

The legal, ethical and organizational aspects of medical practice in Quebec

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Note: In this publication, the masculine gender is used without prejudice and solely to facilitate reading.

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FOREWORD

We are delighted to present the new digital edition of the document *Legal, ethical and organizational aspects of medical practice in Quebec (ALDO-Quebec)*. This document replaces the online edition and has been created in response to requests from numerous users who would like to be able to print all or part of the document. However, it remains a user-friendly tool, with the addition of an interactive table of contents and hyperlinks to allow quick access to the contents.

The document will evolve as new legislative or regulatory provisions are introduced and in step with any other ethical or organizational changes.

This document was initially intended for those applying for a permit to practice medicine in Quebec. Over the years, however, it has become a reference for all physicians practicing in Quebec who wish to improve their knowledge of these topics. From 1988 to 2007 for residents in family medicine and from 1996 to 2007 for residents in other specialties, successful completion of the ALDO examination, administered by the Collège des médecins du Québec, was necessary to obtain a permit to practice. Since 2007, a mandatory educational activity based on the content of the document has replaced the examination. This is why it is important for us to keep it up to date.

We believe that the ALDO-Quebec document can fuel the reflection of physicians in Quebec. It can help them to quickly grasp the key components of the organization of the health and social services system and the legal and ethical framework of medical practice in Quebec. These components are guideposts physicians can refer to in order to better situate themselves and to better bear the moral burden of decisions they must make in the interest of and in collaboration with their patients.

Once again, we would like to thank everyone who contributed to the creation and development of the ALDO-Quebec document: the writers, the publishing team and the many contributors who have joined us along the way.

Mauril Gaudreault, M.D.
President
Collège des médecins du Québec

INTRODUCTION

In 1988, Quebec's four faculties of medicine and the Collège des médecins du Québec decided to produce a document for medical residents. The document dealt with aspects of medical practice that are specific to Quebec. They were mainly legal, ethical and organizational in nature, hence the name ALDO-Quebec, after the French acronym. The ALDO-Quebec document has undergone several revisions and still aims to provide the information considered necessary to good medical practice in Quebec. It looks at the organization of the health care system, medical ethics and the laws and rules that apply. Moreover, a mandatory educational activity based on the ALDO-Quebec document is organized by the Collège des médecins.

The document is divided into three sections.

Section 1: Organizational aspects

This section deals with organizational aspects and has three broad subsections. The first subsection provides an overview of the history of Quebec's health care system since the late 18th century.

The second subsection presents the overall organization of Quebec's health care system today and the organization that is envisaged for medical services, for it is imperative that physicians know how their professional practice fits into the system as a whole.

The third subsection focuses on the current organization of medical practice. First, the two main types of professional practice in Quebec are described. Practice in an institution is an independent type of professional practice but is linked in many ways to the structure and operation of public institutions. Practice outside an institution is linked to the public system and the health insurance plan but the links are less direct and are not necessarily maintained by the institutions. While increasingly prevalent, medical practice without any link to the public health care system ("non-participating" physicians) remains a marginal phenomenon in Quebec. This is followed by a description of the phenomenon of practice diversification. Running parallel to the common types of practice are a number of other forms of medical practice, including clinical research, medicolegal expertise, public health practice, occupational medicine and administrative and commercial practice. Each in its own way raises the issue of professional independence.

Section 2: Ethical and regulatory aspects

This section concerns physicians more directly, since it focuses on the ethical aspects of medical practice in Quebec. Here, medicine is looked at from the perspective of professional practice. The aim of the *Code of ethics of physicians* is to set out as clearly as possible the obligations that every physician must fulfil. This is not easy in a context of relatively new and complex realities, be it medical

entrepreneurship, clinical research, medicolegal expertise, interprofessional collaborative practice, limited resources, information technologies or relations with the pharmaceutical sector. Therefore, we must be innovative and ask our own questions about the independence of professional practice in the face of increasingly pressing economic, political and administrative constraints in the health sector.

In this context, it must be noted that the Collège is not the only organization to work with physicians. Medical federations, for example, play a key role in negotiating the practice conditions of physicians. The Collège remains a vital regulatory body for the medical profession in order to assure the general public of the quality of services and the integrity of physicians.

Section 3: Legal aspects

This section focuses on the legal aspects of medical practice. In Quebec, as elsewhere, many laws have a bearing on the practice of medicine. This section provides an overview of these laws, highlighting those that impose special obligations on physicians and those that regulate “medical civil liability”. In-depth analysis of the issue of medical civil liability and the risk of legal action shows that it goes beyond the strict legal framework. Indeed, transparency as well as ethical and organizational considerations often improve the quality of medical practice, thereby reducing the risk of legal action.

SECTION 1 – ORGANIZATIONAL ASPECTS

1. Overview

It is essential that all physicians practicing in Quebec understand how the health care system functions. This is not necessarily an easy task, for health care systems throughout the world, whether public, private or mixed, have become imposing, complex structures. What's more, Quebec's system differs from those in other Canadian provinces in some respects. Indeed, one of its longstanding orientations has been the structural integration of health and social services which must be managed by the State, thus adding to its complexity.

The first section gives an overview of the health and social services system — “Quebec-style”. A brief history will illustrate how Quebec's health care system compares to other public systems, sharing their successes, but also certain challenges that have become unavoidable in a situation where needs increasingly exceed resources. This overview will also show how Quebec's system is characterized, for instance, by its centralized general organization, which may seem paradoxical given that, in practice, services are essentially provided at the local level. From 2003 to 2015, the health care system had three levels of management (Ministère de la Santé et des Services sociaux, health and social services agencies and institutions) which were reduced to two in the reform proposed by Minister Gaétan Barrette. Following the reform, only the MSSS and the institutions remained, most of which were grouped into “super institutions” called integrated health and social services centres (centres intégrés de santé et de services sociaux - CISSS) and integrated university health and social services centres (centres intégrés universitaires de santé et de services sociaux - CIUSSS).

The second section specifically aims to situate the professional practice of physicians within the health care system. Medical practice is widely considered an essential component of health care systems. However, the way in which the professional practice of physicians is integrated has not always been clear in Quebec. This is still the case and the various types of practice that exist bear this out. Since 2002, in addition to practice in an institution and office-based practice, other intermediate types of medical practice have been developed. These include specialized medical centres (SMCs), associated specialized medical centres (ASMCs), associated medical centres (AMCs) as well as family medicine groups (FMGs) and their derivatives, namely, university family medicine groups (U-FMGs) and family medicine groups with a network designation (FMG-N or super clinics). Once again, these new developments point to the difficulties inherent in wanting to integrate independent professionals into an essentially public system.

Practice in an institution is an independent type of professional practice. However, since it is often linked to institutions in the public system, this type of practice requires physicians to reconcile their ethical obligations with the medical and administrative constraints of institutions as stipulated in the *Act respecting health services and social services* (AHSSS). While these obligations and constraints are

not usually mutually opposed, it can sometimes become difficult to reconcile them adequately in some circumstances of practice in an institution.

In contrast, medical practice outside public institutions is often referred to as “private practice”. Yet, with a few exceptions, it is also an integral part of the public health care system, if only because medically necessary services are publicly funded; in other words, physicians, irrespective of their place or type of practice, are generally remunerated by public funds when they provide medically necessary services. Here again, many formulae have been put in place to better integrate this type of practice into the public network, from local community services centres (centres locaux de services communautaires - CLSC) to family medicine groups (FMGs), from regional medical staffing plans (plans régionaux d'effectifs médicaux - PREM) to specific medical activities (SMAs). To date, the results have been mixed, so that one can rightly ask whether the tension between the professional independence of physicians and the very centralized organization of the health care system should be considered differently.

The organizational aspects of medical practice in Quebec pose a particular challenge for physicians, in addition to all those they are already facing. Indeed, what we see is that physicians are increasingly practicing in a variety of areas. Clinical research, medicolegal expertise, occupational medicine, public health as well as administrative and commercial types of practice are all areas of activity in which the professional independence of physicians is constantly being put to the test.

2. The health and social services system

2.1 The Quebec way

The health and social services system is a pillar of social policy in Quebec. For the individual, it offers a guarantee of security in the event of health problems. For the community, it represents an instrument of social justice and progress.

Quebec's health and social services system was established in 1970. This was a pivotal moment, marking a culmination, on the one hand, and a point of departure, on the other.

2.1.1 A culmination

The creation of the public health and social services system was the culmination of a long developmental process. There is no need to recall every milestone in the history of medical services and, in a more global sense, of health and social services in Quebec. Suffice it to mention a few salient facts.

Between 1788 and 1831, the *Medical Act* provided for the exclusivity of medical practice in Quebec, then Lower Canada, and medical licences were issued by the governor, on the recommendation of boards formed under his auspices in Montreal and Quebec. In 1831, the *Medical Act* was amended, with boards now composed of members elected by professionals. Finally, the College of Physicians and Surgeons of Lower Canada was established in 1847 to verify and ensure the competence of anyone practicing medicine.¹

In 1867, at the time of the passage of the *British North America Act*, renamed the *Constitution Act of 1867* in 1982, the health sector was occupied mostly by religious or charitable organizations, as well as by individuals, and the State did not play a significant role. This explains why “quarantine and the establishment and maintenance of marine hospitals” were under exclusive federal authority (s. 91(11)), while the “establishment, maintenance, and management of hospitals, asylums, charities, and eleemosynary institutions in and for the province, other than marine hospitals” were under exclusive provincial authority (s. 92(7)). Over time, both levels of government extended their authority to the health sector. The federal government's powers encompassed general spending, authority over certain populations, including the military (s. 91(7)) and “Indians, and Lands reserved for the Indians” (s. 91(24)), penitentiaries (s. 91(28)) as well as procedure in criminal matters (s. 91(27)). Matters assigned to the legislatures of the provinces included “public and reformatory prisons” (s. 92(6)), municipalities (s. 92(8)), “property and civil rights” (s. 92(13)), education (s. 93) and “generally all matters

¹ LEBLOND, Sylvio (1970). “La médecine dans la province de Québec avant 1847”, *Les Cahiers des dix*, Issue 35, pp. 69-95. The CPSLC became the Professional Corporation of Physicians of Quebec in 1974, and the Collège des médecins du Québec in 1994.

of a merely local or private nature in the province” (s. 92(16)). Since health services are considered to be local, there are essentially 13 different health care systems in Canada, one for each province and each territory. However, the federal government maintains a certain influence due to its spending power and the funds it transfers to this sector.

In 1886, following a smallpox epidemic, the provincial government created the Provincial Commission of Health of the Province of Quebec, renamed the Board of Health of the Province of Quebec in 1888. It was mandated to check the spread of infectious diseases and improve sanitary conditions. To achieve this, it established a network of municipal offices and created a mandatory immunization scheme in addition to putting emergency public health measures in place during some outbreaks (mandatory reporting, quarantine and disinfection). It would change name again in 1915, and in 1922, when it became the Provincial Health Service, considered the precursor to the Ministry of Health. At the same time, in 1921, the Government of Quebec passed the *Public Welfare Act*, asserting its authority to fund, but also to intervene and supervise services for the “indigent”, an area until then reserved to the Church and other religious organizations. In 1926, the government passed amendments to the *Public Health Act of Quebec*, allowing the creation of health units, that is, the amalgamation of municipal health authorities on a regional basis, making for immense progress in public health. Lastly, in 1936, under the *Act providing for the organization of a department of health*, the Provincial Health Service was replaced with the Ministry of Health, whose main responsibility was to resolve the issue of hospital deficits and improve their administration. More generally, the Ministry’s responsibilities concerned “public health and hygiene, public welfare, the insane and the inspection of hospitals and other charitable institutions.”

In Canada, as in all industrialized countries, the end of World War II launched a period of tremendous advances in the area of social policy. This was the beginning of the “Trente Glorieuses” (1945–1975), three decades marked by economic prosperity unprecedented in history. As for Quebec, it would have to wait until the early 1960s and the end of the Duplessis era to experience the same effervescence. Indeed, the changes were so swift and sweeping that Quebec was transformed into bubbling cauldron of social ferment. This was the time of the Quiet Revolution.

In the decade preceding it, the federal government had laid the groundwork for social measures. It had implemented old age security (1951), unemployment insurance (1956) and a measure that would have a major impact on the development of health and social services: hospital insurance (1957). The federal government drew its inspiration from the findings of the Marsh Commission (1943), considered to be Canada’s social charter, and from the policies of the United Kingdom, in particular the Beveridge Report (1942), which led to the establishment of the British health care system, the National Health Service (1948).

Saskatchewan was the first province to establish publicly funded plans, namely, a hospital insurance plan in 1948 and a universal health insurance plan in 1962. The Cooperative Commonwealth Federation (CCF), the precursor of the New Democratic Party (NDP), may therefore be considered the “pioneer” of health insurance in Canada.

In Quebec, in the 1960s, a series of measures were adopted, in particular the *Hospital Insurance Act* (1960), which provided free hospital services to the user, the *Act respecting the Québec Pension Plan* (1965) and the *Medical Assistance Act* (1966), which represented the Government of Quebec’s first incursion into the field of professional practice to insure medical and surgical services for social welfare recipients. This Act was passed following the conclusion of an agreement between the government and the Fédération des médecins omnipraticiens du Québec (FMOQ) and the Fédération des médecins spécialistes du Québec (FMSQ), created in 1963 and 1965 respectively. This agreement and the Act provided, in particular, that physicians would be remunerated on a fee-for-service basis and at a negotiated rate, in addition to recognizing the two medical federations as the only representatives of all physicians in Quebec for the purposes of this negotiation.

In the area of health, social services and social development, the lack of a global perspective was, however, cause for deep concern. Conclusions would emerge from two important task forces: the Study Committee on Public Assistance (Boucher Committee, 1963) and the Commission of Inquiry on Health and Social Welfare (Castonguay-Nepveu Commission, 1966-1972). The Boucher Committee recommended that the public sector take over activities related to social assistance from the Church and other charitable organizations. It insisted on the need for Quebec to adopt a global economic and social policy and it defined its broad parameters. The Castonguay-Nepveu Commission presented the government with a global and generous vision of social security based on three pillars: health, social services and income security. It also proposed the implementation of an innovative model for the organization of services that would take these concerns into account.

2.1.2 A point of departure

In the early 1970s, the Government of Quebec established a new legislative framework to support the implementation of the public health and social services system. This framework included the following key pieces of legislation: the *Act respecting the Ministère des Affaires sociales* (1970), the *Health Insurance Act* (1970) and the *Act respecting health services and social services* (1971).

Bringing together the Ministry of Health and the Ministry of the Family and Social Welfare, the new Ministry of Social Affairs, led by Minister Claude Castonguay, elected following his resignation as commissioner, was responsible for adopting the government’s broad policy directions with respect to health, social services

and income security, and for defining the rules for the administration and operation of institutions. In 1970, the *Health Insurance Act* introduced free medical services for all users, a prerequisite to obtaining new federal funding. In 1971, the *Act respecting health services and social services* broadened the scope of the *Health Insurance Act* and provided for universal access to a complete range of health services and social services. It also specified how the new public system would be organized: the mission of institutions, the role and responsibilities of the institutions' committees, the role and responsibilities of the new regional body (Regional Health and Social Services Board), the powers of the minister, etc.

In the 1970s, Quebec underwent a complete overhaul. But the new organization would soon run into obstacles that would affect its development over the next thirty years:

- > The cost of services continued to increase rather than decrease as had been predicted after the required period of investment, given that the population would be healthier. Thus, the problem of hospital deficits, in particular, remained unresolved.
- > The new institution, the local community services centre (CLSC), which was to be the cornerstone of primary care services, did not fulfil its promise for a variety of reasons: hesitation on the government's part, a lack of resources, an unfavourable climate in some CLSCs, resistance on the part of physicians to practicing there, etc. In this context, medical clinics and hospital emergency rooms became the real front line.
- > The coordination of efforts had its shortcomings; the dividing lines between institutions and between professionals were impediments to the effectiveness and efficiency of services.
- > Centralized decision making, which made for great rigidity.

These difficulties would become more pronounced over the years and, coupled with the economic crisis in the early 1980s, would lead to an impasse. The government then created a commission of inquiry chaired by Jean Rochon; its mandate was to find solutions to the problems of funding and operating the system. Fifteen years later, another commission of inquiry, chaired by Michel Clair, would be given the very same mandate. Yet, during this period, we would witness profound changes that would clearly improve the system's general performance, but at the cost of severe budget cutbacks that led to the compulsory retirement of health professionals, reductions in hospital beds and hospital closures. However, these changes did not appear to satisfactorily resolve the basic problems that had remained since 1970: the weaknesses in primary care, the ever-growing needs with respect to coordination and the funding problems. Other reforms would therefore be introduced to tackle these very problems. Two other commissions of inquiry were established in the 2000s to re-examine the problem

of funding. One, chaired by Jacques Ménard, tabled its report in July 2005; the other, chaired by Claude Castonguay, the very father of health insurance in Quebec, published its report in February 2008. Both reports identified an increase in health spending in excess of government revenues, inevitably leading to a financial impasse. To offset the impasse, they proposed using additional revenues, in the form of a specific tax or private sources of funding (user's contribution, insurance, etc.). The mixed nature (public/private) of medical practice was central to the debate. They also noted that there was still room to improve the efficiency and effectiveness of the public system, whose adaptability and flexibility were still weighed down by a cumbersome bureaucracy that seemed resistant to streamlining. The objective of Minister Gaéтан Barrette's latest reform, undertaken in 2014, was to tackle these very issues by reducing the bureaucracy and improving the efficiency and effectiveness of the health care system in order to increase access to care.

2.2 General characteristics

In many ways, Quebec's health and social services system is similar to those in other Canadian provinces. Thus, throughout Canada, access to medical services and hospital services is subject to similar rules and the general organization of services shares common characteristics, mainly due to the *Canada Health Act*, which sets out certain principles that must be respected across the country with respect to the allocation of resources, such as the universality of care and the public administration of health insurance. In other important respects, however, Quebec's system has its own unique characteristics. The reason for these similarities and differences lies in the very origins of the system and in its recent developments.

2.2.1 Canadian characteristics

Health care is under provincial jurisdiction. However, since the mid 20th century, the federal government has used its spending power to gradually introduce a truly Canadian health insurance plan and to impose its vision on the development of this plan. From this perspective, for example, we can understand this government's major planning exercises, in particular the Hall Commission in the early 1960s, the National Forum on Health in the 1990s and the Romanow Commission in the early 2000s.

The Government of Canada has also used legislation to gradually imprint its vision. The passage of the *Hospital Insurance and Diagnostic Services Act* (1957) was a first step. It provided for 50/50 cost-sharing between the federal government and the provincial governments. This was also the case with the *Medical Care Act* (1966), aimed at encouraging the provinces to enact a similar act and thus cover medical costs. This measure represented a decisive step in establishing a universal health insurance plan. Note that this Act established four conditions for the

provinces: services must be universal (at least 95% of the population must be covered), comprehensive, portable (a citizen from another province must have the same advantages as a resident) and publicly administered.

These principles would be reiterated, adapted and consolidated in the *Canada Health Act* (1984), which is still in force. It regularly provokes strong reactions in the public arena and in the health care sector owing to the limitations it imposes on the introduction of private funding modalities in the system. We know that it was adopted to counter the extra-billing of medical services in some provinces, particularly in Ontario and Alberta. But above all, it was intended to reaffirm the foundations of the “Canadian health insurance plan” and explicitly define the conditions that must be met by provincial governments in order for them to receive federal contributions in support of health.

Today, throughout the country, the provincial plans must respect the following five principles (*Canada Health Act*, s. 7 and following):

- > accessibility;
- > universality;
- > comprehensiveness;
- > portability;
- > public administration.

In addition, the provincial plans must comply with two prohibitions, namely:

- > extra-billing (s. 18);
- > user charges (s. 19).

These two provisions ultimately prohibit physicians and governments from billing citizens an additional amount for publicly funded health services; should a province fail to comply with these prohibitions, financial penalties must, in principle, be imposed by the federal government. These principles and prohibitions apply to medical services and hospital services. From a Canadian perspective, they are not appropriate for other service sectors.

