the appropriate mechanisms are not in place, and/or there is a perception that they may not be in place, to protect the public from the physician whose practice has been compromised. Trust between patient and physician, and trust in the health care system generally, is essential to build and maintain if the aim is to provide patients with high-quality, safe health care services. However, it is equally important to ensure that affected physicians, assuming that such physicians are in need of or could benefit from services, are: (i) able, encouraged and supported to access the services required to address their conditions; and (ii) dealt with in a manner that protects, to a great degree, the confidentiality of their health information.

The privilege of self-regulation is premised, in part, on the "social contract" between the public and physicians, whereby society permits self-regulation of the profession, and, in return, is guaranteed "high standards of competence and moral responsibility."[16] Regulatory bodies have a duty to protect the public, and this arises out of the social contract that is entrenched through legislation. Self-regulation of the medical profession[17] exists with the omnipresent possibility of increased direct government regulation and a reduction of autonomy should the self-regulatory bodies fail to carry out their duties. Such failure would, no doubt, also lead to the erosion of public trust in the medical profession.[18] One of the common criticisms levied against a self-regulated medical profession is the perception that they are unable to protect patients from harm by ensuring the competence of their regulated members.[19] Based on this perception, Canadian provinces and territories have recently enacted novel mechanisms to increase the "accountability and transparency" of the profession.[20] One example, which is particularly relevant to this paper, is the 2007 amendment to the Alberta *Health Professions Act* (the "*HPA*") that provides the Minister of Health and Wellness with the authority to direct the College of Physicians & Surgeons of Alberta (the "CPSA"), after consultation, to either adopt new, or amend existing, standards of practice, bylaws, etc. if "in the opinion of the Minister it is in the public interest or... a direction would provide for matters related to health, safety or quality assurance."[21] This is a significant change from the greater autonomy that self-regulatory bodies have enjoyed hitherto. This trend is certainly not limited to Canada. There are also examples of increased government regulation in other jurisdictions.

Physicians are susceptible to the same illnesses and potential conditions that afflict society at large.[22] Physician Health Programs ("PHPs") exist in provincial and territorial jurisdictions across Canada, and in many other countries, as a mechanism to support physicians in need of assistance. One key rationale for examining PHPs is that existing programs may discourage, rather

than encourage, at-risk or compromised physicians from addressing their health concerns. Our review of the literature suggests that additional research is needed in the area to provide a stronger evidentiary basis with respect to barriers that physicians face in accessing services.[23] Further research is also needed to form a more evidence-based approach to the design of PHPs. However, the research done to date suggests that there are certain obstacles that should be kept in mind. Specifically, explanations for why a physician may not come forward regarding a potential health condition include:

1. The fear that seeking treatment will lead to professional sanctions or practice restrictions;
2. The fear associated with moving from a position of authority to a place of helplessness;
3. The fear of being diagnosed with a serious medical condition;
4. The belief that physicians should be able to heal themselves;
5. Anxiety that their confidentiality may be breached, or that they may be seen in certain locations while seeking out services;
6. The possibility of being exposed to a stigma (real or perceived) or judgment;
7. Denial of the existence of a medical condition;
8. A lack of awareness, or insight, into the condition, or the impact the condition is having, or may have, on their practice;
9. The shame of having let themselves, or others, down;
10. Easy access to medications to facilitate self-treatment;
11. A lack of understanding of, or knowledge regarding, the process that will follow if they seek assistance from a PHP or interact with their professional regulatory body;
12. The fear of potentially losing their ability to earn an income and/or maintain a certain level of income. These fears may be exacerbated if such physicians are without any or sufficient disability or critical illness insurance.[24]

With these introductory thoughts in mind, we now turn to a brief introduction of the questions we were initially given, and the approach employed to develop and present this report.