Furthermore, while the federal government’s contribution to funding has steadily decreased over the years – in 2015, it covered no more than 23% of costs, compared with 50% in the mid 1970s – the principles in the *Canada Health Act* have retained all of their political legitimacy today because they have the support of a very large segment of the population. Discussions on these principles have, however, been reopened by a decision of the Supreme Court rendered in 2005 in the Chaoulli-Zélotis case, in which the Court ruled that purchasing private insurance to obtain medically necessary care should be permitted when wait times in the public system are unreasonable (additional information on the impact of this ruling will be provided further on).

2.2.2 Characteristics unique to Quebec

Since its creation, Quebec's public system has brought health services and social services together under one administration. This has the advantage of better meeting the needs of populations that require more services, in particular, frail older adults and people with disabilities.

Quebec is the only province to have established a general drug insurance plan. The other provinces have various selective programs that serve specific populations, which gives rise to access problems. Before this plan was introduced in 1997, 20% of Quebec's population had no insurance of this type, either public or private.

Quebec is also the first province, in response to the Supreme Court ruling, to legislate certain organizational changes with the potential to increase access to care as well as the possibility of using private resources in specific cases where the care required is not accessible within medically reasonable wait times.

In December 2006, the Government of Quebec passed the *Act to amend the Act respecting health services and social services and other legislative provisions* in order to establish a central mechanism in hospital centres for managing access to surgical procedures and to allow the use of private facilities if access to three types of procedures (hip and knee replacement and cataract surgery) was not available within a reasonable wait time. An opening was also created for the use of private insurance for the same procedures.

Bill 33, which became the *Act to amend the Act respecting health services and social services and other legislative provisions*, established a legal framework whereby certain medical services usually provided in an institution could be provided outside an institution, that is, in specialized medical centres (SMCs), composed exclusively of either physicians who do or physicians who do not participate in the public health insurance plan (AHSSS, s. 333.1 and following). All SMCs that provide services determined by regulation must meet three requirements:

1. obtain an operating permit from the government;
2. appoint a medical director responsible for ensuring the quality of medical services;
3. within three years after the permit is issued, have the services provided in the centre accredited by a recognized accreditation body.

The Minister has the regulatory authority to add other specialized medical treatments that can be privately insured and provided by SMCs after consultation with the Collège des médecins du Québec. In 2008, the *Regulation respecting the specialized medical treatments provided in a specialized medical centre*, which added a number of treatments that could be provided by SMCs, was passed by

the Minister of Health and Social Services Philippe Couillard by ministerial order. The Regulation was subsequently amended several times before reaching its current version in 2010.²

The Act also created associated medical clinics (AMCs), which are private offices of professionals, medical laboratories or AMCs associated by an agreement with a public institution (AHSS, s. 349.1 and following). Physicians who provide services in AMCs must participate in the public health insurance plan and must have an appointment allowing them to practice their profession in a hospital centre. The goal is to improve the accessibility and efficiency of the network.

Agreements must specify:

1. the nature of the specialized medical services to be provided;
2. the minimum and maximum number of services and how those services are to be distributed on a quarterly basis;
3. the unit amount and the terms of payment;
4. a monitoring mechanism that will allow the institution to ensure the quality and safety of the medical services;
5. the fees that may be charged to users and the information that must be given to the user;
6. the bookkeeping, information system and reporting requirements;
7. a mechanism to resolve disputes.

2.3 The organization of care

2.3.1 General organization

The organization of services

In terms of organization of services, the public system now operates on two levels: the Ministry and the institutions, that is, 22 integrated centres and 7 non-amalgamated institutions.

Power sharing between the different levels has changed over the years. In the 1970s, the system was very centralized and most decisions were made at the central level, that is, at the Ministère de la Santé et des Services sociaux (MSSS). Over time, many social players advocated decentralization of the system. In 1987, the Rochon Commission made it one of its key recommendations. As a result, the regional boards of health and social services were created in 1991. But in practice, these new boards did not have the necessary means to create what could be

² *Regulation respecting the specialized medical treatments provided in a specialized medical centre*, CQLR, c. S-4.-2, r. 25.

called regionalization in a true sense. Indeed, throughout the 1990s, the central level held onto the reins of major decision making, such as the rules for budget allocations to institutions, the rules for work organization and the distribution of resources among institutions. It must be said that the climate of budget cutbacks that prevailed as the regional boards took their first steps was not conducive to decentralization.

In 2003, a new trend emerged: the government decided to modify the governance of the health care system by establishing a three-tier management structure. First, it created health and social services agencies (agences de la santé et des services sociaux - ASSS), charged with reorganizing the health care system by amalgamating institutions that at the time operated in the form of networks of local community services centres (CLSCs), residential and long-term care facilities (CHSLDs) and some hospital centres (HCs). In 2005, the second stage of this reform formally created 95 health and social services centres (centres de santé et de services sociaux - CSSS) and established the roles of the different levels of governance. The local level occupied by the CSSSs was responsible for organizing and managing integrated care, the regional level occupied by the ASSSs was charged with coordinating funding, human resources and specialized services as well as public health functions, while the national level occupied by the MSSS established priorities and ensured they were adhered to by the ASSSs. The reform of 2005 also led to the creation of integrated university health networks (réseaux universitaires intégrés de santé - RUIS) and established their advisory role with ASSSs and the MSSS on specific matters such as medical training and the prevention of disruptions in the delivery of services.

In 2014, the Minister of Health and Social Services Gaétan Barrette initiated a reform that was first marked by Bill 10, *An Act to modify the organization and governance of the health and social services network in particular by abolishing the regional agencies* (AMHSSN), adopted in February 2015. The Act does not apply to the James Bay Regional Health and Social Services Centre, the Nunavik Regional Board of Health and Social Services, the Inuulitsivik Health Centre, the Ungava Tulattavik Health Centre and the Cree Board of Health and Social Services of James Bay.

The reform consisted of a recentralization of administrative powers by amalgamating ASSSs and CSSSs and reducing the number of institutions by integrating them at the regional level. The local level which comprised 95 CSSSs was reduced to 22 integrated centres (CISSSs and CIUSSSs) in addition to seven non-amalgamated institutions and five institutions that would serve a northern and indigenous population. In all, 182 structures were replaced by 34. Integrated centres are institutions that resulted from the amalgamation of services centres on a regional basis. Non-amalgamated institutions are the Centre hospitalier de l'Université de Montréal (CHUM), the Centre hospitalier universitaire Sainte-Justine, the McGill University Health Centre (MUHC), the Institut de cardiologie de

Montréal, the Institut Philippe-Pinel de Montréal, the CHU de Québec - Université Laval and the Institut universitaire de cardiologie et de pneumologie de Québec - Université Laval.

The objectives were the same as those presented a little over ten years previously by Minister Couillard, that is, to improve the accessibility, quality and safety of health care and to make the network more efficient and effective. The Act centralized certain powers in new boards of directors, whose members for the most part must be “independent” of the health care system and also established the powers of the president and executive director appointed by the government from a list of names provided by the board of directors. Lastly, the Minister was granted significant regulatory powers relating to the organizational structure of the new organizations and powers to intervene to ensure their compliance with his directives. The powers formerly exercised by ASSSs and CSSSs were transferred to the Minister to be exercised by him with respect to the integrated centres (AMHSSN, s. 46, pars. 2 and 3).

The organization of services is therefore divided as follows:

The Ministère de la Santé et des Services sociaux (MSSS)

The MSSS's mandate is twofold:

- > to propose, on behalf of the government, to other ministries and public agencies, as well as to all social players, action priorities, with a view to positively affecting the health and well-being of the population;
- > to ensure that the health and social services system functions properly and that individuals have access to a complete range of services of the highest quality.

To fulfil its mandate, the MSSS has a number of levers available to it:

- > the development, implementation and evaluation of health and social services policies;
- > the approval of regional priorities arising from ministerial policies;
- > the coordination of the provincial public health program and the introduction of measures to protect the health of the population;
- > the equitable distribution of human, material, financial and information resources among the regions of Quebec;
- > the creation of the necessary management frameworks for the effective and efficient use of these resources;
- > the development of policies and orientations relative to the network's manpower;

- > the inter-regional coordination of services;
- > inter-sectoral action;
- > the evaluation of health and social services policy outcomes.

Institutions (CISSSs, CIUSSSs and non-amalgamated institutions)

The board of directors performs the following functions (AMHSSN, s. 28 and following; AHSSS, ss. 172 to 176 and 178 to 181.0.3 - roles of the boards of directors of public institutions):

- > organizes the institution's services in keeping with province-wide orientations;
- > equitably distributes, within the bounds of the resource envelopes allocated by service program, the human, physical and financial resources at its disposal and ensures that such resources are used economically and efficiently;
- > adopts a strategic plan and produces an annual management report;
- > approves a management and accountability agreement with the MSSS;
- > approves the financial statements;
- > ensures the accessibility of services;
- > ensures the pertinence, quality, safety and effectiveness of services;
- > ensures respect for users' rights and promptness in processing their complaints;
- > ensures the participation of human resources and sees that they are motivated and valued;
- > ensures that performance is monitored and results are reported;
- > ensures that the teaching mission is complied with if it is a CIUSSS;
- > appoints the senior management officers, the service quality and complaints commissioner, appoints pharmacists;
- > appoints physicians and dentists, assigns a status and grants privileges to them and determines the obligations attached to such privileges;
- > establishes a governance and ethics committee and an audit committee and any other committees it deems necessary.

The president and executive director (who may be assisted by an assistant president and executive director appointed by the Government, on the

recommendation of the Minister, from a list of names provided by the board of directors)³ performs the following functions (AMHSSN, s. 32 and following):

- > is responsible for the administration and operation of integrated centres;
- > sees to it that the decisions of the board of directors are carried out;
- > ensures that the institution's clinical activity is coordinated and supervised.

The responsibilities of integrated centres are as follows (AMHSSN, s. 38 and following; AHSSS, ss. 99.5 to 99.7 – roles of former CSSSs):

- > to define a clinical and organizational project that takes needs, objectives, services and organizational methods into account and is consistent with ministerial orientations;
- > to offer general services (prevention, assessment, diagnosis, treatment, rehabilitation, support and lodging);
- > to offer certain specialized and superspecialized services, when available;
- > to coordinate the services required (establish mechanisms for reception, referral and follow-up, enter into agreements with producers of services, provide continuity of service, create conditions that foster accessibility in collaboration with the regional department of general medicine and the regional panel of heads of departments of specialized medicine);
- > to establish regional or inter-regional service corridors after consultation with integrated university health networks in the case of specialized services.

Services provided to the population

With respect to the services provided to the population, the health and social services system maintains its objective to fulfil five missions, defined according to the categories of services offered by the five types of institutions it originally comprised. As a result of the groupings and amalgamations aimed at creating real services networks, one institution (an integrated centre or non-amalgamated institution) may now fulfil many missions. The notion of “centre” therefore refers to a mission and not to a physical space (to denote a physical space, the term “facility” must be used).

- > **A local community services centre** (centre local de services communautaires – CLSC) offers everyday health and social services of a

³ [*Act to amend certain provisions regarding the clinical organization and management of health and social services institutions*](#), SQ 2017, c. 21, s. 5.

preventive and curative nature as well as rehabilitation and reintegration services. Over the years, CLSCs have focused their efforts on services for children and youth (post-partum follow-up and well-baby clinics, immunization clinics, health services in schools), on the one hand, and for older adults, on the other. In 2004, home support (care and assistance) accounted for half of all CLSC activities.

- > A **residential and long-term care centre** (centre d'hébergement et de soins de longue durée - CHSLD) provides, on a temporary or permanent basis, an alternative living environment as well as necessary services (rehabilitation services, nursing services, psychosocial services, medical services and pharmaceutical services) to frail older adults and people with disabilities who cannot stay in their natural living environment despite the support of their family and friends.
- > A **hospital centre** (centre hospitalier - CH) offers diagnostic services as well as general and specialized medical care in the physical health and mental health sectors.
- > A **rehabilitation centre** (centre de réadaptation - CR) provides adjustment, rehabilitation and social reintegration services to people who need them because of physical or intellectual disabilities, behavioural, psychosocial or family difficulties, or alcoholism or other dependencies. It also provides accompaniment and support services to their family and friends.
- > A **child and youth protection centre** (centre de protection de l'enfance et de la jeunesse - CPEJ) or youth centre, as it is commonly called, provides, in its region, services of a psychosocial nature, including emergency social services, to youth whose situation requires it under the *Youth Protection Act* or the *Young Offenders Act* (Canada). Other services include child placement, family mediation, the submission of expert reports to the Superior Court in child custody cases, adoption and, lastly, research into family origins.

Advisory bodies

Many bodies report directly to the Minister of Health and Social Services. They perform a variety of functions: advisory (Health and Welfare Commissioner), administrative (Régie de l'assurance maladie du Québec - Quebec health insurance board), joint action (Office des personnes handicapées du Québec - Quebec office for people with disabilities), etc. Three of these are particularly important for medical practice: the Institut national de santé publique du Québec [National public health institute of Quebec], the Health and Welfare Commissioner and the Institut national d'excellence en santé et en services sociaux [National institute for excellence in health and social services].

The Institut national de santé publique du Québec (INSPQ)

The main function of this organization is to support the Minister of Health and Social Services, regional public health authorities and institutions in carrying out their public health responsibilities.

The INSPQ ensures the coordination of public health expertise in Quebec. To fulfil its mission, the INSPQ relies on:

- > the pooling and sharing of expertise;
- > the development of research;
- > the sharing and harnessing of knowledge;
- > international exchanges.

The INSPQ offers a variety of activities and services:

- > consulting and specialized assistance services;
- > new knowledge development and research activities;
- > educational activities;
- > information activities;
- > specialized laboratory services;
- > international cooperation and knowledge sharing activities.

The INSPQ has several sites in Quebec where it conducts its activities.

The Health and Welfare Commissioner

The position of Health and Welfare Commissioner was created in 2006, the objective being to inform public debate and government decision making in the area of health and welfare with a view to improving the performance of the system. The Commissioner's main functions are:

- > to assess the results achieved by the health and social services system and examine the ethical aspects of issues that arise in the health and welfare sector;
- > to consult with citizens, including experts and other players in the health and social services system;
- > to inform the Minister of Health and Social Services, the National Assembly and all citizens in order to promote a better understanding of major issues in the area of health and welfare;
- > to recommend changes to the Minister of Health and Social Services to, among other things, improve the overall performance of the system.

The Institut national d'excellence en santé et en services sociaux (INESSS)

The Institut national d'excellence en santé et en services sociaux (INESSS) was created on January 19, 2011. It succeeded the Conseil du médicament [Medication council] and the Agence d'évaluation des technologies et des modes d'intervention en santé (AETMIS) [Agency for the evaluation of technologies and methods of intervention in health]. INESSS's mission is to promote clinical excellence and the efficient use of resources in the health and social services sector.

At the heart of its mission, INESSS assesses, in particular, the clinical benefits and costs of the technologies, medications and interventions used in health care and personal social services. It makes recommendations concerning their adoption, use or coverage by the public plan, and develops clinical practice guides in order to ensure their optimal use.

To fulfil its mission, INESSS merges the perspectives of network professionals and managers with those of patients and beneficiaries. It brings together knowledge and know-how from myriad sources in order to shape them in a way that is useful to achieving the objectives of clinical excellence and the efficient use of resources. Lastly, it helps to rally the players concerned with a view to improving the care and services provided to the public. It acts with a constant concern for equity and ethics.

2.3.2 Medical organization

The collaboration of physicians is clearly essential to the development of health and social services networks. Certain structural mechanisms were therefore established to ensure that the practice of physicians is aligned with regional priorities. In practice, however, medical services deemed to be a priority, such as emergency services, proved to be momentarily unavailable in some regions. Thus, legislative measures were adopted to remedy these situations. In particular, they require physicians to respect the medical staffing plans of institutions (PEM) and regions (PREM) and to take part in specific activities deemed to be a priority (SMAs), failing which the terms of their agreement with the Régie de l'assurance maladie may be changed. Other legislative provisions were also adopted to promote interdisciplinary work and a better sharing of responsibilities with respect to medical activities.

The regional department of general medicine

A regional department of general medicine (département régional de médecine générale - DRMG) was established in each region. It is composed of all the family physicians who practice in the region and who are remunerated by the RAMQ, irrespective of their place of practice. The DRMG performs the following eight functions within integrated centres (or nonamalgamated institutions):

- > makes recommendations on the number of family physicians required in the region;
- > defines and proposes regional organization plans for the provision of primary care medical services;
- > defines and proposes a system of access to general medical care that may include an integrated duty roster and an on-call duty roster for services provided in residential and long-term care centres and under the home care program;
- > makes recommendations on the nature of general medical care services arising from the region's priority programs;
- > makes recommendations concerning the specific medical activities required in the region;
- > evaluates the extent to which objectives for general medical care services have been met;
- > advises the integrated centres on new projects relating to primary care services;
- > carries out any other functions assigned to it by the integrated centres in connection with the organization of primary care services.

Under the authority of a department head elected by all family physicians in the region, the DRMG is administered by a supervisory committee composed of the following: three members elected by their colleagues who, in turn, choose two to nine other members (based on the region's profile) to represent the various practice profiles of family physicians in the area of jurisdiction. The president and executive director of the integrated centre, or a physician designated by the latter, also sits on the committee. A family physician is designated by and from among the members of the department who practice in an integrated centre's area of jurisdiction to sit on the integrated centre's board of directors.

The regional panel of heads of departments of specialized medicine

Formed more recently, this body is the equivalent of the DRMG, but for specialized care. The panel is composed of all the medical specialists who, in an integrated centre, act as department heads within an institution (AHSSS, s. 417.10; AMHSSN, s. 46). Within the framework of the powers conferred on integrated centres and taking into account the responsibilities of these institutions, the panel performs the following eight functions:

- > makes recommendations concerning the part of the regional medical staffing plans pertaining to it and, once the Minister has approved the plan, ensures the implementation and application of the integrated centres' decision concerning the plan;

- > proposes an organization plan, divided by specialty, which must specify, for each integrated centre, the specialized care likely to best meet the needs of the people (including specialized services provided in private health facilities) and ensures the application of the decision concerning the plan;
- > proposes a system of access to specialized medical care which may include patient management at the regional level, a regional duty roster and agreements between institutions and ensures the implementation of the integrated centres' decision concerning the system;
- > evaluates the extent to which the objectives of the organization plan and medical staffing plan have been met;
- > gives its opinion on any project concerning the provision of specialized medical services, the equipment necessary and telemedicine;
- > gives its opinion on certain projects relating to the use of drugs;
- > gives its opinion on the establishment of the services corridors proposed by the integrated university health network;
- > carries out any other functions assigned to it by the president and executive director of the integrated centre in connection with specialized medical services.

The panel is administered by a supervisory committee composed of the following: three members elected by their colleagues from three different clinical fields (from those specified in the Act) who, in turn, appoint five to seven other members. The president and executive director of the integrated centre, or a physician designated by the latter, also sits on the committee. If there is a faculty of medicine in a region's area of jurisdiction, the supervisory committee must include a member appointed by the dean of the faculty of medicine as well as a medical resident acting as an observer. A specialist is appointed to sit on the board of directors of the integrated centre by the council of physicians, dentists and pharmacists (CPDP).⁴

University medicine

In 2002, the MSSS announced the creation of four integrated university health networks (réseaux universitaires intégrés de santé - RUIS). These networks must ensure that highly specialized care is integrated into educational, research and technology assessment activities and that training is evenly distributed among the university and community institutions to which they provide professional support. They must also establish services corridors, provide on-site support in the regions

⁴ See AHSSS, s. 397(2) and AMHSSN, ss. 9(2) and 10(2).

and meet the needs of local services networks. Lastly, integrated university health networks have a responsibility to advise ministerial authorities.

The integrated university health networks rely on partnerships between affiliated hospital centres, their research centres and the faculties of medicine. For consultations and training, a close partnership links every integrated university health network with the regions and may even include staffing support, where necessary. This mandate includes professional development activities and on-site training for physicians practicing in the regions.

Distribution and undertakings of physicians

From the late 1980s to the early 2000s, various legislative amendments were made concerning the medical activities, distribution and undertakings of physicians. Thus, applications submitted by physicians who wish to practice in an institution are now examined in relation to medical staffing plans (plan d'effectifs médicaux - PEM). These plans are used to determine the status and volume of activity of physicians practicing in institutions and are reviewed at least once every three years. Other regional medical staffing plans determine where physicians practice in a region (plan régionaux d'effectifs médicaux - PREM).