B. Genesis of this Policy Paper, Questions Posed, Process Employed and Roadmap for the Report

i. Genesis of this policy paper

As discussed, the issue of physician health and the risks posed by compromised physicians continuing to practice has recently received wide-spread attention, both from members of the medical profession, as well as in the realm of public discourse, including numerous media reports. The Health Law Institute (the "HLI") had previously conducted work on related issues and was considering this as the topic of a policy paper. Serendipitously, at the time such a project was under consideration, the HLI was approached by the CPSA and the Alberta Medical Association (the "AMA") about the possibility of conducting research on, and establishing a Working Group to examine, related issues, and to ultimately make recommendations to the two organizations about the appropriate framework to protect the public, as well as physician-patients. While the research would have been conducted and the report written in any event, this coincidence of interest and concern allowed for the additional involvement of a Working Group to provide feedback on the research conducted, and enhanced the analysis and ultimate recommendations through perspectives from other areas of expertise and experience. The project went ahead with the support of these two organizations on the basis that the final report would be published and disseminated regardless of its findings. Both the AMA and the CPSA fully endorsed this approach. The Working Group acknowledges that the decision made by these organizations to jointly commission this policy paper, without advance knowledge of the conclusions reached, and with knowledge that that it will be publically available, is commendable.

Our task was to examine the issues, conduct research, and respond to the issues from a legal, ethical and public policy perspective. One objective of this report is to assist these entities as they work together and with other stakeholders in Alberta. Another aim of this work is to assist other jurisdictions that may be engaged in or considering a similar review.

ii. Questions initially posed

The issues initially posed by the two organizations are listed below. We set out this starting place for our research as it may help to illustrate a number of the initial issues

with which the respective organizations were grappling. However, the structure of this report is not organized as a set of answers to each of these questions in the order that they were initially set out. The questions and issues to be addressed were refined over time, through dialogue, to reach consensus regarding the key issues to be addressed. This was done with the involvement of and dialogue among the Working Group, and key members of the AMA and the CPSA.

1) The overarching query is as follows: for Alberta, what is the recommended model for a program that strives to meet both the regulatory imperatives and the rehabilitative needs of at-risk physicians?

2) Related questions include:
   (i) What should the respective roles of the CPSA and the AMA be in the recommended model?
   (ii) What agency/organization is best suited to assess the risk of a physician with a condition that could affect his/her ability to provide safe patient care? Who has primary responsibility to assess and determine risk, and what other factors should be considered?
   (iii) How should questions be framed on regulation applications and annual renewals within the Standard of Practice?
   (iv) Should the questions only address conditions that have already impacted practice? Should questions attempt to identify risk to patients before practice has been impacted? How should this be balanced with the privacy needs of physicians?

3) Is there any evidence that requiring physicians to report health problems leads to delays in seeking help?

4) Do other regulatory bodies use a different approach to address this issue?

5) Given that self-regulated professions owe a duty to the welfare of the public, does failing to have a proper program in place potentially expose the medical profession to accusations that it is failing to meet this duty?

iii. Process employed

Crafting the most appropriate PHP is of concern across jurisdictions; Alberta is not unique in its search for an effective program that appropriately recognizes the variety of interests, and the legal, ethical and professional duties that are in play. It is clear from the questions initially posed, and the consensus that certain key issues must be addressed, that the AMA and CPSA want to implement the most appropriate PHP, and to deal with the nuances of such a program. While working towards improvements where necessary, the aim was to achieve this without compromising the positive aspects of the programs and frameworks that are currently in place.

In order to address the issues, the Health Law Institute formed a Working Group comprised of the following individuals:

1) Tracey Bailey, Executive Director, Health Law Institute, Faculty of Law, University of Alberta.
2) Cameron Jefferies, Research Associate, Health Law Institute, Faculty of Law, University of Alberta.
3) Sister Elizabeth Davis. Sr. Davis served as a voice for the public interest. She also brought extensive personal and professional experience in health administration.
4) Dr. Philip Hébert, family physician, Professor Emeritus, Department of Family and Community Medicine at the University of Toronto. Dr. Hébert is recognized as having expertise in the field of medical ethics and also provided a physician's perspective.
5) Professor William Lahey, Associate Professor, Schulich School of Law, Dalhousie University. Professor Lahey contributed additional expertise in the area of health law, and combined expertise and experience in the area of human rights and professional regulation in particular.