For family physicians, specific medical activities (SMAs) are provided for by the AHSSS and negotiated between the MSSS and the FMOQ, with the last agreement dating back to 2015.⁵ The DRMG is responsible for ensuring physicians comply with it. There are six categories of SMA: (1) emergency medicine; (2) registration and follow-up in primary care; (3) inpatient care; (4) obstetrics; (5) on-call duty in a residential and long-term care centre or rehabilitation centre or home care and (6) any other activity authorized by the Minister. SMA (1) has priority and must be provided so that SMAs (2) to (5) can be provided followed, finally, by SMA (6) when the other needs have been met. Physicians who have been practicing for 15 years or less must do a minimum of 12 hours a week once they become members of the DRMG. A reduction in remuneration may be imposed if a physician does not comply with the conditions of exercise of SMAs or does not participate in SMAs.⁶

Physicians' undertakings with respect to regional medical staffing plans and SMAs are reviewed periodically to ensure the availability everywhere of medical services deemed to be a priority.

⁵ Régie de l'assurance maladie du Québec, [*Infolettre #115: Remplacement de l'entente particulière sur les activités médicales particulières*](#) [Newsletter #115: Replacement of the special agreement on specific medical activities], August 31, 2015.

⁶ Fédération des médecins omnipraticiens du Québec (2017). [*Les activités médicales particulières*](#) [Specific medical activities], 2017. [Powerpoint presentation]

2.3.3 Interprofessional collaboration

In recent years, interdisciplinary work has also been considered one of the best ways to maintain the accessibility and quality of medical services despite limited medical resources. The *Act to amend the Professional Code and other legislative provisions as regards the health sector*, passed in June 2002, redefined the fields of professional practice in the physical health sector and provided for a sharing of activities reserved to professionals in the orders concerned.

The same model served as a basis for proposing a reform in the field of mental health and human relations by the adoption, in 2009, of the [*Act to amend the Professional Code and other legislative provisions in the field of mental health and human relations*](#).

Diagnosing illnesses and determining medical treatment remain activities reserved to physicians. However, specialized nurse practitioners (SNPs) will be authorized to diagnose certain illnesses once the proposed amendments to the *Nurses Act* come into force.

Other activities, such as using techniques or applying treatments that entail risks of injury, are shared with one or more professionals who are authorized to engage in them; some of these activities are performed in accordance with an individual or collective medical prescription. These activities are clearly defined in the *Professional Code* or in specific legislation affecting the professional orders concerned. Some examples are provided below:

1. Pharmacists

The *Act to amend the Pharmacy Act*, passed by the Government of Quebec in 2011, added the following activities to the activities reserved to pharmacists:

- > the renewal of prescriptions for a specified period;
- > the adjustment of prescriptions;
- > the substitution of another medication in the case of a complete disruption in the supply of the prescribed medication in Quebec;
- > the administration of medications to demonstrate proper usage;
- > the prescription of certain medications when no diagnosis is required; and
- > for pharmacists practicing in a centre operated by a health or social services institution, the prescription and interpretation of laboratory tests.

Furthermore, the new *Regulation respecting certain professional activities that may be engaged in by a pharmacist*, in force since 2013, determined, among the professional activities that may be engaged in by physicians, those that may be engaged in by a pharmacist. Under this regulation, pharmacists may prescribe

medication for some minor conditions and as well as certain laboratory tests pursuant to the terms and conditions set out in the Regulation.

Lastly, the *Act to amend mainly the Pharmacy Act to facilitate access to certain services*, some of the provisions of which came into force in 2020, makes amendments to the list of activities reserved to pharmacists. The following activities have been added to those reserved to pharmacists in the practice of pharmacy:

- > issuing a pharmaceutical opinion;
- > assessing the physical and mental condition of a person to ensure the proper use of medications;
- > taking specimens by introducing an instrument in the pharynx;
- > renewing a physician's prescription, in accordance with the terms and conditions determined by regulation, to avoid interruption of the treatment prescribed by the physician to a patient; the renewal period may not be longer than the original prescription period or, if the original prescription period is longer than one year, the renewal period may not exceed one year;
- > adjusting a physician's prescription, in accordance with the terms and conditions determined by regulation, by modifying the form, dosage, quantity or directions of the prescribed medication;
- > substituting another medication from the same therapeutic subclass for a prescribed medication if there is a complete disruption in the supply of the prescribed medication in Quebec, in accordance with the terms and conditions determined by regulation;
- > administering a medication by the oral, topical, subcutaneous, intranasal, intradermal or intramuscular route or by inhalation in the following cases: (a) to demonstrate proper use of the medication; (b) for vaccination purposes; or (c) in an emergency situation;
- > for pharmacists practicing in a centre operated by an institution within the meaning of the *Act respecting health services and social services* (chapter S-4.2) or within the meaning of the *Act respecting health services and social services for Cree Native persons* (chapter S-5), prescribing and interpreting laboratory analyses to ensure the proper use of medications, in accordance with the terms and conditions determined by regulation.

The activity of prescribing a medication is also reserved to pharmacists in the following cases:

- (1) it is an over-the-counter medication determined in a regulation and the patient's clinical situation or any other circumstance so warrants;
- (2) no diagnosis is required.

Moreover, under the new sections 1.1 and 1.2 of the *Regulation respecting the administration of medication by pharmacists* (chapter P-10, r. 3.1), a pharmacist may administer any vaccine to a patient 6 years of age or over. However, a pharmacist may administer required travel vaccines and the influenza vaccine to a patient 2 years of age or over. In an emergency situation, a pharmacist may also administer an over-the-counter medication or salbutamol.

2. Nurses

The *Regulation respecting certain professional activities that may be engaged in by a nurse* authorizes nurses, under certain conditions, to prescribe tests, products, medications and dressings:

- > under the national public health program;
- > as part of the activity reserved to nurses to determine the treatment plan for wounds and alterations of the skin and teguments and to provide the required care and treatment;
- > in cases of common health issues.

Specialized nurse practitioners (SNPs) may also, since 2018, perform some medical activities that may be performed by physicians. They may, under the terms and conditions set out in the Regulation:

- > prescribe diagnostic tests;
- > use diagnostic techniques that are invasive or entail risks of injury;
- > prescribe medications and other substances;
- > prescribe medical treatments;
- > use techniques or apply medical treatments that are invasive or entail risks of injury.

New opportunities for collaboration with SNPs can therefore be anticipated, since their medical activities will no longer be governed by the *Medical Act* and its regulations. From now on, their own professional order will be responsible for the regulatory framework for their roles and practice conditions.

These legislative and regulatory changes mean that SNPs will, depending on their class of specialization, be able to diagnose certain illnesses, determine medical treatments and provide pregnancy follow-up. In addition, these changes will extend to SNPs the possibility of performing certain examinations or engaging in certain acts reserved to physicians to date, in particular with respect to occupational health and safety, individual or family support, automobile insurance, health and social services and educational child care services.

3. Respiratory therapists

Under the *Regulation respecting certain professional activities that may be engaged in by respiratory therapists*, updated in 2018, a respiratory therapist is, pursuant to certain terms and conditions, authorized to:

- > assess the cardiopulmonary condition of a symptomatic person;
- > under the national public health program made under the *Public Health Act*, prescribe a drug for smoking cessation, except varenicline and bupropion;
- > perform a radial arterial puncture pursuant to an individual prescription;
- > operate and tend pulmonary or circulatory assistance equipment that has an extracorporeal membrane, pursuant to a prescription; operate and tend autotransfusion equipment, pursuant to a prescription; clinically monitor the condition of persons connected to pulmonary or circulatory assistance equipment that has an extracorporeal membrane; clinically monitor the condition of persons connected to autotransfusion equipment.

4. Dietitians

Since 2018, under the *Regulation respecting certain professional activities that may be engaged in by dietitians*, dietitians may, where a prescription indicates that nutrition is a determining factor in the treatment of an illness, as part of the determination of the nutritional treatment plan, prescribe for a patient:

- > nutritional formulas, vitamins and minerals to ensure the nutritional needs are met;
- > enteral feeding material necessary in the nutritional treatment plan;
- > the pancreatic enzyme solution used to restore the functionality of a feeding tube.

Furthermore, dietitians may administer, according to a prescription, medications or other substances, orally or enterally, as part of the determination of the nutritional treatment plan and during the monitoring of the nutritional status of persons whose nutritional treatment plan has been determined. They must communicate, to the attending physician or professionals concerned who are responsible for the follow-up of the patient's condition, the name of the nutritional formulas, vitamins and minerals and the pancreatic enzyme solution they prescribed.

Lastly, dietitians may permanently remove a feeding tube under a prescription.

5. Medical student / Resident / Fellow

Note that there is a regulation that authorizes medical students, residents or fellows to engage in professional activities reserved to physicians under the supervision of competent persons and in compliance with the rules applicable to physicians, including those regarding ethics, prescriptions and the keeping of records, consulting rooms or physician's offices. Note the following definitions:

(1) **medical students:** persons registered in a program of study leading to a diploma in medicine, and persons registered in such a program of study but within the scope of a host or exchange program approved by the faculty of medicine or by government authorities. A student must hold a registration certificate issued by the Collège des médecins;

(2) **fellows:** persons serving periods of advanced education under a university program, in clinical medicine or research, within the scope of a host or exchange program approved by the faculty of medicine or by government authorities. A fellow must hold a registration certificate and a training card issued by the Collège des médecins;

(3) **residents:** holders of a diploma in medicine or candidates for whom the Collège has recognized diploma equivalence and who, being registered in a university post-doctoral program, are performing training as part of this program. A resident must hold a registration certificate and a training card issued by the Collège des médecins.

2.4 In short

The health and social services system is an imposing and complex organization. According to the Canadian Institute for Health Information,⁷ in 2014, total health expenditure in Quebec was an estimated 46.3 billion dollars, which represented 12.2% of GDP and 21.5% of spending on health in Canada. At the time, the health and social services sector also employed over 549 800 people in Quebec.

Note that the creation of the public health and social services system, coupled with constant improvements in living conditions, has translated into incalculable gains in the area of health and wellness. This is why, despite the criticisms leveled against it, the health and social services system is still seen as a major achievement and a key lever of development.

⁷ Canadian Institute for Health Information. [*National Health Expenditure Trends, 1975 to 2015: Report*](#), 2015.

3. The professional practice of physicians

3.1 Practice in an institution

Medical practice in institutions represents a significant share of the clinical activities of physicians in Quebec. Many factors explain this situation: the complexity of health problems; the cutting-edge technologies used in modern medicine; the necessary contribution of other health and social services professionals; the obligation to bring these professionals and resources together into functioning organizational entities; and the need to hospitalize or provide accommodation for a great many people so as to ensure the continuity and quality of their care.

One can expect that, in the future, an even greater number of physicians will practice in the different health care institutions. Under a provision of the *Act respecting health services and social services* (AHSSS), all family physicians must undertake to devote part of their practice to specific medical activities (SMAs), in particular the provision of care in the emergency room or to patients admitted to a hospital centre or to a residential and long-term care centre (AHSSS, ss. 360 and 361). Physicians who do not make this undertaking could see a reduction in remuneration imposed upon them. The *Act respecting health services and social services* has an equivalent provision for all medical specialists who do not have privileges in an institution operating a hospital centre and whose specialty is stipulated in an agreement concluded to this effect (AHSSS, s. 361.1). The terms and conditions of a physician's participation in specific medical activities (SMAs) are determined by agreement with the Fédération des médecins omnipraticiens du Québec (FMOQ) or the Fédération des médecins spécialistes du Québec (FMSQ), whichever is applicable.

Health care institutions in Quebec (within the meaning of the AHSSS) are public. Professional medical practice in these institutions is governed by several pieces of legislation, in particular:

- > The *Act respecting health services and social services* (AHSSS) and its *Organization and Management of Institutions Regulation* (OMIR);
- > The *Professional Code* and its various regulations, including the *Code of ethics of physicians*;
- > the *Medical Act* and its regulations;
- > the *Health Insurance Act* (HIA) and the agreements concluded with the medical federations pursuant to this Act.
- > the *Act respecting end-of-life care*.

In their relations with health care institutions, physicians enjoy a special position because of their status as independent workers. They are deemed to be neither members of the staff of these institutions (AHSSS, s. 236) or employees. Physicians are not subject to the provisions of the *Labour Code* or the *Labour Standards Act*, which apply to other health professionals (HIA, s. 19). Medical residents are considered employees of the institution and are subject to these laws even though, as medical doctors, they maintain their professional independence and are subject to Quebec's *Code of ethics of physicians*.

Physicians are independent professionals and the agreements concluded between the MSSS and the FMOQ, on the one hand, and the FMSQ, on the other hand, reaffirm this independence, in particular by ensuring “therapeutic freedom” and freedom to choose their place of practice as well as respect for the personal and private nature of the patient-physician relationship, an important aspect of which is professional secrecy. Therapeutic freedom means that physicians have the right to determine the medical care required, to prescribe the appropriate treatments and their method of administration (*Entente relative à l'assurance maladie et à l'assurance hospitalisation entre le ministre de la Santé et des Services sociaux et la Fédération des médecins omnipraticiens du Québec*, s. 7.04) [Agreement on health insurance and hospital insurance between the Minister of Health and Social Services and the Fédération des médecins omnipraticiens du Québec]. Institutions must respect this professional independence, within the framework of their mission and their resources (*Entente relative à l'assurance maladie et à l'assurance hospitalisation entre le ministre de la Santé et des Services sociaux et la Fédération des médecins omnipraticiens du Québec*, s. 8.01).

While the “special status” enjoyed by physicians has its guarantees, it also has its obligations. Physicians must comply with the rules in effect in the institution, provide the professional services attached to their functions and assume on-call duties in their department or service. In choosing to practice in an institution, physicians also agree to be part of a medical team and health care teams and to collaborate with these teams with a constant concern for the quality of care provided to their patients. When physicians practice in institutions, they, of necessity, have very close relations with the health care network. Hence the importance of being thoroughly familiar with its structures, the internal organization of its institutions and the components that create an even more specific framework for medical practice.

3.1.1 Institutions

Since 1991, the AHSSS has distinguished between an institution and a centre. An institution refers to the legal entity engaging in the activities inherent in the mission of one or more centres. Institutions include, since 2015, integrated centres (CISSSs and CIUSSSs) and non-amalgamated institutions. “The function of institutions is to ensure the provision of safe, continuous and accessible quality health or social services which respect the rights and spiritual needs of individuals and which aim at reducing or solving health and welfare problems and responding to the needs of the various population groups. To that end, institutions must manage their human, material, information and technological and financial resources effectively and efficiently and cooperate with other key players [...]” (AHSSS, s. 100).

To summarize, the institution assumes the functions of planning, management and provision of services within the scope of one or several missions defined in the Act and in an agreement with the MSSS (AMHSSN, Schedule I).⁸

The notion of centre refers to the mission of an institution and not to a physical place, which is denoted by the term “facility”. Each type of centre has a specific mission, which defines and limits the nature of the services offered there (AHSSS, ss. 79 to 93; see also [2.3.1 General organization](#)).

Physicians’ private consulting rooms are not institutions within the meaning of the Act (AHSSS, s. 95). They are, however, one of the partners with which the integrated centres can enter into agreements to better meet the needs of the population. A new legal framework was in fact created in 2006 so that resources outside of institutions can be called upon in order to increase access to certain services without compromising the quality of these services (see also [3.2.4 Diverse organizational models](#) on the topic of associated medical clinics and specialized medical centres) (AHSSS, s. 108).

3.1.2 The internal organization of institutions

Every institution must establish its own organization plan, but all institutions have a similar organizational structure, which includes a board of directors, a president and executive director, management personnel (which includes a director of professional services – DPS), a council of physicians, dentists and pharmacists (CPDP), a council of nurses, a multidisciplinary council, a users’ committee and a council of midwives, where applicable. Each of these bodies performs its functions in all centres operated by the institution.

⁸ Section 55 of the Act provides for a “management and accountability agreement” that contains “a definition of the institution’s mission, the objectives it wishes to achieve while the agreement is in force and the main indicators to be used to measure results”.

The board of directors

The board of directors of an integrated centre is composed of the following (AMHSSN, s. 9):

- (1) one general practitioner who practises in the territory of the integrated centre, designated by and from among the members of the regional department of general medicine;
- (2) one medical specialist designated by and from among the members of the council of physicians, dentists and pharmacists;
- (3) one institution pharmacist, designated by and from among the members of the regional pharmaceutical services committee;
- (4) one person designated by and from among the members of the institution's council of nurses;
- (5) one person designated by and from among the members of the institution's multidisciplinary council;
- (6) one person designated by and from among the members of the institution's users' committee;
- (7) one person appointed by the Minister from a list of names provided by the bodies identified by the education community as representing that community;
- (8) nine independent persons appointed in accordance with sections 15 and 16; and
- (9) the president and executive director of the institution, appointed by the Government on the recommendation of the Minister, from a list of names provided by the members referred to in paragraphs 1 to 8.

In the case of a non-amalgamated institution or a university integrated centre, the board of directors is composed of the following (AMHSSN, s. 10):

- (1) one general practitioner who practises in the region in which the unamalgamated institution is situated or in the territory of the integrated centre, as applicable, designated by and from among the members of the regional department of general medicine;
- (2) one medical specialist designated by and from among the members of the council of physicians, dentists and pharmacists;
- (3) one institution pharmacist, designated by and from among the members of the regional pharmaceutical services committee;
- (4) one person designated by and from among the members of the institution's council of nurses;

- (5) one person designated by and from among the members of the institution's multidisciplinary council;
- (6) one person designated by and from among the members of the institution's users' committee;
- (7) two persons appointed by the Minister from a list of names provided by the bodies identified by the universities with which the institution is affiliated, if applicable;
- (8) ten independent persons appointed in accordance with sections 15 and 16; and
- (9) the president and executive director of the institution, appointed by the Government on the recommendation of the Minister, from a list of names provided by the members referred to in paragraphs 1 to 8.

The Minister designates one of the independent directors as chair (AMHSSN, s. 22).

The independent persons provided for in paragraph 8 are appointed by the Minister according to their competency, expertise or experience profiles in 9 specific areas (AMHSSN, s. 15), namely, (1) governance and ethics; (2) risk management, finance and accounting; (3) human, property and information resources; (4) auditing, performance and quality management; (5) expertise with respect to community organizations; (6) youth protection expertise; (7) rehabilitation expertise; (8) mental health expertise; and (9) experience as a user of social services. One or more expert committees may be established to make appointment recommendations to the Minister.

Under section 131 of the AHSSS (as amended successively in 2011 and 2015), a person qualifies as independent "if the person has no direct or indirect relation or interest, in particular of a financial, commercial, professional or philanthropic nature, likely to interfere with the quality of the person's decisions as regards the interests of the institution."

Since 2011, the boards of institutions must establish a governance and ethics committee, an audit committee and a watchdog committee (AHSSS, ss. 181 to 181.0.3). The functions of the governance and ethics committee include establishing governance rules, a code of ethics and professional conduct applicable to members of the board of directors, expertise and experience profiles for independent board members, criteria for evaluating the performance of the board of directors and initiation and training programs for board members. The functions of the audit committee include ensuring the optimal utilization of resources, ensuring that a risk management process is put in place, ensuring the institution's financial health, examining the financial statements and recommending their approval by the board of directors and seeing that internal control mechanisms are appropriate and effective. Lastly, the watchdog

committee is responsible for ensuring the follow-up of the recommendations made by the service quality and complaints commissioner or the Ombudsman and for coordinating and ensuring the follow-up of recommendations.