Our Working Group convened twice in person. The first in-person meeting, held in Edmonton, Alberta in July, 2011, was also attended, in part, by representatives from the AMA and CPSA who introduced the issues and described Alberta's current arrangement. After the HLI completed the necessary research, with conference calls as necessary to ensure that we had consensus from all members of the Working Group in terms of issues and work to be done, the Working Group convened again in

person in November, 2011, in Toronto, Ontario. Here, the Working Group applied the research to the issues and began crafting the recommendations that form the substance of this policy paper. The HLI drafted an initial report, which was circulated to the members of the Working Group for comment and edits in March, 2011. Following a number of revisions, this policy paper is the final product of the Working Group.

The legal research and analysis contained within this report is not a legal opinion and does not constitute legal advice. The work represents the consensus reached by the Working Group in response to the questions we were tasked with answering by the AMA and CPSA, based on the research conducted. For legal advice, individuals and/or organizations should contact legal counsel.

II. Executive Summary & Recommendations

A. Executive Summary

The impetus for the work behind this Report is an increasing awareness that physicians may face barriers that prevent, or reduce the likelihood of, them from seeking out and utilizing beneficial services when experiencing health conditions. While physicians are tasked with treating patients, at times, they themselves are patients and need appropriate care and protections that acknowledge this reality. Physician health is also a concern when considering the goal of maintaining a healthy population of physicians to serve the public through the practice of medicine. While great strides should be taken to eliminate or reduce the barriers that physicians face, an appropriate framework must be in place to protect the public from the harm they could suffer if such physicians' health conditions are not appropriately addressed. The aim of the work leading to our recommendations is to reduce such barriers, increase access to services, whether through physician health programs ("PHPs") or elsewhere, and ensure that the regulators of the profession charged with the protection of the public are able to carry out their legislative mandate.

When physicians become members of the medical profession, they take on legal, ethical and professional obligations to patients and others impacted through their practice of medicine. Given the nature of the profession, physicians have the knowledge, expertise and ability to heal. However, along with the power to maintain or restore health in many circumstances comes the potential to inflict grave harm. One of the key duties discussed in this report is the duty to prevent reasonably foreseeable harm; another is the necessity to place the patient's well-being first. Physicians with health conditions that are negatively impacting their practice must take steps to stop harm from occurring. At-risk physicians have obligations to take steps to avoid causing reasonably foreseeable harm.

While many such duties are well established, others are not necessarily so, or at least are not explicit. The result of this is that physicians, in certain instances, lack appropriate guidance as to the steps they should take.

The first set of recommendations is aimed at appropriate licensure questions, both at the time of an initial application for registration as a member of the profession in a given jurisdiction, and questions posed at the time of annual renewal applications.

Many of the recommendations set out in this Report aim to clarify both the duties of physicians, as well as the protections that should be provided to them.

The first set of recommendations is aimed at appropriate licensure questions, both at the time of an initial application for registration as a member of the profession in a given jurisdiction, and questions posed at the time of annual renewal applications. Human rights legislation, which is applicable to membership in the medical profession, requires that such questions be non-discriminatory. Information requested should be limited to that which is necessary to carry out the mandate of such a regulatory body. As a result, such licensure questions may not be worded too broadly. However, our review of licensure questions from numerous jurisdictions clearly illustrates the point that licensure questions too narrowly focused on certain health conditions may also be discriminatory. Not only does this potentially violate human rights but it contributes

to the barriers physicians and others face in seeking particular types of health services and the stigma related to certain health conditions. Such licensure questions must meet the needs of the regulatory body mandated to protect the public. While much of the practice of medicine encompasses the provision of health services to patients and, as such, the protection of patients in health care settings is key, it is important that such questions relate to the practice of medicine in a broader sense. Physicians whose practice encompasses other spheres, such as research, administration or education, can also cause harm to individuals and this must be captured in the licensure process.

The second set of recommendations sets out the instances when physicians with health conditions should be reported to the regulatory body. Given physicians' legal and ethical duties, we are recommending a standard of practice that makes the obligation to self-report clear. We are also recommending a standard of practice that establishes a duty on treating physicians and staff of PHPs to report. We also recommend that a standard of practice be established for physician-colleagues. In the Alberta context, while such standards of practice exist, our recommendations are aimed at setting different reporting thresholds for each of these groups. Where such standards do not exist in other jurisdictions, we are recommending that they be established. Regardless of whether they exist or not, we are recommending the same reporting thresholds.