The organization plan

“Every institution must prepare an administrative, professional and scientific organization plan. The plan shall describe the administrative structure of the institution, its divisions, services and departments as well as the clinical programs of the institution.” (AHSSS, s. 183, par. 1)

With respect to medical activities, the organization plan of the institution must:

- > indicate, on the recommendation of the CPDP or the medical service, which department or service is responsible for the medical acts of a clinical program (AHSSS, s. 183);
- > provide for a risk management committee charged with identifying, analyzing and preventing the risk of care-related incidents or accidents (including nosocomial infections) as well as providing support to victims and their close relatives (AHSSS, ss. 183.1 to 183.4);
- > include the departments required under the Act (AHSSS, s. 185);
- > provide for a central mechanism for managing access to the specialized and superspecialized services of the clinical departments; to ensure uniform management, the Minister may determine the information to be collected (AHSSS, s. 185.1);
- > identify the person responsible for the access management mechanism who, under the authority of the director of professional services, will ensure the proper operation of the mechanism in the department and offer users the alternative arrangements provided for by the mechanism (AHSSS, s. 185.1);
- > in a local community service centre, rehabilitation centre or residential and long-term care centre, provide for the creation of a medical service or the appointment of a physician in charge of medical care, if at least one physician practices in the centre (AHSSS, s. 186);
- > must include a part concerning the family physician staffing plan and a part concerning the specialist staffing plan. Each part must indicate respectively the number of family physicians and specialists, by specialty, who may practice their profession in each department or service. Once approved by the Minister of Health and Social Services, these parts of the organization plan will constitute the medical staffing plan of the institution (AHSSS, ss. 184 and 186). The CPDP, including the university concerned, where applicable, must be consulted on the part of the organization plan

pertaining to the creation of clinical departments and services and the part pertaining to medical staffing plans.

The organization plan must be reviewed every three years (AHSSS, s. 186, par. 8).

The director of professional services

In institutions operating a hospital centre or a health centre, the board of directors must appoint a director of professional services (DPS) after consultation with the CPDP. The DPS, who must be a physician, holds a management position in the institution and is paid by the institution. Under the authority of the president and executive director, the DPS is mandated to coordinate, “with the other directors concerned, the professional and scientific activity of any centre operated by the institution” (AHSSS, s. 203). In performing his duties (see box), he supervises the activities of clinical department heads and acts as an interface between the administration and the medical organization of the institution.

The functions of the director of professional services (AHSSS, s. 204)

1. Directs, coordinates and supervises the activities of the clinical department heads.
2. Obtains the opinion of the clinical department heads on the administrative and financial consequences of the activities of the physicians and dentists in the various clinical departments.
3. Applies the administrative sanctions provided for in cases of non-compliance with rules for the use of resources and informs the CPDP and clinical department heads concerned thereof.
4. Supervises the operation of the committees of the CPDP and ensures that the council monitors and assesses adequately the medical, dental and pharmaceutical acts performed in any centre operated by the institution.
5. Takes all necessary steps to ensure that any examination, autopsy or expertise required under the *Act respecting the determination of the causes and circumstances of death* is carried out.
6. Carries out any other function provided for in the organization plan of the institution.
7. Discharges the obligations imposed by the *Civil Code* and the *Public Curator Act* regarding the protective supervision of incapable persons and protection mandates.

The institution's resources: striving for efficiency

Every institution has human and material resources at its disposal to help it achieve the missions of the centres it operates. The MSSS allocates the institution

a global budget for this purpose. The range of resources of each institution and the budget at its disposal have an effect on the type of medical services physicians can provide there. For example, a local community services centre (CLSC) does not have an operating room, and hospital centres do not, as a rule, provide home care. Capital and operating budgets, which determine the total expenditure authorized, restrict the sphere of activity of institutions.

Given the State's limited financial capacity and with a view to equitable resource allocation, government authorities and administrators of the health and social services network must reconcile the dual objectives of making efficient use of these resources and ensuring the quality of services, accessibility being one aspect. Since medical activities have a direct effect on the effectiveness and quality of services offered in a health care institution, physicians are asked by the board of directors of the institution where they practice, through the CPDP and the DPS, to contribute to the efforts needed to improve the efficiency and quality of the network.

3.1.3 Medical and administrative organization

The medical and administrative organization of an institution comprises the council of physicians, dentists and pharmacists (CPDP), its committees and the clinical departments and services. Thus, it includes all the physicians, dentists and pharmacists practicing in the institution. The lines of authority are established by the AHSSS and its regulations, which impose obligations on both physicians and the medical and administrative organization and on the administration of the institution.

The council of physicians, dentists and pharmacists (CPDP)

A council of physicians, dentists and pharmacists must be established for every institution which operates one or more centres in which not fewer than five physicians, dentists or pharmacists are practicing (AHSSS, s. 213).

The CPDP is composed of all the physicians, dentists and pharmacists practicing in any centre operated by the institution. Its main function is to ensure the quality of services provided by its members and, in this capacity, is directly accountable to the board of directors. The CPDP also has responsibilities with respect to medical activities.

The responsibilities of the council of physicians, dentists and pharmacists (AHSSS, s. 214)

1. Controls and assesses the quality, including the pertinence, of the medical, dental and pharmaceutical acts performed in the centre.
2. Assesses and maintains the professional standards of the physicians, dentists and pharmacists practising in the centre.

3. Makes recommendations on the qualifications and competence of a physician or dentist who applies for appointment or the renewal of an appointment and on the privileges and the status to be granted to him.
4. Makes recommendations on the qualifications and competence of a pharmacist who applies for appointment and on the status to be granted to him.
5. Gives its opinion on the disciplinary measures the board of directors should impose on physicians, dentists or pharmacists.
6. Makes recommendations on the rules governing medical and dental care and on the rules governing the use of medicines applicable in the centre and formulated by each clinical department head.
7. Makes recommendations on the obligations which must be attached to the enjoyment of the privileges granted to a physician or a dentist by the board of directors in relation to the specific requirements of the centre, particularly those concerning:
 - a) the participation of a physician or dentist in the clinical activities of the centre, including being on duty;
 - b) the participation of a physician or dentist in teaching and research activities, where the case arises;
 - c) the participation of a physician or dentist in professional, scientific, medical or administrative committees;
 - d) the participation of a physician or dentist in medical activities pursuant to an agreement referred to in sections 108 and 109.
8. Develops the modalities of a duty roster system ensuring, on a permanent basis, the availability of physicians, dentists and, where the case arises, pharmacists and clinical biochemists, according to the needs of the centre.
9. Gives its opinion on the professional aspects of the following questions:
 - a) the technical and scientific organization of the centre;
 - b) the rules governing the utilization of resources and the administrative sanctions to be included therein.
10. Makes recommendations on the professional aspects of the appropriate distribution of medical and dental care and pharmaceutical services, and on the medical organization of the centre.
11. Carries out any other function entrusted to it by the board of directors.

The CPDP must perform its functions in accordance with its mission and the institution's resources. "In exercising its functions, the council of physicians, dentists and pharmacists shall take into account the necessity of providing adequate and efficient services to users and the organization and available resources of the institution" (AHSSS, s. 214). It must submit an annual report on its activities to the board of directors.

In addition to its responsibilities to the board of directors with respect to the quality of services provided and the competence of its members, the CPDP must assist the president and executive director of the institution by giving its opinion on the administrative aspects of various matters (see box below) concerning the organization and provision of care.

Matters on which the CPDP gives its opinion to the president and executive director (AHSSS, s. 215)

1. The measures to be taken in order to ensure that the medical, dental and pharmaceutical services provided in the centre are complementary to those provided in a centre operated by another institution of the region and respond to the needs of the population to be served, taking into account the resources available and the necessity of providing adequate services.
2. The rules governing the utilization of resources and the administrative sanctions to be included therein.
3. The technical and scientific organization of the centre.
4. The appropriate distribution of medical and dental care and pharmaceutical services, and the medical organization of the centre.
5. Any other question brought to its attention by the executive director.

“The council of physicians, dentists and pharmacists may adopt by-laws concerning its internal management, the creation and operation of committees and the pursuit of its objects. The by-laws come into force after having been approved by the board of directors.” (AHSSS, s. 216)

The CPDP must create, in addition to an executive committee, a committee on professional qualifications, a committee on medical, dental and pharmaceutical evaluation, a committee of pharmacology and a disciplinary committee (OMIR, ss. 97 and 106; AHSSS, ss. 46 and 48).

The **executive committee** exercises all the powers of the CPDP and reports on its activities at least once a year at the general meeting of the council’s members. Its responsibilities encompass all medical activities performed in the institution as well as the activities specific to the CPDP (OMIR, s. 98). It is composed of not fewer than five physicians, dentists or pharmacists designated by the CPDP, the president and executive director and the DPS or, when a DPS has not been appointed, a physician designated by the executive director (AHSSS, s. 217).

The **qualifications committee** is responsible for processing the applications of physicians, dentists and pharmacists and recommending to the executive committee the granting of a status and practice privileges as well as their renewal

or non-renewal every two years. It is responsible for opening and keeping a professional file for each member of the CPDP (OMIR, s. 100).

The **committee on medical, dental and pharmaceutical evaluation** assesses the quality of care and makes recommendations to the executive committee in this regard. More specifically, it ensures that the content of patients' records complies with the various regulations; it assesses the quality and appropriateness of the medical, dental and pharmaceutical care given to users; it studies preoperative and postoperative diagnoses as well as operations where there was no exeresis and it examines the records of patients who presented with complications and deaths that occurred in the hospital centre. It also periodically reviews the treatment prescribed for nosocomial infections and for the most common complaints in the centre (OMIR, s. 103). The CPDP must, in collaboration with the council of nurses, adopt clinical protocols for continuous palliative sedation and medical aid in dying (*Act respecting end-of-life care*, s. 33). A physician who administers either type of care, within 10 days of its administration, must inform the CPDP. The committee on medical, dental and pharmaceutical evaluation will assess the quality of the care provided, particularly with regard to applicable clinical protocols (*Act respecting end-of-life care*, s. 34).⁹

The **pharmacology committee** ensures the proper use of medications in the institution and makes recommendations to the executive committee in this regard. More specifically, it ensures that control mechanisms are put in place, including the review of past records, in particular records of patients who had untoward reactions or allergies. It advises the head of the department on the selection of medications to be prescribed in the institution and on the rules concerning their use. It also assesses requests to use medications for research purposes or for special medical needs (OMIR, s. 105).

The **disciplinary committee** is an ad hoc committee formed by the executive committee to examine a complaint made against a physician, dentist or pharmacist concerning the quality of services provided, his skill, his industry or his conduct or his compliance with the by-laws of the institution or of the CPDP. As required, this committee follows the prescribed procedure for examining complaints concerning physicians, dentists and pharmacists. Essentially, the disciplinary committee hears the professional concerned and his counsel, if any. After examining the complaint, the disciplinary committee reports to the executive committee, which then takes the appropriate measures. Where it decides to recommend that a disciplinary measure be applied, the executive committee sends the file to the board of directors (OMIR, ss. 106 to 109).

⁹ Physicians who provide such care at the patient's home or in the premises of a palliative care hospice must, within 10 days following its administration, inform the Collège des médecins (*Act respecting end-of-life care*, s. 36).

Given the nature of the activities of the various committees of the CPDP, the records and minutes of the meetings of the CPDP and of each of its committees are confidential. Thus, no one may have access to them except those duly authorized to do so (AHSSS, s. 218).

Clinical departments

The organization plan of an institution, in addition to describing the departments, services and clinical programs, must provide for their formation (AHSSS, ss. 183 and 184).

“The organization plan of a hospital centre operated by a public institution [an integrated centre or a non-amalgamated institution] must include the following departments:

- (1) anesthesia;
- (2) surgery;
- (3) gynecology-obstetrics;
- (4) medical imaging;
- (5) general medicine;
- (6) specialized medicine;
- (7) emergency medicine;
- (8) pediatrics;
- (9) pharmacy;
- (10) psychiatry.

The Minister shall determine the public institutions that must include a clinical department of laboratory medicine, a clinical department of dentistry or a clinical department of public health in their organization plan.

The clinical department of medical imaging must group the radiology and nuclear medicine services, and the clinical department of laboratory medicine must group the hematology, biochemistry, pathology, microbiology and genetics laboratory services. The clinical department of specialized medicine must include the radiation oncology service, the medical oncology service and the clinical activities in hematology and in microbiology and infectious diseases.

The Minister may authorize an institution to derogate from this section.” (AHSSS, s. 185)

A clinical program generally encompasses a group of multidisciplinary activities geared to a defined clientele or specific health problem, such as a palliative care program, a pulmonary disease program or a home care program. It should be noted that many health care institutions have now adopted a program-based management model, meaning that all their clinical activities are grouped by

themes. Lastly, the organization plan must indicate which department or service is responsible for the medical, dental and pharmaceutical acts performed in the context of a program (AHSSS, s. 183).

In local community services centres (CLSCs), residential and long-term care centres (CHSLDs) and rehabilitation centres (CRs), the plan must provide for the creation of a medical service or the appointment of a physician in charge of medical care, if at least one physician practices in the centre (AHSSS, s. 186). This service is equivalent in a sense to the department of general medicine in a hospital centre, and the physician's duties are the same as those of a department head (OMIR, ss. 78.1 to 81).

All medical activities carried out in institutions are therefore overseen either by the departments and their services in a hospital centre or by the medical service in other types of centres. Hence the importance attributed to the role of department head.

Clinical department head

“Every clinical department formed in a hospital centre shall be directed by its head who must be a physician, dentist or pharmacist, except for the clinical department of laboratory medicine whose head may be a clinical biochemist.” (AHSSS, s. 188). The department head, under the authority of the DPS, directs the professional activities of all physicians in his department (AHSSS, s. 189). Furthermore, he is accountable to the CPDP, in particular for supervising the manner in which medicine is practiced and for establishing rules for medical care (AHSSS, s. 190). In CLSCs and CHSLDs where there is no DPS, the head of the medical service reports to the executive director. Depending on the responsibilities he assumes, the clinical department head is accountable to a DPS or a CPDP (see box on the next page). The legislator has also entrusted the department head with the task of supervising, in collaboration with the director of nursing services, the medical activities engaged in by nurses or other professionals in his department who are authorized to engage in those activities by a regulation of the board of directors of the Collège des médecins du Québec (AHSSS, s. 190(1.1)).

Responsibilities of the clinical department head depending on the authority under which he acts

Under the authority of the DPS (AHSSS, s. 189):

1. Coordinates, subject to the responsibilities of the CPDP, the professional activities of the physicians in his department.
2. Manages the medical resources.
3. Draws up, for his department, rules governing the use of medical resources and material resources used by physicians and ensures that the rules and procedures of the central access management mechanism are observed.
4. Manages, in the case of the head of the clinical department of medical imaging, the head of the clinical department of laboratory medicine and the head of the clinical department of pharmacy, the resources of his department.
5. Draws up a duty roster.
6. Ensures an appropriate distribution of medical care in his department.
7. Sees that the rules governing the use of resources are complied with.
8. Informs the board of directors of the nature of and grounds for any administrative sanction imposed.

Under the authority of the CPDP (AHSSS, s. 190):

1. Supervises the manner in which medicine is practiced in his department.
2. Supervises, subject to the responsibilities of the director of nursing care, the medical activities that are engaged in by nurses or other professionals in his department who are authorized to engage in those activities.
3. Draws up, for his department, rules governing medical care and rules governing the use of medicines which take into account the necessity of providing adequate services to users and the organization and available resources of the institution.
4. Gives his opinion on the privileges and status to be granted to a physician upon an application for appointment or renewal of appointment and on the obligations attached to the enjoyment of such privileges.

The head of a service generally performs the functions of the head of his department with respect to the physicians in the service. However, he still answers directly to the department head for all functions performed as head of the service.

In all matters, a physician practicing in an institution is first accountable to the head of his service and to the head of his department.

3.1.4 Conditions for practice in an institution

To practice in an institution, a physician must meet the following conditions:

- > be appointed by a resolution of the board of directors of the institution (AHSSS, ss. 237 to 243 and s. 251);
- > produce a document in which he or she acknowledges having read the resolution (AHSSS, s. 243);
- > hold a valid professional liability insurance policy (AHSSS, s. 258);
- > fulfil the obligations attached to his or her appointment (AHSSS, s. 242);
- > observe the by-laws of the institution and of the CPDP (AHSSS, ss. 242 and 249).

Appointment

The conditions for the appointment of a physician in an institution are set out in the AHSSS (ss. 237 to 248). The steps leading to the appointment are the same in all institution categories (see box below).

Steps leading to the appointment of a physician in an institution (AHSSS, ss. 237 to 248)

1. The physician must submit an application for appointment to the president and executive director of the institution.
2. The president and executive director informs the candidate, in writing, of the state of the medical staffing plan of the institution.
3. The qualifications committee of the CPDP examines the application for appointment.
4. The CPDP and the DPS must be consulted on the obligations that must be attached to the enjoyment of the privileges.
5. The CPDP makes a recommendation to the president and executive director, who must obtain an opinion from the DPS before referring the application to the board of directors.
6. The board of directors verifies whether the appointment complies with the organization plan of the institution and the medical staffing plan (PEM).
7. The board of directors accepts or refuses the application for appointment. It communicates its decision in writing to the physician, giving the reasons.
8. If the physician's application for appointment is accepted, he must produce a document in which he acknowledges that he has read the resolution.

When it accepts a physician's application for appointment, the board of directors must set out the status and privileges assigned to the physician, the period for which they are granted, and the nature and range of the medical activities he will be allowed to engage in at the centre. In addition, the resolution of the board of directors must include the physician's undertaking to fulfil the obligations attached to the enjoyment of his privileges, which are determined based on the recommendations of the CPDP (AHSSS, s. 242).

All appointments must comply with the medical and dental staffing plan in the institution's organization plan. The board of directors must, before accepting a physician's application for appointment, obtain the Minister's approval. The Minister verifies that the appointment complies with the medical staffing plan of the institution, approved by him, and the ministerial orientations on medical workforce management. The appointment is absolutely null if it does not comply with the staffing plan, except in the event of an emergency or temporary replacement (AHSSS, ss. 239 to 240.2).

The board of directors must transmit its decision in writing to the applicant within 90 days of receipt of the application by the president and executive director. The reasons for any refusal must be given in writing (AHSSS, s. 241).¹⁰ A physician who is not satisfied with a decision rendered in his regard on the basis of criteria of qualification, scientific competence or conduct, may, within 60 days of the decision, contest the decision before the Administrative Tribunal of Québec (AHSSS, s. 252).

A physician's status determines his membership and level of participation in the CPDP (active member, associate member, advisory member or honorary member). A status is granted to a physician, dentist or pharmacist based on the extent of his activities in the institution (OMIR, ss. 87 to 96). Privileges are granted to a physician or dentist based on the hospital centre's organization and staffing plan. Privileges determine the nature and scope of the medical acts that a physician may perform in a department (OMIR, s. 86).

The obligations that must be attached to the enjoyment of privileges concern the physician's participation in activities in relation to the centre's requirements based on the recommendations of the CPDP, in particular (AHSSS, s. 214):

- > participation in clinical activities, including being on duty;
- > participation in teaching and research activities, where the case arises;
- > participation in professional, scientific, medical or administrative committees;

¹⁰ If the decision is not rendered within the time prescribed, it may be considered unfavourable and the physician may apply to the Administrative Tribunal of Québec within 60 days (AHSSS, s. 252, par. 2).

- > participation in medical activities pursuant to an agreement between institutions (AHSSS, ss. 108 and 109). In this case, the agreement must be made known to the physician and be valid at the time of his application for appointment or renewal of appointment.

Regulations and by-laws

The regulations and by-laws a physician must comply with in an institution are, in particular:

- > the regulations of the *Act respecting health services and social services*;
- > the regulations of the *Professional Code*, including the *Code of ethics of physicians* and the *Regulation respecting records, places of practice and cessation of practice by a physician*;
- > the *Regulation respecting the standards relating to prescriptions made by a physician*;
- > the by-laws of the institution;
- > the by-laws of the CPDP.

The by-laws of the CPDP govern the functioning of the council itself and member participation in its activities. The by-laws of the institution are adopted by the board of directors. These generally concern the administrative aspects of everyday activities in the institution and medical practice. This applies to rules governing the use of the institution's resources, which are drawn up by the department head and approved by the board of directors, after consultation with the CPDP (AHSSS, s. 189).

Some of these rules are also fundamental to medical practice in an institution:

Rules governing the use of medical resources and material resources in a centre — These are established by each department head, under the authority of the DPS. Before they come into force, the rules must be approved by the board of directors, which must have first obtained the opinion of the CPDP on the subject. They must provide for administrative sanctions in the event of non-compliance (AHSSS, ss. 189, 191, 192, 214 and 215).

Rules governing medical care and the use of medicines — These rules must take into account the necessity of providing adequate services to users and the organization and available resources of the institution.

They are usually drawn up by the head of a clinical department, under the authority of the CPDP (AHSSS, s. 190). The head of the pharmacy department or the pharmacist may also, under the authority of the CPDP, draw up rules for the use of medications (OMIR, s. 77). When these rules concern nurses authorized to

engage in the medical activities referred to in section 36.1 of the *Nurses Act*, the director of nursing care must cooperate in determining the rules (AHSSS, s. 207) and the council of nurses (CN) must make a recommendation concerning such rules (AHSSS, s. 192).

The rules come into force after they have been approved by the board of directors, on the recommendation of the CPDP (AHSSS, ss. 189, 192 and 214). The AHSSS also stipulates that physicians practicing in the various departments must be subject to the same set of rules. Thus, in an identical clinical situation, two departments may not adopt different rules. It is up to the CPDP to recommend a single set of rules (AHSSS, s. 190). Note that some of these rules may concern only specialized nurse practitioners.

Non-compliance with regulations and by-laws

A physician who does not comply with certain regulations or by-laws is subject to disciplinary measures or administrative sanctions (ss. 189, 205 and 249).

“The board of directors may take disciplinary measures with respect to a physician or dentist. The disciplinary measures that may be taken include a reprimand, a change in status, the withdrawal of privileges, the suspension of status or privileges for a specific period and the cancellation of status or privileges. They may also include a recommendation that the physician or dentist serve a period of refresher training, take a refresher course or both, and may, if necessary, restrict or suspend some or all of the physician’s or dentist’s privileges for the duration of the refresher period. Every disciplinary measure taken against a physician or a dentist must give reasons and be based solely on lack of qualifications, scientific incompetence, negligence, misconduct, non-compliance with the by-laws of the institution, having regard to the specific requirements of the institution, or non-compliance with the [terms of his appointment]. The disciplinary measures must be imposed in accordance with the procedure prescribed by regulation [...]. The [president and] executive director must send a copy of the decision to the professional order concerned.” (AHSSS, s. 249)

When the board of directors decides to apply a disciplinary measure against a physician, it must communicate its decision to the physician, to the executive committee of the CPDP and to the Collège des médecins. It must also have given the physician in question the opportunity to be heard beforehand (OMIR, s. 109). A physician who is the subject of a disciplinary measure may, within 60 days of the date on which the decision was notified to him, contest the decision before the Administrative Tribunal of Québec (AHSSS, s. 252).

The administrative sanctions provided for in cases of non-compliance with the rules governing the use of resources “may have the effect of limiting or suspending the right of a physician to use the resources of the institution” (AHSSS, s. 189). However, they cannot be considered as a breach of the privileges

granted to the physician by the board of directors. When an administrative sanction must be applied, the DPS informs the physician concerned of the grounds on which he based his decision and ensures that it is applied. The physician may contest the decision before the Administrative Tribunal of Québec (AHSSS, s. 205).

Cessation of practice in an institution

A physician's cessation of practice must not in any way compromise the quality of patient follow-up, since all physicians are bound by their code of ethics to ensure that the patients they examine, investigate or treat receive the medical follow-up required by their condition (*Code of ethics of physicians*, ss. 32 and 35). Provisions for overseeing the cessation of practice in an institution are also in place.

A physician may cease to practice in an institution by choice or following the non-renewal of his appointment. A physician who decides to cease practicing in a centre must give prior notice of at least 60 days to the board of directors. The decision becomes irrevocable upon receipt of the notice by the board of directors (AHSSS, s. 254). However, the board may authorize a physician to leave before the end of the 60-day period if it believes that his departure does not affect the quality or adequacy of the medical services offered to the population (AHSSS, s. 255).

When a physician ceases to practice in a centre without the authorization of the board of directors or before the end of the 60-day period, the institution may ask the Régie de l'assurance maladie du Québec (RAMQ) to issue an order cancelling the physician's participation in the health insurance plan. In other words, the physician would no longer be authorized, for a given period, to bill for the insured services he had rendered. The non-participating period is fixed by the RAMQ and is equal to twice the number of days remaining in the 60-day period (AHSSS, s. 257). Furthermore, the Collège des médecins must be informed in writing if the board of directors believes that the physician's departure will affect the quality or accessibility of medical services.

The board of directors may refuse a physician's application for appointment on the grounds that the physician, in the course of the three preceding years, failed to give the board the prior notice required under section 254 (AHSSS, s. 238).

In cases where the board of directors decides not to renew an appointment, the cessation is determined by the board. This decision must be based solely on criteria of qualifications, scientific competence or conduct, as they pertain to the specific requirements of the institution, and fulfilment of the obligations attached to the enjoyment of the privileges granted (AHSSS, s. 238). The physician may contest this decision before the Administrative Tribunal of Québec (AHSSS, s. 252). The board of directors may also refuse to renew an appointment if the

conditions prescribed by the government for granting a status cannot be met (AHSSS, s. 238, par. 4 and 506(3)).

Remuneration

Like the AHSSS and its regulations, the agreements with medical federations and their appendices determine the conditions for medical practice with respect to health insurance and hospital insurance. Thus, the agreements prescribe payment methods and payscales in institutions and elsewhere. They also determine certain conditions for practice in institutions for physicians paid a set fee or a salary and for physicians paid a per diem. Physicians and institutions are bound by these agreements.

The remuneration model is specified in the agreements. Fee-for-service, flat rate, mixed payment, hourly rate, capitation and salary are the main physician remuneration models. The conditions for applying each of these remuneration models are also defined in the agreements, depending on the institution in which the physician practices, his appointment and the medical activities performed. Except in a measure provided by government regulation, no individual agreement may be concluded between a physician and an institution concerning remuneration for the provision of insured services (AHSSS, ss. 259, 259.1 and 505(22); HIA, s. 19).

3.1.5 Procedure for examining complaints concerning physicians

Every institution must establish a procedure for examining complaints made by users (AHSSS, ss. 29 to 59). A special procedure applies for examining a complaint made by a user against a physician or a medical resident (AHSSS, ss. 41 to 59).

After consultation with the CPDP, the board of directors must appoint a medical examiner, who may or may not practice in a centre operated by the institution, who will be responsible for applying this procedure. Note that this physician may also examine a complaint made by any person other than a user (AHSSS, s. 44).

When a complaint against a physician or a medical resident is referred to the medical examiner, the medical examiner must choose the appropriate steps to be taken from among the following possibilities:

- > examine the complaint in accordance with the AHSSS (ss. 45 to 50);
- > refer it to the CPDP for “a disciplinary investigation by a committee established for that purpose”;
- > refer it to the authority determined by regulation, if it concerns a medical resident;
- > dismiss the complaint if, in the medical examiner’s opinion, it is frivolous, vexatious or made in bad faith.

The physician must cooperate in the examination of a complaint against him with the medical examiner and the members of the disciplinary committee, if any.

The medical examiner must “transmit his or her conclusions, including reasons, in writing to the user and the professional concerned, together with any appropriate recommendations, and inform the user of the conditions and procedure for applying to the review committee” (AHSSS, s. 47).

A user who disagrees with the conclusions transmitted by the medical examiner or deemed to have been transmitted by that medical examiner may apply verbally or in writing for a review of the complaint by the review committee (AHSSS, s. 53). The review committee is composed of three members appointed by the board of directors of the local authority. The chair of the committee is appointed from among the members of the board of directors of the local authority who are not employed by or do not practice their profession within the authority. The other two members are appointed from among the physicians, dentists and pharmacists who practice in a centre operated by one of the institutions in the territory of a local health and social services network whose activities and services are coordinated by the local authority (AHSSS, s. 51).

When the medical examiner refers a complaint to the CPDP for a disciplinary investigation, the latter must form a disciplinary committee. The disciplinary committee must then follow the stipulated procedure, which is to hear the professional concerned and report on its evaluation to the CPDP. Should it decide to recommend that a disciplinary measure be applied, the executive committee of the CPDP must send the file to the board of directors (OMIR, ss. 106 to 109).

If the user’s complaint concerns administrative or organizational problems that involve medical, dental or pharmaceutical services, it must be examined by the service quality and complaints commissioner.

3.1.6 Physicians: essential care providers in institutions

This subsection described the medical and administrative structures and the obligations inherent in medical practice in an institution, since physicians are essential care providers in most institutions in the health care network. They enjoy a special status as independent professionals, but they must also meet many requirements, including working as part of a medical team and discharging the duties they have undertaken.

3.2 Practice outside an institution

Traditionally, there are two types of medical practice in Quebec: in an institution and in an office. However, for a number of reasons, the boundaries between offices and institutions are becoming increasingly permeable.

On the one hand, family physicians do not work only in their office: they contribute to the delivery of care and services in institutions. On the other hand, increasingly specialized care is moving out of institutions to sites that are no longer simple doctors' offices. New organizational models somewhere between institutions and offices have been growing in number in recent years, their only common denominator being the delivery of care outside of an institutional setting.

In this section, we will endeavour to provide an overview of medicine practiced outside of public institutions in Quebec and to offer a coherent interpretation of its development. We will focus on certain aspects that, irrespective of the organizational model, we believe raise major issues with respect to the quality of physicians' professional practice.

To respond to these issues, current laws and regulations do not always offer the clear answers we might expect. As we will see in the following pages, the requirements of the [Code of ethics of physicians](#) apply to all physicians irrespective of their place of practice (see "[Duties and obligations of physicians](#)"). Over the years, new administrative rules have been adopted with respect to, for example, the types of associations possible for physicians, advertising and records. These regulations are reviewed regularly and updated in order to take the changing context of medical practice into account. For example, the *Regulation respecting records, places of practice and cessation of practice by a physician* was revised in 2017 (awaiting approval by the Office des professions) to take into account the shift to electronic medical records. By amending certain provisions of the *Act respecting health services and social services* (AHSSS) and the *Health Insurance Act* (HIA) in 2006 and 2009, the Quebec government established a governing framework for two new entities, specialized medical centres (SMCs) and associated medical clinics (AMCs). Since then, several other bills have also reshaped the organization of the health care system.

Of all the requirements imposed in an institution, which are still relevant in a non-institutional setting? For example, must written consent be obtained before every surgery, invasive procedure or research project? Practice outside an institution raises many new questions that the Collège tries to address, be it in the *Code of ethics*, the regulations, [guidelines or practice guides](#). But, as we will see, physicians must remain vigilant.

With respect to the more practical aspects of practice outside an institution, we suggest you consult the documents published by medical federations (FMRQ, FMOQ and FMSQ) and medical associations (CMA, CFPC, RCPSC). The websites of the three medical federations offer several training modules for medical residents that focus on topics such as choosing a place to practice, possible modes of compensation, billing, financial planning and insurance, specific medical activities (SMAs), regional medical staffing plans in family medicine (plans d'effectifs médicaux en médecine de famille – PREM), medical staffing plans in

family medicine and in specialties (plans d'effectifs médicaux par établissement – PEM). For more information about the new organizational models, it might be helpful to consult the [Ministère de la Santé et des Services sociaux \(MSSS\)](#) and [Régie de l'assurance maladie du Québec \(RAMQ\)](#) sites. However, given the extremely rapid pace of change, often the only way to stay informed is to follow the news.

3.2.1 Practice outside an institution and the health care system

We often make a distinction between practice in an institution and practice outside an institution as if these two types of medical practice were totally different. In fact, according to the terms of the *Act respecting health services and social services*, private doctors' offices are not institutions (AHSSS, s. 95). Nevertheless, the care provided in these offices is an essential component of the health care system. Most of the medical services provided outside of institutions are in fact covered by the health insurance plan because they are medically necessary. They are often needed before or after care is provided in institutions in the public network, which makes private offices, and more broadly resources other than public institutions, essential partners in Quebec's health care system. These resources are increasingly seen as partners, with network institutions entering into agreements with them in order to better meet the population's growing needs.

Private practice

In recent decades, the position of physicians who practice outside an institution has changed considerably with respect to the health care system. Compared with working in an institution, private practice is still considered to offer several advantages both for patients and physicians, including, in theory, increased access, more direct contact with patients and simplified administrative formalities. Physicians in private practice enjoy more professional freedom and are actively involved in managing many aspects of their practice, such as appointment scheduling, record keeping, work scheduling, personnel management and the material organization of the office, not to mention the quality of equipment and professional services.

However, we know that private practice also has some disadvantages. First of all, management costs can be relatively high. Of course, these costs vary depending on the particular discipline, the type of activities and the place of practice. In order to partially compensate for the costs associated with private practice, provision has been made for differential remuneration for interventions based on whether they are carried out in institutions or in offices. In the context of some organizational models, such as family medicine groups (FMGs) and super clinics, additional support is offered for time-consuming administrative tasks and for technological support. In the case of private practice, this support is usually more

limited, particularly for physicians in solo practice, which reduces the range of services they can offer.

In general, basic services in office-based family medicine include consultations with or without an appointment, minor surgery, home visits and, sometimes, a specimen collection centre. For specialties, the range of services offered varies depending on the discipline. If the size of the office and its location, such as in a polyclinic, allow, laboratory, imaging and specialized consultation services may be offered. Place of practice and proximity to a hospital centre are also factors that influence the range of health care services offered. It is important to note that an increasing number of clinics are complementing the skills of physicians with those of other health professionals, most notably in the areas of nutrition, psychology, social work and physiotherapy. The management framework for FMGs and super clinics specifically provides for funding in order to foster close collaboration between family physicians and other health professionals.

Networking among primary care services

Since the introduction of health insurance, much has been done to further integrate private doctors' offices into the public network. One of the most significant initiatives is unquestionably the creation of local community services centres (centres locaux de services communautaires - CLSCs), which formed the basis for establishing integrated primary care services networks. The primary objective was to increase access to these services in a specific territory. Private offices that voluntarily join these networks must meet certain criteria with respect to the type of services offered and hours of availability. In some cases, they are part of an on-call system that operates 24 hours a day, 7 days a week and is established in their territory to offer home care services to clients in collaboration with integrated health and social services centres (centres intégrés de santé et de services sociaux - CISSSs) and integrated university health and social services centres (centres intégrés universitaires de santé et de services sociaux - CIUSSSs). CISSSs and CIUSSSs are obliged to assume responsibility for the population in the territory of their local health networks (réseaux locaux de santé - RLSs). In order to meet all their population needs, they must establish agreements with medical clinics and FMGs.

For their part, regional departments of general medicine (départements régionaux de médecine générale - DRMGs) are responsible for defining primary care service needs in their territory. They advise the MSSS with respect to the regional medical staffing plans (PREMs) of their respective regions and ensure that physicians participate in special medical activities (SMAs) they deem to be a priority in their regions. In several regions of Quebec, there are local joint CISSS/CIUSSS and DRMG tables in place to ensure that private offices work increasingly in a network with other resources, thereby promoting the accessibility, continuity and integration of general medical services in the region.

As we will see further on, other organizational models, in particular specialized medical centres (SMCs) and associated medical clinics (AMCs), are designed to bring about the desired complementarity.

3.2.2 Practice outside an institution and the health insurance plan

For most of their interventions, the overwhelming majority of physicians are remunerated by the Régie de l'assurance maladie du Québec (RAMQ). Physicians who practice outside institutions can always choose not to participate in the health insurance plan or to withdraw from it. However, relatively few choose to do so in Quebec, despite an increase in their number in recent years.

Consequently, it is hard to understand the current situation and its issues without being aware of the broad strokes of Quebec's health insurance plan as it operates at present. The following recap is based on information from the [Régie de l'assurance maladie du Québec](#)'s site, with the addition of some clarifications. The RAMQ is the organization that administers the province's public health and drug insurance plans: it informs the public, determines eligibility, compensates health professionals (physicians, pharmacists, dentists) and ensures the secure flow of information.

People insured under the plan

Since November 1st, 1970, all residents or visitors to Quebec who meet the conditions set out in the Act are covered by the health insurance plan. To be eligible for insured health services, a person must present their valid health insurance card. If they do not have a health insurance card or if the card has expired, they must pay for any services received and apply for a reimbursement from the RAMQ. Generally, a person who comes from outside Canada, even if they are a Canadian citizen, will be eligible for Quebec health insurance after a waiting period of up to three months after they register.

However, some health services may be provided free of charge given a person's particular situation. These include services for victims of conjugal or domestic violence or sexual assault; services related to pregnancy, childbirth or termination of pregnancy; or services for people with health problems of an infectious nature that could have repercussions on public health. Quebec has also signed social security agreements with some countries exempting citizens of these countries from the usual waiting period.

A person who comes from another province to settle in Quebec will be eligible for coverage under the health insurance plan once they are no longer covered by their province of origin's plan. Coverage under the Quebec plan generally begins on the first day of the third month after the person's arrival in Quebec. The person will receive their health insurance card within two weeks of the date they are

covered by the Quebec plan. For the time the person remains covered under their province of origin's health insurance plan, they must show the health insurance card issued to them by that province to the physician if they require health care in Quebec. Their province's health insurance plan will cover the costs incurred. However, if the physician refuses the card, the person must pay the physician themselves and then file a claim for reimbursement with the body that administers their province's health insurance plan.

Services covered in Quebec

Insured people are entitled to a number of free services under the health insurance plan. In addition to medical services, the health insurance plan covers a range of other health services designed to meet more specific needs, such as dental services for children under the age of 10.

With respect to medical services, irrespective of where they were provided, the health insurance plan was initially designed to cover medically necessary services provided by a physician, be they a family physician or another type of specialist. These services included examinations, consultations, diagnostic services, therapeutic interventions, psychiatric treatments, surgery, radiology and anesthesiology. Health care systems have since undergone many changes and it is not always easy to determine what is now part of the "basket of services" covered in Quebec.

Since the beginning, health care services deemed by the plan to be unnecessary from a medical standpoint have not been covered, even though they are provided by physicians. The health insurance card cannot be presented to obtain these services, irrespective of what physician provides them. The person must pay for these services themselves. Services provided for purely cosmetic purposes are a classic example of these types of services.

Some services are not covered because they are not related to the prevention or cure of an illness. For example, when a person sees a physician and undergoes tests for the sole purpose of obtaining a health certificate, they may have to cover the cost themselves. Nor are tests required for legal purposes covered, although some exceptions may apply.

Coverage of some services may vary depending on where they are provided. For example, some services are only covered if they are provided in an institution. This applies to most laboratory services and some medical imaging tests such as computed axial tomography or magnetic resonance imaging. Other services are not covered if they are provided by one type of specialist rather than another. For example, office-based ultrasound is covered if it is done by a radiologist but not if it is done by a cardiologist or urologist.

Some services are covered upon special authorization only. Since treatments provided for cosmetic reasons are not covered under the health insurance plan, a physician must sometimes determine if the service is requested for purely cosmetic purposes or if it is medically necessary. Services for which a consultation with a physician is required to determine if they can be covered by the RAMQ include mammoplasty, abdominal lipectomy, blepharoplasty, electrolysis for hirsutism, etc.

Coverage can also be more or less comprehensive. Even if a person presents their health insurance card to obtain health services that are covered under the plan, some costs may be billed to them. The term “incidental fees” or “accessory costs” refers to costs billable to patients for some services, even if they are associated with insured services. Note that the *Regulation abolishing accessory costs related to the provision of insured services and governing transportation costs for biological samples* came into force on January 26, 2017. This regulation prohibits all accessory costs related to the provision of services insured by the RAMQ. The regulation makes an exception for costs associated with the transportation of biological samples collected at a private office or in a specialized medical centre, since transportation costs are not covered by the RAMQ. A fee may therefore be charged for the transportation of these samples, once per sample.

Participating physicians, non-participating physicians and physicians who have withdrawn from the plan

Under the terms of the *Health Insurance Act* (HIA), a distinction is made between health professionals who are authorized to provide insured services based on whether or not they participate in the health insurance plan.

Most physicians in Quebec participate in the plan, that is, they accept the health insurance card. This means that people who are insured do not generally have to pay for covered services. The RAMQ pays these “participating” physicians directly for services rendered in accordance with the agreements negotiated between the government and the medical federations (FMOQ, FMSQ).

Although few in number, some physicians, who are said to have “withdrawn”, do not accept the card but follow the fee structure provided for in the agreements. They bill their services to their patients, who can then apply for a reimbursement from the RAMQ using the form obtained during their visit. Of course, these physicians must inform people who consult them of this situation in advance.