Our next recommendation sets out a framework for the governance and administration of a PHP in Alberta. This recommendation may well serve as a model in other jurisdictions. This model also aims to reduce barriers that physicians face in accessing appropriate services while enabling the regulatory body to meet its legislative mandate to protect the public. As the PHP in Alberta was functioning well in many ways, the key additions we have recommended are the addition of tools that will ensure accountability regarding reporting thresholds, as well as ensuring appropriate oversight and accountability to stakeholders, including the Alberta Medical Association, the College of Physicians & Surgeons of Alberta, the public and others.

Our final set of recommendations encompass the need to appropriately evaluate PHPs, to conduct research to bolster evidence about barriers and effective aspects of PHPs, to minimize financial barriers that physicians may face and to urge other stakeholders, both within and outside of Alberta, to seriously consider the recommendations and rationale set out in this Report.

B. Recommendations

The following recommendations, if viewed in isolation from one another, will not achieve the aims of the work contained in this report. Many are interdependent and will not result in the intended effect if they are implemented in a piecemeal fashion. Therefore, the recommendations should be considered as an overall set of steps to be taken to strike a balance between two key objectives: (i) protecting the public; and (2) reducing barriers that physicians face in accessing appropriate health services. Such services should be provided in a way that protects physicians' interests to the greatest extent possible.

Recommendation 1:

We recommend that the following wording be used, along with other relevant information, for initial application licensure questions directed at health conditions:

Do you presently have a physical, cognitive, mental and/or emotional condition that is negatively impacting your work, or is reasonably likely to negatively impact your work in the future?

Have you ever had a physical, cognitive, mental and/or emotional condition that, were it to reoccur, would or would be reasonably likely to negatively impact your work in the future?

Recommendation 2:

We recommend that the following wording be used, along with other relevant information, for renewal application licensure questions directed at health conditions:

Do you presently have a physical, cognitive, mental and/or emotional condition that is negatively impacting your work, or is reasonably likely to negatively impact your work in the future that has not been previously reported to the College?

Have you ever had a physical, cognitive, mental and/or emotional condition that, were it to reoccur, would

or would be reasonably likely to negatively impact your work in the future that has not been previously reported to the College?

Recommendation 3:

We recommend that "negative impact" on work must be defined in the applications. The definition should make clear two main points:

a. Harm to patients or others as a result of the practice of medicine is the negative impact that these questions intend to address. If the impact of a physician's condition is not related to the well being, health and/or safety of others within his or her practice of medicine, the questions need not be answered in the affirmative.

b. The practice of medicine includes research, education and administration with respect to health, in addition to the practice associated with patients.

Recommendation 4:

We recommend that the following criteria apply to whatever wording is used for questions asked on initial and renewal applications relative to reportable conditions:

a. Make it clear that all health conditions are contemplated and included. Wording should list examples of various conditions to illustrate the breadth of conditions being contemplated, and should not be restricted to particular conditions or types of conditions, to the exclusion of others.

b. Require conditions to be reported only where there is a connection between the condition and a negative impact on the practice of the physician.

c. Encompass past conditions, as well as present conditions, where such a condition is reasonably likely to negatively impact the practice of the physician should it reoccur.

d. Make it clear that applicants are not being asked for information about a condition that has been previously provided.

e. Ensure that licensure questions are identical on both the initial application and the renewal application, with the following exception: the renewal questions should be limited to information not previously collected.

Recommendation 5:

We recommend that a Standard of Practice for Self-Reporting to the College be implemented to align with the recommendations made with respect to the licensure questions.

Recommendation 6:

We recommend that a new Standard of Practice be created setting out the duty of a treating physician to report a physician-patient to the CPSA. The new Standard of Practice for treating physicians should create a duty in instances where it is reasonably foreseeable that patients of the physician-patient (or others in the context of the practice of the physician-patient) could be seriously harmed (whether physically or psychologically) as a result of the physician-patient's condition. This standard would apply to treating physicians whether the health services provided are done so within the PHP, or independently of the PHP. Non-treating physicians working within a PHP should also be subject to this standard.