Other physicians, also few in number, do not participate in the health insurance plan in any way. Referred to as “non-participating”, they bill their services directly to their patients and establish their fees entirely on their own. With some exceptions, the RAMQ does not reimburse the cost of any services provided by these physicians, even covered services. A non-participating physician who

provides a service that is insured under the Act in an emergency situation may bill the RAMQ for the amount of fees payable under the agreement. Non-participating physicians are also obliged to inform people who consult them of their situation before any services are provided.

Unless otherwise specified, all physicians are deemed to participate in the health insurance plan. Should a physician decide not to participate or to withdraw, he must inform the RAMQ in accordance with the terms and conditions set out in the agreements. A physician who decided not to participate or who withdrew from the plan can rejoin it and become subject to the application of the agreement again by making a formal request. Therefore, physicians can always choose not to participate in the health insurance plan or to withdraw from it. However, a number of provisions in the HIA serve to prevent physicians from both participating and not participating in the plan (“mixed practice”). The RAMQ makes a list available of health professionals who have withdrawn or who do not participate in the health insurance plan. While this list is growing, the number of physicians concerned is relatively low. Moreover, the government reserves the right to intervene if the Minister considers this number to be too high so that insured services can continue to be provided under uniform conditions throughout Quebec or in any of its regions (HIA, s. 30).

Since all combinations of these three variables (people insured under the plan, services covered under the plan and physicians who do or do not participate in the plan) are possible, situations can vary widely outside of institutions. Most of the time, physicians who participate in the plan provide covered services to insured people. However, participating physicians may also provide services that are not covered. Or again, they may provide covered services, but to people who are not insured. An insured person may also decide to consult a non-participating physician to obtain services that would be insured if the physician participated in the plan. And so on.

Despite this diversity, the key issues are essentially the same with respect to a physician’s professional ethics. A physician may only claim the fees that are justified by the nature and circumstances of the professional services rendered. When certain costs are billable to the patient, the physician must advise them of this in a very clear and timely manner. Whether the physician participates in the plan or not, whether the patient is eligible for coverage under the plan or not and whether the services are insured or not, this rule remains unchanged. Furthermore, if a patient believes that a physician’s fees are unjust and wishes to contest the fees charged by their physician, they can contact the Collège’s Inquiries Division to obtain information and request conciliation of the account.

Extension of the RAMQ's powers

In December 2016, the Government of Quebec adopted the *Act to extend the powers of the Régie de l'assurance maladie du Québec, regulate commercial practices relating to prescription drugs and protect access to voluntary termination of pregnancy services*. Under the Act, the RAMQ may recover from a health professional or a third person an amount unlawfully obtained from an insured person without an application for reimbursement being filed beforehand. Monetary administrative penalties may be imposed on health professionals or third persons who have claimed or obtained a payment contrary to the law. The recovery of amounts unduly paid is prescribed five years after the insured services are received. In the case of a false declaration, recovery is prescribed five years after the date on which the RAMQ becomes aware of a person's ineligibility for such services, but not later than 10 years after the services are received.

Under the new Act, the RAMQ may also communicate information obtained for the carrying out of the *Health Insurance Act* to a police force and to certain government departments and to certain bodies if such information is necessary to prevent, detect or repress an offence under an Act applicable in Quebec.

The RAMQ may authorize any person to act as an inspector for the purpose of verifying compliance with the provisions of the Act adopted by the government in 2016, the *Health Insurance Act*, the *Act respecting prescription drug insurance* and their regulations. The person acting as an inspector may:

- (1) enter, at any reasonable time, any place where a health professional, a dispenser or a drug manufacturer or wholesaler accredited by the Minister or an intermediary within the meaning of section 80.1 of the *Act respecting prescription drug insurance* exercises functions or carries on activities;
- (2) require the persons present to provide any information relating to the functions exercised or activities carried on by the persons referred to in subparagraph 1 and to produce any related document for examination or for the purpose of making copies. Any person who has custody, possession or control of such documents must, on request, make them available to the person conducting the inspection and facilitate their examination. Note that an inspector authorized to act by the RAMQ cannot be prosecuted for acts performed in good faith in the exercise of the functions of office.

Moreover, the RAMQ may require that a health professional's statement of fees or claim for payment be transmitted to the Board by electronic means only.

3.2.3 Health care delivery outside of institutions

Once medical practice outside of institutions is more clearly situated relative to the health insurance plan on the one hand and the health care system on the

other, it is easier to understand that this form of practice complements various organizational models. Moreover, the type of health care system that prevails in Canada and Quebec is often described as a “mixed system”, with funding of the plan and management of the system being essentially public, while health care delivery is far from being limited to public institutions.

It is important to distinguish clearly between the funding of organizations providing health care and the funding of services themselves, which is or is not covered by the health insurance plan depending on whether or not the person and the service are covered and whether or not the physician is participating in the plan. Since the creation of the health insurance plan in Quebec, the main sources of funding for organizations other than institutions have been the professional fees claimed from the Régie de l'assurance maladie du Québec by physicians, while the management of these organizations has, more often than not, been ensured by these professionals. However, funding may also come from another government body, such as the Commission des normes, de l'équité, de la santé et de la sécurité du travail (CNESST) [Labour standards, pay equity and occupational health and safety board], a private insurer or from fees and expenses billed directly to patients.

When physicians adopt certain newer organizational models, other sources of funding specific to each model are added to the so-called “private” funding we have just described. A public subsidy may be granted in return for a commitment to a specific service offer. This is the case for FMGs and super clinics and is what is planned for AMCs. Various combinations are therefore possible, even if some of these are still newly emerging phenomena for the moment. At this juncture, there are a few specialized medical centre (SMC) projects. But they are already raising new funding and management challenges because they involve substantial private investment out of all proportion to what has been required to date by private doctors' offices.

3.2.4 Diverse organizational models

Be it to develop medical services offered outside of institutions by physicians in solo or group practice or to promote their integration into the public network, several formulae have been applied. Models that have expanded significantly in recent years are family medicine groups (FMGs), super clinics, specialized medical centres (SMCs) and associated medical clinics (AMCs). Health care cooperatives are another non-institutional organizational model. A brief description of these diverse organizational models will be provided below.

Solo practice and group practice

In the case of solo practice, a family physician or other specialist works alone in their own office or individually at a private polyclinic. A minority of physicians opt for this type of practice now. It is a model that is losing ground.

In the case of group practice, a number of physicians join together in a clinic that is independently organized and managed or they associate with an already established larger group, such as a private polyclinic. Physicians who practice in a group must create a single medical record per patient and per place of practice.

Family medicine groups (FMGs), university family medicine groups (U-FMGs) and super clinics

In 2000, the Commission d'étude sur les services de santé et les services sociaux (Clair Commission) [Commission for the study of health and social services] recommended the implementation of family medicine groups (FMGs). This new service delivery structure was introduced in order to improve accessibility, delivery and continuity of care and to encourage clients to assume greater responsibility. There are both small and large FMGs at present. Since 2002, the FMG has been the preferred model for the organization of primary health care and services in Quebec. The first FMGs appeared in November 2002. In November 2012, there were 250 accredited FMGs in Quebec and, in 2017, 302 FMGs were recognized by the MSSS.

An FMG is made up of a sufficient number of physicians to ensure the equivalent of six to twelve full-time family physicians (FTEs) who agree to perform activities specific to FMGs: consultations with an appointment, without an appointment and home care. These physicians work in a group in offices or local community services centres (CLSCs). A university family medicine group (U-FMG) is an FMG where family medicine residents, students and interns in various disciplines can receive training and be supervised. Physicians in FMGs work in close interdisciplinary collaboration with nurses and other health professionals.

Recognized as a functional entity, the FMG defines the services it offers in accordance with those expected of an FMG. In return, it enjoys the benefits of MSSS support. In each FMG, one physician is designated to distribute tasks, assign responsibilities to group members and manage, with the staff provided, the budget it has been allocated.

The new Programme de financement et de soutien professionnel pour les groupes de médecine de famille [Program to provide funding and professional support for family medicine groups] came into force on November 16, 2015 (replacing the FMG Management Framework adopted in 2002).

According to the new program, a recognized FMG is:

- > an FMG that has been recognized by the Minister of Health and Social Services: a letter bearing the Minister's signature attests to this recognition;
- > an FMG whose recognition is still effective after assessment at the time of the annual review.

The basis of the model is the same, that is, patients register with a physician in the group and the service offer allows registered patients to benefit from accessible services. The basic structure of FMGs requires them to ensure that registered patients can access services in a reasonable and timely manner, as evidenced by the addition of a loyalty measure to ensure that patients use the FMG they have registered with. Voluntary, free registration without any territorial restrictions is a fundamental feature of this organizational model. On an administrative level, the subsidy is based on a sliding scale that takes the weighted number of individuals registered with all members of the FMG into account.

Super clinics offer the same services as an FMG but must provide a wider range of primary care services for semi-urgent and simple urgent needs. For example, they must provide consultations to patients who do not have a family physician or who are registered with another FMG and be open 7 days a week, 12 hours a day (with some exceptions).

Super clinics are also places where public specimen collection and imaging services are available on site or nearby. It is also easier to access specialized services in super clinics.

Associated medical clinics and specialized medical centres

As we saw previously, a new legal framework was created following the Supreme Court's ruling in the *Chaoulli* case in 2005. This framework is intended to ensure that the use of resources outside of institutions improves access to some specialized services without compromising the quality of these services.

Specialized medical centres (SMCs) are defined as places outside of institutions where physicians can, under certain conditions, provide a number of specialized medical services specified by law or regulation that were provided in institutions until now. The conditions include obtaining an operating permit issued by the government, appointing a medical director responsible for ensuring the quality of the medical services provided, and accreditation by a recognized body within three years of obtaining the operating permit. The services specified in the regulation subsequently adopted and in effect since March 31, 2010 consist of surgical procedures that were determined based on the length of stay and type of anesthesia required as well as the risks involved. The law recognizes two types of SMC: those where only physicians who participate in Quebec's health insurance plan practice and those where only non-participating physicians practice.

Associated medical clinics (AMCs) include general or specialized medical clinics and laboratories. They are defined as places where physicians who participate in the health insurance plan offer certain services under a partnership agreement with an institution.

Health care cooperatives

Another health care services organizational model has developed since the early 1940s. Many health care cooperatives have now been formed by citizens in Quebec, generally in locations where there was a scarcity or risk of losing medical staff or health care services. The formula relies on the leadership of people who are engaged in their community and who work in collaboration with health care professionals. Their goal is to allow the members of a community to join forces to meet their health care needs.

In addition to family medicine services, health care cooperatives rent premises to other professionals (e.g., rehabilitation, alternative medicine, pharmacology and fitness centre), organize public education activities in health and prevention (e.g., talks on diabetes), set up groups that promote physical activity (e.g., walking club) based on their community's specific needs.

3.2.5 Common professional issues

The framework for medical practice was designed for institutional practice on the one hand and private practice on the other. What happens in all those situations where physicians practice their profession in settings that are neither institutional nor private in the classic sense of the term? The question is pertinent and does not necessarily have an easy answer.

Some of these situations probably require a framework that resembles what exists in institutions for the same types of medical interventions and which we discussed previously. Others are closer to private practice.

Fortunately, however, some points of reference are common to all situations. Regardless of the place or type of practice, physicians remain, in all circumstances, autonomous professionals responsible for their actions. Whether in an institution, a private office or elsewhere, the practice of the profession is governed in Quebec by the *Professional Code*, the *Medical Act* and its regulations, including the *Code of ethics of physicians* and the *Regulation respecting records, places of practice and the cessation of practice by a physician*. A physician is always bound by the same ethical obligations, be it with respect to competence, the obligation to provide assistance, follow-up, maintaining professional secrecy or his professional independence. Moreover, some provisions of the *Code of ethics* were formulated and others added to better guide physicians in some situations of greater concern.

For instance, the Code stipulates that:

- > a physician must not be “directive”, that is, he must respect the patient’s freedom of choice to have prescriptions filled in the place of his choice (s. 77);
- > in order to maintain professional secrecy, a physician must, for instance, refrain from holding or participating, including on social networks, in indiscreet conversations concerning a patient or the services rendered him or from revealing that a person has called upon his services (s. 20);
- > a physician may not be party to an agreement in which the nature and extent of professional expenses can influence the quality of his practice. Likewise, a physician may not be party to an agreement with another health professional in which the nature and extent of the professional expenses of the latter can influence the quality of his practice (s. 72);
- > a physician must refrain from seeking or obtaining a financial benefit other than the physician’s fees from the prescription of apparatus, examinations or medications, either directly, indirectly or through an enterprise controlled by the physician or in which the physician takes part. Nevertheless, a physician may make a profit from the sale or marketing of an apparatus or examination that the physician prescribes and has developed or contributed to its development, directly, indirectly or through an enterprise controlled by the physician or in which the physician takes part, in which case the physician must so inform the patient (ss. 73);
- > a physician who claims fees must provide the patient with an itemized invoice for his or her services, the medical supplies and apparatus, medications and products presented as having a benefit to health whose cost is claimed by the physician (s. 104).

Furthermore, the rules governing advertising by physicians and those governing practice in a partnership or a company have been updated. They are much more explicit with respect to acceptable practices for physicians. A physician’s duties and obligations under the *Medical Act*, the *Professional Code* and their regulations are in no way changed or reduced by the fact that he practices the profession in a partnership or a company. Indeed, a physician must ensure that the persons he employs or with whom he is associated in the practice of his profession comply with this Act, this Code and these regulations (s. 8).

The [Regulation respecting records, places of practice and the cessation of practice by a physician](#), adopted in May 2012 and currently being updated, is intended for all physicians. In very clear terms, it sets out the rules concerning records and places of practice and specifies the procedure to follow in the event of cessation

of practice or reorientation. Furthermore, the new regulation will specifically address the rules concerning electronic medical records.

In addition, there are some specifications regarding the billing of medical interventions. Billing is subject to the agreements concluded between the MSSS, the Fédération des médecins omnipraticiens du Québec (FMOQ) [Quebec federation of general practitioners] or the Fédération des médecins spécialistes du Québec (FMSQ) [Quebec federation of medical specialists], as applicable. For reference purposes, the various associations also publish fee schedules for the costs charged to patients (for uninsured services and the costs associated with an insured service).

The MSSS also exercises some control through the issue of permits, which are mandatory for the new organizational models. In short, the formal framework is in the process of adjusting itself to this evolution in medical practice. Until this process is complete, however, physicians must remain vigilant, since this evolution is giving rise to numerous challenges on a daily basis.

Respect for patients: appointment scheduling and communication

As a professional, it is also important to ensure one has the practical means to serve clients properly. When practicing outside of institutions, physicians bear the primary responsibility for this. Thus, appointment scheduling and communication systems deserve some comment.

Managing appointments

There is no doubt that an inadequate appointment system tends to put clients off, while an efficient system is a draw for them. There is a wide variety of options to choose from and each has its advantages and disadvantages. What is important is that the physician adopt a system and adapt it to optimize its ability to meet both his patients' expectations and his own needs and work habits. In the case of group practice, it may be advantageous to select a method that everyone will use so as to avoid confusion and error.

Take, for instance, the growing popularity of a proactive appointment scheduling method based on interprofessional collaboration that improves access to care: advanced access. Advanced access aims to help clinics respond to patient requests and facilitate access by scheduling appointments within a short period of time, thereby providing timely access to primary care services. This method, which has proven its worth in the United States and in other parts of Canada, allows patients to choose the date and time of their appointment within a two-week period. Appointment slots are maximized to emphasize the relevance of appointments. Waiting lists are reduced to a minimum, appointments are no longer scheduled months in advance but in a timely manner for patients.

Communication

Rigorous mechanisms must always be put into place to guarantee the confidentiality of records and communications, irrespective of the means used. In addition to traditional means of communication (telephone and fax), physicians have many other options to choose from now. Information technology systems can be very useful, particularly when it comes to RAMQ billing and the use of email. A large-scale project to computerize the health care network is currently underway in Quebec. This initiative will allow professionals to access certain valuable information for patient treatment. The Québec Health Record (QHR) is one of the major innovations of recent years aimed at improving quality of care and the efficiency of Quebec's health care system through computerization. This tool is available to physicians and health professionals in Quebec. Authorized individuals can use it to access their patients' health information (list of medications, laboratory, medical imaging, etc.) allowing them to intervene more rapidly and more effectively.

There is no doubt that changes in communications technology are changing medical practices, as evidenced by a number of initiatives. Take "[telemedicine](#)", for instance, the practice of medicine at a distance. Given a proper framework, telemedicine can help improve access to quality care.

The medical profession is not immune to the trend, now well established, of using text messages, email and social media. These tools have many advantages but also come with significant risks and are leading to major changes in communications. Despite increased user awareness and the many documents published on the topic, we have observed that frequent reminders are needed.

In 2015, the *Code of ethics of physicians* was amended to take this new work environment into account. It now stipulates that a physician must take reasonable measures to preserve professional secrecy when he uses, or persons working with the physician use, information technologies.

In practical terms, this means that indiscreet conversations on social media about a patient are prohibited, as are medical consultations using Facebook.

A physician must always remember that when he uses new information technologies, including social media, the information sent is public (can be accessed by anyone), permanent (in time) and universal (no geographic limit). When using text messages, email and other social media, physicians must comply with their legal, ethical and professional obligations.

Professional independence and administrative aspects

A number of observers believe, however, that the greatest challenges today relate to the professional independence of physicians, with business and administrative

aspects necessarily creating situations of potential conflict of interest. This is a subject that warrants more detailed discussion.

Purchase, rental and keeping of premises

According to some studies, approximately half of private practice offices belong to physicians and the remaining half to financial promoters or other individuals. The decision to rent or buy is, first and foremost, a business decision.

However, whatever physicians decide in this regard, they must ensure that their agreements allow them to respect the *Code of ethics* and to organize and keep a consulting space that meets the standards set out in the *Regulation respecting records, places of practice and the cessation of practice by a physician*.

With respect to rental agreements, physicians must ensure that they do not compromise either their professional independence or patients' freedom of choice.

Although the *Code of ethics of physicians* already contained several provisions aimed at controlling conflicts of interest and maintaining the physician's professional independence, it was amended in March 2008 to establish new rules pertaining to leases. It now stipulates that a physician must refrain from accepting, in his capacity as a physician or by using his title of physician, any commission, rebate or other material benefit, with the exception of customary presents and gifts of modest value (s. 73, subpar. 3).

Any agreement entered into by a physician regarding the use of a building or a space to practice his profession must be entirely recorded in writing, must indicate that it complies with the *Code of ethics of physicians* and must be released to the Collège des médecins du Québec upon request (s. 72). In addition, the Code stipulates that the use of a building or a space at no charge or at a discount will be considered to be a material benefit prohibited by the Code if it is granted by:

- > a pharmacist or a partnership or company of which the pharmacist is a partner or shareholder;
- > a person whose activities are linked, directly or indirectly, to the practice of pharmacy;
- > another person in a context that may present a conflict of interests, whether real or only apparent (s. 73.1).

To gauge the scope of these amendments and illustrate in a concrete way the behaviour expected of physicians in this regard, it should first be made clear that agreements or leases must not contain conditions that affect a physician's professional independence, in particular, by regulating the act of prescribing or

directing patients after a prescription is written. In addition, a lease entered into by a physician with a professional or a natural or legal person leading to the sale of goods, products, medications or apparatus prescribed by the physician must provide for the payment of a fair and reasonable rent so as not to be considered a material benefit prohibited by the Code. Fair and reasonable means that the rent is in line with the region's socioeconomic conditions and with the nature and intensity of the services provided. The rent could be calculated based on the rental cost per square foot, the period of occupancy or as a percentage of the physician's billings.¹¹

In short, all physicians who practice outside of an institution and who do not own the property where they practice must have a written agreement that includes a statement by the physician to the effect that the obligations arising from the agreement comply with the *Code of ethics of physicians* and a clause authorizing the release of the agreement to the Collège des médecins upon request. The medical federations have posted rental agreement templates on their websites.

Forms of association and types of partnership

A physician working in private practice or in an institution may enter into a partnership agreement governed by the *Civil Code of Québec*. In this partnership, he may practice alone or agree to pool any pecuniary profits resulting from professional activities in accordance with certain terms and conditions.