Recommendation 7:

We recommend that the policies and procedures of any PHP model adopted establish and enforce the same reporting threshold for staff, contractors and/or other affiliated individuals of the PHP as that recommended for treating physicians of physician-patients.

Recommendation 8:

We recommend that the present Revised Draft for Consultation of the Duty to Report a Colleague Standard of Practice be further revised. The basis of reasonable grounds and the reference to health conditions that "could" limit a physician's ability should be retained. The reference to "patients at risk" should be expanded to others at risk within the context of a physician's practice of medicine. The list of health conditions set out as examples should be expanded in keeping with the findings of this report.

Recommendation 9:

We recommend that the Physician Health Program Co-Management Model in our report be adopted. This model has most of the PHP functions primarily residing with the AMA. The CPSA continues to conduct monitoring of physicians when such is appropriate. This will see the addition of a Review Panel to assess cases where it is unclear whether the reporting threshold applicable to treating physicians, and others with the same reporting obligation, has been met. In each case where this reporting threshold is met, the case will be reported to the CPSA. This Co-Management Model will also see the implementation of a Program Monitoring Feature to ensure quality control, and to satisfy both the public and the CPSA that appropriate policies and procedures are in place, and are being followed.

Recommendation 10:

We recommend that an evaluation mechanism of the new PHP be implemented, to assess the effects of the changes after a specific time period. We recommend that such an initial evaluation be completed within two years of implementation of a new PHP model.

Recommendation 11:

We recommend that research be undertaken to assess the most effective tools for encouraging physicians to seek assistance for the health conditions that have an impact on their work life.

Recommendation 12:

We recommend that an amendment to Alberta's *Health Information Act* to enshrine a duty, rather than a discretion, to report in instances of imminent danger be proposed to government to be considered.

Recommendation 13:

We recommend that the AMA and the CPSA discuss ways to ensure that physicians are adequately insured, whenever possible, if they are unable to practice (whether temporarily or permanently).

Recommendation 14:

We recommend that the AMA and the CPSA recommend to their counterparts across Canada that they examine the licensing questions, as well as the reporting obligations in place in their respective jurisdictions and consider making changes in keeping with the findings of this report. In particular, instances of certain conditions being singled out should be eliminated. These distinctions not only fail to address the aim of protecting the public, but also, of arguably equal concern, may well contribute to the stigma associated with certain conditions such as mental health issues.

Endnotes

1 See Tracey M Bailey and Cameron S G Jefferies, *Physicians with Health Conditions: Law and Policy Reform to Protect the Public and Physician-Patients* (2012), online: HLI <http://www.hli.ualberta.ca/en/~/media/hli/Publications/Docs/Physicians_with_Health_Conditions_Complete.pdf>.

2 Sharon Kirkey, "Addictions in the Operating Room: Patients are in Danger when an Anesthetist's top Priority is feeding a drug habit" *Postmedia News* (12 February 2012), online: Edmonton Journal <http://www2.canada.com/edmontonjournal/news/sundayreader/story.html?id=747933dc-e0c7-44a0-840f-b19ec5ac9d41 >.

3 *Ibid.*

4 Michael R Oreskovich et al, "Prevalence of Alcohol Use Disorders Among Surgeons" (2012) 147:2 Arch Surg 168 at 168.

5 *Ibid.*

6 *Ibid.*

7 *Ibid* at 171.

8 *Ibid.*

9 *Ibid.*

10 *Ibid* at 171, 173.

11 Wagners: A Serious Injury Law Firm, "New Brunswick Medical Malpractice Class Action goes to Court" (12 September 2011), online: Wagners Medical Malpractice Lawyer Blog <http://www.wagnersmedicalmalpracticelawyerblog.ca/2011/09/new-brunswick-medical-malpractice-class-action-goes-to-court.html>.

12 *Ibid.*

13 Dr. Barry McLellan, Dr. Robin McLeod & Dr. John Srigley, *Report of the Investigators of Surgical and Pathology Issues at Three Essex County Hospitals: Hotel-Dieu Grace Hospital, Leamington District Memorial Hospital and Windsor Regional Hospital* (July 2010),

online: <http://www.health.gov.on.ca/en/public/publications/ministry_reports/surgical_pathology_issues/docs/surgical_pathology_issues.pdf> [Report of the Investigators].

14 Andre Picard, "What we should learn from our pathology problems" (2 January 2012), online: <http://m.theglobeandmail.com/life/health/new-health/andre-picard/what-we-should-learn-from-our-pathology-problems/article2289094/?service=mobile >. Report of the Investigators, *ibid* at iv.

15 Dawn Walton, "Botched Medical Tests Prompt Alberta to Order Sweeping Review", *The Globe and Mail* (29 December 2011), online: The Globe and Mail <http://www.theglobeandmail.com/news/national/botched-medical-tests-prompt-alberta-to-order-sweeping-review/article2286769/>.

16 Tracey Epps, "Regulation of Health Care Professionals" in Jocelyn Downie, Timothy Caulfield & Colleen M Flood, eds, *Canadian Health Law and Policy*, 4th ed (Markham: Lexis Nexis, 2011) 75 at 78 [Epps].

17 *Health Professions Act*, RSA 2000, c H-7 provides for self-regulation of the medical profession in Alberta [*HPA*].

18 Tracey Epps, *supra* note 16 at 78.

19 *Ibid* at 85.

20 *Ibid* at 97.

21 HPA, s 135. There are other important examples of increased government involvement across Canada. Firstly, in 2009, Ontario adopted the *Regulated Health Professions Statute Amendment Act 2009*, SO 2009, c 26. This statute added section 5.0.1 into the *Regulated Health Professions Act*, SO 1991, c 18. Section 5.0.1 gives the Minister of Health broad authority to appoint a supervisor to govern any health profession college in Ontario in place of its governing council when the Minister has agreement of the Lieutenant Governor in Council. Section 5.0.2 provides factors that the Minister may consider in making their recommendation. This power was recently exercised by the Minister of Health with the College of Denturists after a government ordered audit called into question the governance of this college (see Nicholas Keung, "Province takes over denturists' regulator" *The Star* (27 March 2012), online: The Star <http://www.thestar.com/news/ontario/article/1152870--province-takes-over-denturists-regulato>). In announcing the move, the Minister quoted the audit to effect that "There is an inability of college leaders to distinguish between the public interest and the profession's self-interest." (*Ibid.*) Secondly, a number of provinces in Canada have introduced legislation that creates a government office tasked with overseeing the "fairness" of the registration process of self-regulating professions, under the broad framework of the *Agreement on Internal Trade* (see *Agreement on Internal Trade*, online: <http://www.ait-aci.ca/index_en.htm >). For example, see the *Fair Registration Practices Act*, SNS 2008, c 38 in Nova Scotia, *The Fair Registration Practices in Regulated Professions Act*, CCSM c F12 in Manitoba, and the *Fair Access to Regulated Professions Act, 2006*, SO 2006, c 31 in Ontario.

22 College of Physicians & Surgeons of Alberta, "Frequently Asked Questions: Licensed Physicians", online: College of Physicians & Surgeons of Alberta <http://www.cpsa.ab.ca/Resources/PHMC_Overview/PHMC_Monitoring_Medical_Conditions.aspx>.

23 See Margaret Kay, Alexandra Clavarino & Jenny Doust, "Doctors as patients: a systematic review of doctors' health access and the barriers they experience" (2008) 58:552 Br J Gen Pract 501 at 501 for a systematic review of research in the area. A few other examples of research conducted include: Fiona Fox et al, "What happens when doctors are patients? Qualitative study of GPs" (2009) 59:568 Br J Gen Pract 811; Sandra K Davidson & Peter L Schattner, "Doctors' health-seeking behaviour: a questionnaire survey" (2003) 179:6 Med J Aust 302; William T Thompson et al, "Challenge of culture, conscience, and contract to general practitioners' care of their own health: qualitative study" (2001) 323:7315 BMJ 728; and JG Richards, "The health and health practices of doctors and their families" (1999) 112 NZ Med J 96.

24 See Kate O'Connor & Joanna MacDonald, "Chapter 16: Doctor's Health" in Ian St George ed, *Cole's Medical Practice in New Zealand* (Wellington: Medical Council of New Zealand, 2009) at 139 for a list of a variety of reasons why a physician may be reluctant to become a patient [O'Connor & MacDonald].