— A partnership between individuals

To form a partnership between individuals, three elements are essential: an investment, profit sharing and the intention to form a partnership. In this case, all professional fees are pooled and shared.

The *Professional Code* allows physicians to join forces to form a limited liability partnership (LLP) or a joint stock company (Inc.). Thus, in March 2007, the *Regulation respecting the practice of the medical profession within a partnership or a company* came into effect. Unlike partners in a general partnership (GP), physicians who are partners in a limited liability partnership or shareholders in a joint stock company are not held jointly liable for the professional acts of their partners if they did not participate in those acts. However, professional liability towards the patient remains unchanged. Moreover, section 8 of the *Code of ethics of physicians* was amended to make this clear. A physician who practices his profession within a partnership or a company must provide and maintain on behalf of the partnership or company coverage for liabilities of the partnership or company arising from the fault or negligence of the physicians in the course of the practice of their profession within such a partnership or company.

¹¹ See [Points for physicians to consider before signing a lease](#).

The regulation adopted by the Collège allows physicians to practice within this type of partnership or company. However, they may do so only on the condition that they hold all the shares or voting rights attached to the shares and that the partnership's or company's board of directors is composed entirely of physicians.

Furthermore, a physician may only join forces with other physicians, his spouse, blood relatives or relatives by marriage, or with legal entities, trusts or companies whose shareholders, partners or trustees are physicians, a spouse, blood relatives and/or relatives by marriage. He may also join forces with a trust where at least 50% of the voting rights attached to the ownership interests are owned by at least one physician and at most 50% by a single one of the following professionals: chartered administrator, lawyer, chartered professional accountant or notary.

To practice within one of these structures, physicians must first obtain authorization from the Collège.¹²

— A nominal partnership

Physicians may associate to form a nominal partnership or “partnership for expenses”. A nominal partnership is formed by two or more professionals who wish to share the expenses associated with their practice while maintaining their own clientele and income. The sharing may or may not be on an equal basis, depending on the context and their choice.

The advantages of a nominal partnership include the rational use of human resources, the sharing of on-call duties, the assurance of finding replacements, the optimal use of premises, contact among partners, a certain autonomy, greater purchasing power for acquiring equipment, easier practice startup and respect for everyone's individual work pace. On the other hand, competition is greater with this type of partnership and team spirit is less developed than in a partnership between individuals.

There is a formula known as “mixed distribution” whereby fixed expenses are distinguished from variable expenses. In general, fixed expenses are those that do not vary with the volume of activity, such as rent, telephone, office equipment and part of the office staff. Some partnerships exclude various expenses from shared expenses, such as the purchase of books and periodicals, professional dues, conference and symposium participation fees as well as motor vehicle expenses. Others set a cap on the sharing of expenses so as not to penalize members who work longer hours.

¹² See the [Steps to follow](#) section on the Collège's website.

– The partnership agreement

As we can see, there are many types of partnerships, none of them being better or worse than the other when it comes to the practice of medicine. The relative advantages and disadvantages are organizational, financial and, above all, fiscal in nature. Physicians who decide to work in partnership have the freedom but also the responsibility to define the agreements that suit them. The first step in establishing a partnership agreement is to decide on the terms. They must be specific enough to prevent interpretation problems and flexible enough to allow the signatories sufficient autonomy. The clauses should take individual needs into account and should reflect the type of partnership selected. The number of clauses in an agreement can vary. By way of indication, here is a list of the most important clauses:

- > the purpose of the agreement and the company name;
- > the duration of the agreement;
- > the investment and conditions of the partnership;
- > ownership of the furnishings;
- > administration of the partnership;
- > professional liability;
- > the workload;
- > the sharing of expenses and fees, where applicable;
- > the obligation to maintain competence and the policy pertaining to vacations and participation in conferences and symposia;
- > sabbatical leave;
- > sick leave;
- > maternity leave;
- > arrangements for the transmission or retention of records in the event of dissolution of the group or departure of a member;
- > the dissolution of the partnership;
- > the departure or death of a partner;
- > the hiring of a family member;
- > the fiscal year;
- > arbitration.

It is strongly recommended that the services of taxation specialists be retained to draw up the agreement.

The practice of the medical profession within a partnership or a company changes nothing for the public and in no way affects the Collège's oversight and monitoring authority over its members. Professional ethics and civil rules remain the same, such that neither ethics remedies nor civil remedies are affected.

In addition, a physician who wishes to practice his professional activities within a partnership or a company should always consult a professional, such as a legal expert, before creating the partnership or company. Indeed, the Collège does not provide a model charter, model articles of incorporation or a model partnership agreement. It is the responsibility of the professional (legal expert) who is setting up the partnership or company to ensure the appropriate form is used.

Rules concerning advertising and public statements

The *Code of ethics of physicians* was amended to create a specific section pertaining to advertising and public statements by physicians (ss. 88 to 93.3).

Thus, the Collège acknowledges the existence of new marketing practices and the emergence of new information technologies in a context where numerous types of care and services, whether they are covered by the health insurance plan or not, are publicly advertised. This section echoes the *Professional Code*, which assigns responsibility and certain obligations to professionals with respect to advertising messages promoting their services. The cornerstone of the new rules is the honesty of the message. Some practices that were previously prohibited are now permitted, unless they contribute to biasing information. A physician must, however, clearly indicate his specialist's title corresponding to one of the medical specialties recognized by the Collège.

At the same time, the Collège reiterated the rule stipulating that physicians must display the price of any services, supplies and accessory costs they charge their patients (*Health Insurance Act*, s. 22.0.0.1; *Code of ethics of physicians*, s. 105).

Here are a few examples of advertising or marketing practices that are not acceptable:¹³

- > the display, in the physician's office or waiting room, of posters or images that promote a device or a product, in particular by using the brand name of the product;

¹³ See the updated version of the guide published by the Collège in 2019: [*Le médecin, la publicité et les déclarations publiques*](#) (Physicians, advertising and public statements; available in French only).

- > the presence of links, on a physician's or clinic's website, to companies selling products prescribed or recommended by the physician or devices used in his office;
- > the use of the commercial logos of products used by the physician on his website or in the clinic where he practices;
- > contests or draws;
- > the sale of products by a third party associating them with his own title or status as a physician or with one or more other physicians;
- > advertisements that might influence people who may be vulnerable due to their age, their condition or a specific event.

The Collège's Syndic's Office determined that, for a physician, offering influencers (such as bloggers, vloggers or youtubers) any type of care or treatment in exchange for visibility constitutes a benefit that is prohibited by the *Code of ethics*.

While using social media to advertise their services is not prohibited, physicians who do so must be very vigilant in order to avoid any departure from the standards of professionalism expected of a physician. Note, in particular, the obligation to maintain professional secrecy, to refrain from using one's title for commercial purposes, to refrain from guaranteeing a result and to avoid any situation where there is a conflict of interest or apparent conflict of interest.

Lastly, a physician must retain control over all the information disseminated in the context of any advertising that concerns him. He may not claim that the advertisement is disseminated by a third party to justify an advertisement that does not comply with his *Code of ethics*.

— Responsibilities of the physician employer

The *Act respecting labour standards* governs all work relations between physician employers and their employees. As part of their professional activities, physicians must reconcile constraints on the use of their time and those related to the application of management standards. If they want to devote most of their time to the practice of medicine, they must surround themselves with competent and reliable staff. Indeed, efficiency is contingent on the effective distribution of tasks and responsibilities in accordance with the respective skills of staff members.

Furthermore, as principals, physicians are accountable for their staff's actions. Therefore, it is important for physicians to determine as precisely as possible situations when their staff must ask them to intervene with respect to a patient, for example, to respond to a telephone message or to advise them of an incident that has occurred. It is also important that staff members always respect the rules

of confidentiality. Sound personnel management relies on good human relations. It is well known that employees are most productive when they are looked upon as partners and treated with respect. Physicians have numerous obligations as employers. They must learn the art of delegating and allow their trusted staff to show initiative, while supervising their work carefully and remaining responsible for it.

3.2.6 In short

The practice of the medical profession within a partnership or a company changes nothing for the public and in no way affects the Collège's oversight and monitoring authority over its members. Professional ethics and civil rules remain the same, such that neither ethics remedies nor civil remedies are affected. Despite the complexity of the systems implemented to make health care accessible to all, we must not lose sight of the ultimate objective of the practice of medicine, which is to assure each and every person of the care they need and of the best care possible.

3.3 Diversification of the practice of medicine

After obtaining a degree from a faculty of medicine and a permit to practice from the Collège des médecins, physicians may practice their profession in settings as varied as the roles they may play. They may also engage in clinical or non-clinical activities or divide their time between the two.

Physician clinician

As was explained earlier, a physician clinician practices in institutions such as a hospital centre, a CHSLD or a CLSC, in private practice or in one of the network's new structures, in particular the family medicine group (FMG). A clinician may also practice in spheres not covered by the public plan. In this case, the patient assumes the cost of the medical services provided.

A physician may also engage in activities and assume professional responsibilities of a non-clinical nature. Although less well known, these are essential, very varied and increasingly recognized.

Physician administrator

A physician may be an administrator. In the public sector, he may be a director of professional services or a department head in an institution, for example. In the private sector, he may be the medical director of a pharmaceutical company or a parapublic agency, such as Héma-Québec.

Research physician

A physician may be a researcher in a university research centre, a clinical research centre or in the private sector, for a pharmaceutical company, for example. He may be the principal researcher and lead the research team or he may provide support in the analysis, recruitment, assessment, treatment or follow-up of study participants. He may also act as a consultant for a clinical research study or as a safety monitor.¹⁴ While his obligations and responsibilities vary depending on his role in research, a physician is never exempted from his medical obligations.

Research involving humans meets standards set out in various acts, regulations, declarations and other statements.¹⁵ Physicians should be familiar with their common general principles and keep up to date with Canadian and Quebec regulatory provisions related to their practice. They must ensure they manage the risk of conflict of roles (especially in clinical research) and interests (in particular financial interests).

Teaching physician

A physician may also teach, either as a university professor or as a teacher in a facility used for training purposes. He may teach in other settings, in particular by giving talks during scientific activities or by taking part in continuing professional development activities.

Public health practice

Some physicians opt to work in public health. These physicians are community health specialists or family physicians who have completed additional university training in public health and epidemiology. Most practice in CLSCs, regional public health departments, at the Institut national de santé publique du Québec (INSPQ) [Quebec national institute of public health] or at the Public Health Branch of the MSSS.

¹⁴ Collège des médecins du Québec, *Le médecin et la recherche clinique* (Physicians and clinical research; available in French only), practice guide, 2007, under revision; CMPA, *Physicians and research: understanding the legal, ethical and professional obligations*, 2014.; CMPA, *Clinical research activities*, revised 2013.

¹⁵ *Civil Code of Québec*; Fonds de recherche en santé du Québec, *Standards du FRSQ sur l'éthique de la recherche en santé humaine et l'intégrité scientifique* (Ethical standards of the FRSQ for research on human health and scientific integrity; available in French only), May 2008; *World Medical Association Declaration of Helsinki* – Ethical Principles for Medical Research Involving Human Subjects; Canadian Institutes of Health Research, Natural Sciences and Engineering Research Council of Canada and Social Sciences and Humanities Research Council, *Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans*, 2018; Health Canada, *Guidance Document: Good Clinical Practice: Integrated Addendum to E6(R1)/ICH Topic E6(R2)*.

Medicolegal expertise

Medicolegal expertise activities represent a significant, non-marginal practice, with physicians becoming increasingly involved in this field. Consequently, the Collège des médecins regularly receives requests related to such expertise and is in the process of developing a guide on medicolegal expertise.

Medical experts have an important role to play when their opinion is sought. Their primary role is to inform people who are required to make decisions on clinical, scientific or technical issues that are beyond their knowledge.

The different forms of medicolegal expertise are as follows:

1. Expert opinion – case review

In some circumstances, a medical expert may, without having to examine the person, provide an opinion based on a thorough scientific analysis of the case as a whole. This is called a “case review” or “expert report”. A concrete example is a medical evaluation that is done in the context of a civil lawsuit.

2. Independent medical evaluation (IME)

An independent medical evaluation is defined as a medicolegal assessment for a third party, with an interview and examination of the person concerned. A designated medical expert provides his opinion on a person’s condition or medical care needs or on various aspects of their health. The evaluation usually serves to help settle a dispute or to allow a decision maker to exercise his judgement.

Here are two concrete examples:

2.1 Medical evaluation required by the social programs administrator

The vast majority of these evaluations concern a person who is required to undergo an independent medical evaluation because there is a problem related to the determination of his disability or functional limitations. This practice is mainly seen in disputes with government bodies (e.g., CNESST, SAAQ, RRQ, etc.).

2.2 Court-ordered medical evaluation

Some evaluations are prescribed by law or by the court. A significant proportion of these evaluations is done in a context of legal psychiatry, mainly when the court issues an assessment order because it has reasonable grounds to believe that evidence concerning a person’s mental state is necessary (e.g., the accused’s ability to stand trial, a person who is not responsible by reason of a mental disorder).

3. Expert opinion related to the practice of medicine

An expert opinion may be sought in order to answer a question related to the practice of medicine, but not to one case in particular. In most cases, this type of expert opinion is intended to inform the court as to the natural course of a condition, the diagnostic and therapeutic modalities, current scientific knowledge, etc. It does not involve a medical examination of a person. The physician's mandate is to share his knowledge of a situation or of medical practice based on his area of expertise and practice. A concrete example is an expert opinion on current scientific knowledge on toxicology in the context of a criminal lawsuit.

Moreover, when the *Code of Civil Procedure* was revised in 2014, the provisions regarding expert medical evidence were amended. Here are some of these provisions, which set out experts' duties and powers, the content of the expert report and expert testimony:

“22. The mission of an expert whose services have been retained by a single party or by the parties jointly or who has been appointed by the court, whether the matter is contentious or not, is to enlighten the court. This mission overrides the parties' interests.

Experts must fulfill their mission objectively, impartially and thoroughly.

231. [...] To provide expert evidence is to give an expert opinion, taking into consideration the facts relating to the dispute, on particulars relating to a person's personal integrity, status or capacity or adaptation to a given set of circumstances, or on factual or real evidence; to determine or audit accounts or other data; to give an expert opinion on the liquidation or partition of property; or to ascertain the state or situation of certain premises or things.

235. Experts are required, on request, to provide the court and the parties with details on their professional qualifications, the progress of the work and the instructions received from a party; they are also required to comply with the time limits given to them. They may, if necessary to carry out their mission, request directives from the court; such a request is notified to the parties.

Experts act under their professional oath. If an expert has not sworn a professional oath, the parties or the court may require that the expert be sworn in. In addition, experts must sign a declaration regarding the carrying out of their mission, corresponding to the model established by the Minister of Justice, and attach it to their report.

236. Court-appointed experts act under the court's authority to gather the evidence required to carry out their mission. They may examine any document or thing, visit any premises and, with the authorization of the

court, take testimony under oath. They must preserve such testimony and certify its origin and integrity.

Experts are required to give the parties at least five days' notice of when and where their operations are to begin.

237. An expert who does not have the required qualifications or who is seriously remiss in carrying out their mission may be replaced or disavowed, including at a case management conference, on the court's initiative or on a party's request.

238. An expert report must be brief but provide sufficient details to enable the court to make its own assessment of the facts set out in the report and of the reasoning that led to the conclusions drawn by the expert. It must mention the analytical methodology used.

Any testimony taken by the expert is attached to the report and forms part of the evidence.

The expert's conclusions are not binding on the court or on the parties, unless the parties declare that they accept them.

239. A joint or court-appointed expert submits an operations report, with conclusions, to the parties and files a copy with the court office before the expiry of the time limit given.

An expert appointed by one party submits the report to the party, which, if it intends to use the report, must disclose it to the other parties and file it in the court record within the prescribed time limits for disclosure of evidence.

240. After the report has been filed but before the trial begins, the joint or court-appointed expert must, if the court so requires or on the parties' request, provide clarifications on certain aspects of the report and meet the parties to discuss the expert's opinions ahead of the trial.

If conflicting expert reports are filed, the parties may call the experts to a meeting so that they may reconcile their opinions, identify the points on which they differ and, if necessary, prepare an additional report on those points. At any stage of the proceeding, the court, even on its own initiative, may order the experts to meet and file an additional report within a specified time.

293. The report of an expert stands in lieu of their testimony. To be admissible, the expert report must have been disclosed to the parties and filed in the record within the time limits for disclosure and filing of evidence. Otherwise, it may be admitted only if it was made available to the parties by another means in a timely manner so that they could react and determine whether the expert's presence might be useful. It may however be admitted outside such time frames with leave of the court.

294. Each of the parties may examine an expert that it has appointed, a joint expert or a court-appointed expert to obtain clarifications on points covered in the expert report or to obtain the expert's opinion on new evidence introduced during the trial; they may also examine such an expert for other purposes, with the authorization of the court. A party adverse in interest may cross-examine an expert appointed by another party.”

A physician may also act as a medical consultant and use his clinical expertise to improve the conditions and quality of medical practice in organizations such as medical federations, the Collège des médecins or various bodies within the MSSS.

A physician may be a medical evaluator employed in the health services of a large company or as a consultant for an insurance company, for example. Finally, a physician may have the medicolegal expertise required by the Coroner's Office for the investigation of causes of death.

In all cases, the same code of ethics and the same laws and regulations serve as a framework for determining good medical practice. The most recent versions of the *Code of ethics of physicians* and some regulations include sections that specify the physician's obligations when practicing certain professional activities, in particular those of the research physician, the public health physician and the medicolegal expert.

From the very beginning of their training, medical students and medical residents are bound in their clinical training activities by the same rules and regulations applicable to all medical practice. Medical practice will continue to diversify as medical knowledge evolves and new societal needs emerge.

4. A social achievement worth preserving

While physicians' links to the health care system are very obvious to those working in institutions, all physicians need to have a thorough knowledge of the history, characteristics and organization of the system, which is still considered to be a major social achievement. Whether they work in private practice, in other settings or even outside the public system, physicians must be familiar with the system and how it functions.

Physicians have a responsibility to provide the best possible care for patients and the population. Since most care is provided within the health care network, physicians must take their full and rightful place within it.

Physicians who choose to provide professional services outside the public system must also take into account that they are practicing in a society that has placed the public system at the heart of its social policy.

SECTION 2 – ETHICAL AND REGULATORY ASPECTS

5. Overview

Medical ethics refers to all of the obligations and duties associated with the practice of the medical profession.

The duties allowing physicians to collectively fulfil a social role have changed over time. One way to better understand the nature and scope of these duties is to recall what a profession is. In order to promote health in today's world, all physicians must have expertise and use it to serve others. They are allowed to regulate themselves so that their practice is free of all influences that might run counter to this social role.

Medical ethics unquestionably occupies an important place in Quebec. Since the creation of the College of Physicians and Surgeons of the Province of Quebec in 1847, all physicians in Quebec have been obliged to be entered on the role of this professional order. Over the years, in accordance with the applicable laws and regulations, the Collège has put many mechanisms in place to ensure the competence of its members and to supervise the practice of their professional activities in an ever more effective manner.

The *Code of ethics of physicians* has contributed to the success of these interventions. In fact, the Code includes obligations that meet the expectations the public now has for all professionals, namely, they must be competent, serve others and discipline themselves. This section will show that from one revised version to the next, the Code has been increasingly precise in defining the obligations of physicians toward patients, the community and the profession. Provisions have been added to help physicians deal with new situations.

While the structure and functions of the Collège date back to a time when the professions were poorly understood, they comply with the mandates that have since been entrusted to professional orders: to verify the competence of their members and their fitness to practice; to maintain their competence and oversee their practice; to examine the reasons for dissatisfaction concerning them; to conduct inquiries and file complaints with the disciplinary council. The Government's takeover of the health care system and the profound changes that characterized it did not spell the end of professional independence for physicians in Quebec. On the contrary, we will see that the professional system is considered a vital part of the health care system and that the Collège remains the principal body guaranteeing the quality of care provided by physicians.

The last section explains why physicians have had to create other associations to defend their interests. With respect to the Collège, it ensures that physicians fulfil the obligations that allow them to pursue their social mission, that is, to practice quality medicine at the service of the public.

6. The legal context

6.1 The *Professional Code*

Assented to in 1973 and amended several times, the *Professional Code* is the legal framework that governs all recognized professions in Quebec. It clearly establishes that every order's principal function is to ensure the protection of the public and that, to this end, it must oversee the professional practice of its members. To do this, the Code stipulates that a professional inspection committee, a syndic or an expert whose services are retained by a syndic, a disciplinary council and the secretary or executive director of the order cannot be prosecuted by reason of acts engaged in in good faith in the performance of their duties or functions.

Furthermore, a person cannot be prosecuted for having, in good faith, sent information to a syndic to the effect that a professional has committed an offence or for having cooperated in an inquiry conducted by a syndic, whatever the findings of the syndic's inquiry. Where the person who has sent information to the syndic to the effect that a professional has committed an offence is a professional who is himself a party to the offence, a syndic may, if he considers it warranted by the circumstances, grant that person immunity from any complaint filed with the disciplinary council in connection with the facts related to the commission of the offence.

The *Professional Code* contains provisions common to all orders relating to the issue of permits and recognition of the required training or diplomas. No order may "refuse to issue a permit or specialist's certificate or to grant a special authorization for reasons of race, colour, sex, religion, national extraction or social origin" (s. 43). It prescribes entry on the roll and defines the reasons for temporary or permanent striking off the roll. It also determines the circumstances in which the board of directors of an order may oblige a member to undergo a medical examination to ascertain whether his physical or mental condition is compatible with the practice of his profession.

The Code also determines the organizational structure of professional orders.

With respect to admission to practice, legislative amendments introduced by the *Act to amend various legislation mainly with respect to admission to professions and the governance of the professional system* in 2017 led to the replacement of the Commissioner for complaints concerning mechanisms for the recognition of professional competence by the Commissioner for Admission to Professions. The functions of the new Commissioner are:

- (1) to receive and examine any complaint lodged by a person about admission to a profession;

(2) to monitor the operation of any process or activity relating to admission to a profession; and

(3) to follow the activities of the Pôle de coordination pour l'accès à la formation (Access to Training Coordination Hub) and, if necessary, to make the recommendations the Commissioner considers appropriate to it regarding such matters as the time it takes before training is offered.

The Commissioner may:

(1) submit advisory opinions or make recommendations to any professional order, department, body, educational institution or other person on any matter relating to admission to a profession;

(2) solicit or receive advice and suggestions from professional orders or interested groups and from the general public on any matter relating to admission to a profession; and

(3) conduct or commission studies and research that the Commissioner considers useful or necessary for the exercise of the Commissioner's functions.

Note that the Commissioner may, upon summary examination, dismiss a complaint if, in the Commissioner's opinion, it is excessive, frivolous or clearly unfounded. He may also refuse or cease to examine a complaint if he has reasonable grounds to believe that his intervention would serve no purpose or if the plaintiff refuses or neglects to provide information or documents requested.

Amendments introduced by the *Act to amend various legislation mainly with respect to admission to professions and the governance of the professional system* in 2017 established a new structure, namely, the Access to Training Coordination Hub. Its function is to draw up a status report on access to training, identify problems and issues related to training, identify statistical data collection needs, ensure collaboration between the professional orders, educational institutions and departments concerned, and propose solutions to the problems identified.

The Access to Training Coordination Hub is chaired by the chair of the Office des professions and is composed of the other members designated by the Government after consultation with the Office.

Lastly, in order to oversee and coordinate the activities of professional orders, now numbering more than fifty, half of which are in the health sector, the Code provides for two bodies: the Office des professions du Québec and the Québec Interprofessional Council.

The Office des professions du Québec (OPQ)

The function of the OPQ is to see that each order ensures the protection of the public. It must, in particular, ensure that each order:

- > adopts a code of ethics;
- > has a functional professional inspection committee;
- > establishes rules concerning the management and transfer of records, storage of medications, use of equipment, administration of offices, etc.;
- > regulates the procedure for elections to the board of directors, to the office of chair, etc.;
- > prescribes standards of equivalence for diplomas issued by educational institutions outside Quebec;
- > defines the acts that may be performed by other professionals;
- > has a disciplinary council.

The OPQ may also, if it considers it necessary for the protection of the public, require an order to take corrective and appropriate follow-up measures and to comply with any other measure determined by the Office, including supervisory or monitoring measures.

Furthermore, the OPQ recently adopted standards of ethics and professional conduct applicable to directors on a professional order's board of directors.

Among other things, the regulation:

- (1) determines the duties and obligations of directors, including those they must comply with after the expiry of their terms, and the time for which they are bound by those duties and obligations;
- (2) regulates or prohibits practices related to the remuneration of directors;
- (3) requires the board of directors to establish a code of ethics and professional conduct applicable to its members that takes into account the mission of the order, the values underlying its actions and its general management principles;
- (4) determines the cases in and procedure according to which directors may be temporarily relieved of their duties.

The OPQ is funded by mandatory dues paid annually by the members of every professional order.

The Québec Interprofessional Council (Conseil interprofessionnel du Québec – CIQ)

The CIQ brings together all orders governed by the *Professional Code*. Its functions include studying general problems encountered by orders, making the recommendations it considers appropriate, promoting exchange among the different groups of professionals, hearing groups that want to be recognized as professionals and giving its opinion in this regard.

Each order must pay to the CIQ the annual contribution required by the Council for the proper administration of its affairs.

6.2. The Medical Act

Amended several times, the *Medical Act*:

- > defines the practice of medicine;
- > establishes requirements for registration and the subsequent issue of a permit to practice;
- > specifies the organizational structure of the Collège des médecins du Québec.

Definition of the practice of medicine
According to section 31 of the <i>Medical Act</i> , the practice of medicine consists in assessing and diagnosing any health deficiency in a person in interaction with their environment, in preventing and treating illness to maintain or restore health or to provide appropriate symptom relief. The following activities in the practice of medicine are reserved to physicians:
(1) diagnosing illnesses;
(2) prescribing diagnostic examinations;
(3) using diagnostic techniques that are invasive or entail risks of injury;
(4) determining medical treatment;
(5) prescribing medications and other substances;
(6) prescribing treatment;
(7) using techniques or applying treatments that are invasive or entail risks of injury, including aesthetic procedures;
(8) providing clinical monitoring of the condition of patients whose state of health is problematic;
(9) providing pregnancy care and conducting deliveries;

Definition of the practice of medicine (cont.)
(10) making decisions as to the use of restraint measures;
(11) deciding to use isolation measures in accordance with the Act respecting health services and social services (chapter S-4.2) and the Act respecting health services and social services for Cree Native persons (chapter S-5);
(12) administering the drug or substance allowing an end-of-life patient to obtain medical aid in dying under the Act respecting end-of-life care (chapter S-32.0001).

With the *Act to amend the Professional Code and other legislative provisions as regards the health sector* (Bill 90), the legislator confirmed the exclusive nature of medical practice as it pertains to diagnosing illness and determining treatment plans. However, certain activities are now shared with other professionals.

Note that the “protocol” and “medical supervision” previously established as conditions for allowing persons who are not physicians to perform authorized acts have been eliminated from the professional system. The conditions for practice – more flexible than under the old system – now include a prescription (individual or collective), a training certificate or a legal application.

The legislator has also provided for common activities reserved to the eleven health professions contemplated in the reform. For example, every professional may, within their field of practice, participate in activities to disseminate information, promote physical and mental health and prevent illness, accidents and social problems.

6.3 Permit to practice

Under the *Professional Code* and the *Medical Act*, the right to practice medicine is restricted solely to those who have obtained a permit to practice in Quebec. The *Regulation respecting the terms and conditions for the issuance of the permit and specialist’s certificates by the Collège des médecins du Québec* (c. M-9, r. 20.1) determines the conditions for the issue of permits and the rules governing access to the medical profession.

“Regular” permit

To submit an application for a “regular” permit, applicants must satisfy the following prerequisite:

- > Have a Doctor of Medicine degree from Quebec or a have a Doctor of Medicine degree that has been recognized as equivalent by the Collège.

The requirements for a permit to practice are as follows:

- > Have completed postgraduate training in family medicine or postgraduate training in [another specialty](#) in a training program recognized by the Collège or have obtained recognition of equivalence of training (other provisions apply if the training program is not equivalent in duration and content to the training program in Quebec).
- > Have successfully completed the specialty certification examinations of the CFPC or the Royal College.
- > Have provided proof of status as a Licentiate of the Medical Council of Canada (LMCC).
- > Have participated in the [ALDO-Quebec](#) educational activity.
- > Have provided proof of French language proficiency or have successfully completed the [Office québécois de la langue française \(OQLF\)](#) examination.

Restrictive permit

[International medical graduates](#)

Under [section 35 of the Medical Act](#), the Collège des médecins du Québec may issue a restrictive permit in accordance with established guidelines.

There are three categories of restrictive permit:

1. Sponsored professor;
2. Clinician;
3. Mutual Recognition Agreement (MRA) between France and Quebec.

The respective requirements for each category are listed on the [Collège's website](#).

The permit is restricted with respect to three aspects :

- 1° the professional activities authorized;
- 2° validity (1 year, renewable annually);
- 3° place of practice, that is, the holder is only authorized to practice in an institution.

The permit does not authorize “independent” or private practice.

Restrictive permit holders may apply to have their permit converted, under certain conditions, to a regular permit after one year, upon successful completion of the

certification examination. After 5 years, successful completion of the certification examination is no longer a requirement.

6.4 Registration

Like the permit to practice for physicians, a registration certificate authorizes medical students, residents or fellows to perform, under the supervision of a physician and at a Collège-accredited training site, the professional activities required to complete their training. A holder of a registration certificate must comply with the same rules as those that apply to physicians, in particular those relating to professional secrecy, professional conduct, prescription writing and record keeping.

6.5 Training card

Residents registered with the Collège des médecins du Québec who are enrolled in a postgraduate training program in a faculty of medicine in Quebec must have a training card. This card allows them to perform medical activities under medical supervision and to gradually assume responsibilities in keeping with their level of competence at training sites determined by the Collège. The card is also mandatory for fellows who come to Quebec to do fellowships. Fellows are subject to the same rules as residents. The training card prohibits them from performing certain activities. For example, they may not charge fees or write medical certificates other than a certificate to confirm a visit. During their training, residents and fellows must always be under the direct or indirect supervision of competent people.

Additional information is provided in the following documents which are available on the [Collège's website](#):

- > Information sheet: [*Professional activities that may be performed by residents and fellows.*](#)
- > Guide for learners and their supervisors: [*Role and responsibilities of the learner and the supervisor.*](#)

7. Duties and obligations of physicians

7.1 The Code of ethics of physicians

The *Code of ethics of physicians* is a set of rules, principles and practices that all physicians, residents, medical students and fellows must observe. Failure to do so may lead to disciplinary measures.

It governs the everyday practice of medicine in both the private and public sectors. Far from discouraging the physician from introspection and the use of his professional judgement, the *Code* is intended to promote reflection by specifying the responsibilities and duties now considered to be essential to good medical practice.

The Code takes into account relevant provisions in other legislation in force in Quebec, in particular the *Professional Code*, the *Youth Protection Act* and the *Public Health Act*. It also reflects recent debates on bioethics, for instance in the medical research field. The last revision of the Code takes the growing use of information technologies into account. It defines the general duties of physicians and their duties toward the patient, the public and the profession. Moreover, since the relationship between physician and patient is built on competence and mutual trust, the Code recognizes that know-how (technical skills) must co-exist with “soft skills” (non-technical skills). It also emphasizes the affirmation of the rights of people who interact with physicians.

The first sections of the Code establish the universal scope of the document, while the other sections set out the general obligations of the physician as well as his professional obligations, which are grouped by topic.

The Code is divided into 4 chapters. The first two contain general provisions and the general obligations of the physician. The third chapter has 11 divisions and is the heart of the *Code of ethics of physicians*: they set out the physician’s duties and obligations toward the patient, the public and the profession. The fourth chapter contains some final provisions.

7.1.1 The obligations of the physician

Of all the obligations a physician must fulfil in the performance of his medical functions, his primary obligation is to protect the health and well-being of the people he attends to, both individually and collectively. In addition, he must:

- > behave in an irreproachable manner toward everyone he comes into contact with in his professional activities;

- > promote measures of education and information in the field in which he practices and, in so doing, inform the public of generally accepted medical opinions on the subject;
- > maintain the competence acquired during his studies and residency by participating in continuing professional development activities to keep abreast of scientific and technical innovations as well as new methods of practice. Indeed, the credibility of medicine would be seriously compromised if the public could not rely on competent professionals who know their limitations and comply with scientific and ethical standards by maintaining a rigorous diagnostic approach whereby they prescribe only what is medically required.

With respect to the mission entrusted to them and the privilege of practicing their profession, physicians are personally responsible for their acts. Consequently, they must maintain their professional independence at all times and attend to the interests of patients without allowing themselves to be influenced by personal or material considerations or by ties with paying agencies and business partners. This responsibility also applies to people and collaborators who work under their authority. It is partially shared in group practice or network practice situations. They may not avoid their obligations indirectly by allowing another person, natural or legal, to perform an act on their behalf that would violate the applicable laws and regulations.

In today's context, physicians must participate actively in the organization of care, know how to make optimum use of the means at their disposal and work as a team with all health professionals. To this end, the Code emphasizes that physicians must be judicious in using the resources dedicated to health care (s. 12). This provision makes it clear that physicians have obligations to the public as well as to the individual (s. 3).

In accordance with section 13, which states that "a physician must refrain from taking part in a concerted action of a nature that would endanger the health or safety of a clientele or population", it is up to the physician to evaluate the practice context and to determine whether the proposed action has serious consequences for his patients or the population. If so, the physician must refrain from taking part in it. This provision is not meant to deprive physicians of the power to negotiate, but to prevent a complete interruption in services and to ensure the essential services required. [...] Furthermore, the interpretation and application of this section must take section 3.1 into account: "A physician must collaborate with other physicians in maintaining and improving the availability and quality of the medical services to which a clientele or population must have access". This clearly illustrates that the Code's sections are not mutually exclusive but must be read in relation to one another.

The practice of medicine is demanding. Physicians must not risk compromising the quality of their practice or the dignity of the profession by the immoderate use of psychotropic substances or any other substance, including alcohol, producing analogous effects, or by practicing in circumstances or conditions incompatible with the practice of medicine (ss. 16 and 43). A physician who is a carrier of a blood-borne infection may have to have his practice reassessed to ensure that it carries no significant risk for patients. In this regard, the Collège partners with the INSPQ's Service d'évaluation des risques de transmission d'infections hématogènes ([SERTIH](#)) [Service for the assessment of the risk of transmission of hematogenous infections] which is intended for health care professionals and students in Quebec who are carriers of a blood-borne infection and who perform [activities where there is a risk of transmission](#). Through this service, they can obtain an assessment of the risk of transmitting their infection to patients during their practice or their training.

7.1.2 The quality of the professional relationship

Chapter III of the [Code of ethics of physicians](#) has 11 divisions that set out more precisely and specifically the physician's duties and obligations toward the patient, the public and the profession. These will be discussed in the following pages, since they provide guidance for physicians on a daily basis with respect to their conduct and demeanor.

The Code emphasizes the importance of respect for human life, the individual and his dignity. One of its most important manifestations is professional secrecy, its protection being key to medical practice because of the patient's fundamental right to privacy. Indeed, a patient must be able to confide the most intimate aspects of his life or the physician must be able to obtain this kind of information – access to it being indispensable to quality of care – provided that both know that nothing of their conversation will be disclosed. A physician, in order to maintain professional secrecy, “may not divulge facts or confidences which have come to his personal attention, except when the patient authorizes the physician to do so or when the law authorizes or orders the physician to do so, or when there are compelling and just grounds related to the health or safety of the patient or of others” (*Code of ethics*, s. 20, subpar. 5). Moreover, the division of the *Code of ethics* on the quality of the professional relationship has been updated to take into account ethical obligations with respect to maintaining professional secrecy when physicians use social media and the Internet (see also, on this topic, [11.3.4 The obligation to ensure confidentiality](#)).

The knowledge the physician has of certain problems makes the patient dependent on him. Thus, the physician must absolutely avoid exploiting the situation for his own personal gain of a financial or other nature. The *Code of ethics* (s. 22) and the *Professional Code* (s. 59.1) condemn all abuses of this relationship, particularly those of an amorous or sexual nature. Furthermore, for

preventive purposes and in order to better defend the public in cases of sexual misconduct by physicians, the *Code of ethics* establishes criteria to better define the duration of the professional relationship (s. 22, par. 3).

Physicians must practice without discrimination. A physician may not “refuse to examine or treat a patient solely for reasons related to the nature of a deficiency or illness, or to the context in which the patient’s deficiency or illness appeared, or because of the race, colour, sex, pregnancy, civil status, age, religion, ethnic or national origin, or social condition of the patient, or for reasons of sexual orientation, morality, political convictions, or language” (s. 23). A physician must, where his personal convictions, of a moral or religious nature, prevent him from prescribing or providing professional services that may be appropriate, acquaint his patient with such convictions; he must also advise him of the possible consequences of not receiving such professional services. He must then help the patient find another physician (s. 24).

7.1.3 Obtaining consent to care¹⁶

A physician must determine the most appropriate care for a patient, that is, care that meets his specific needs and that complies with medical standards. Clinical reasoning is the foundation of medical practice. Its rigour enables the physician to justify decisions regarding investigations and treatments that he considers medically necessary and that he proposes to the patient so that together they can decide on the best possible care. A well-managed decision-making process leads to care that is all the more appropriate for a unique patient, at a particular stage in his illness and his personal journey. The entire legal framework for health care is organized around this decision-making process and consent. It affirms the patient’s rights and the physician’s obligations in this regard.

Quebec society recognizes the ethical principle of autonomy, meaning individual self-determination, as the basis of the relationship between people. But the legal basis for the application of this principle in health care relies on the notions of the individual’s inviolability and right to integrity.¹⁷ The patient’s decision-making autonomy lies in his right to accept or refuse the medically appropriate care proposed by the physician.

A physician must obtain consent before undertaking any type of care.¹⁸ However, obligations with respect to consent differ depending on whether or not care is required by the person’s condition. Consent is given by the person himself or by another person in the cases and conditions provided for by law. It must be free and informed: in a well-managed decision-making process, the patient must be

¹⁶ See the reference document [Le médecin et le consentement aux soins](#) (The physician and consent to care; available in French only), published by the Collège and the Barreau du Québec in September 2018.

¹⁷ CCQ, ss. 3 and 10.

¹⁸ CCQ, s. 11; *Code of ethics of physicians*, s. 28.

completely free to express himself and to decide to accept or refuse the care suggested by the physician. To make this decision and exercise his right to do so in complete freedom, the competent patient, or his proxy if he is incompetent, must be well informed of the ins and outs of the various options proposed. The patient's right goes hand in hand with the physician's duty to provide sufficient relevant information to enable the patient to give his consent.¹⁹ The patient may withdraw his consent at any time by simple verbal notice.²⁰ Regularly confirming his agreement to continuing care may be necessary.

The law and professional practice standards²¹ arising from the rule of consent also provide for exceptions to obtaining consent in specific situations that the physician must be aware of (e.g., an emergency, a disease for which treatment is compulsory, psychiatric assessment and confinement in an institution, etc.).

7.1.4 Medical management and follow-up

The obligation to be available and diligent means that a physician must provide the medical follow-up required by the patient's condition following his intervention, unless he has ensured that a colleague, another professional or another authorized person can do so in his place (ss. 32 to 40). In walk-in clinics, group practices that include numerous consultants or practice settings with medical residents, a physician who cannot provide follow-up for every patient who is undergoing investigation or treatment must ensure that a colleague will do so in his place.

A physician who ceases practicing in a clinic must also compile a list of all patients requiring regular follow-up for various health problems, inform his patients of his departure by giving them advance notice within a reasonable period of time and, lastly, see to it that a colleague agrees to provide follow-up for his patients, excluding those who have chosen another physician.

In exceptional cases, such as illness, a physician working in a group practice may have to suddenly stop his professional activities in a clinic. Should the physician be unable to provide follow-up for his patients, the other physicians in the group must assume responsibility for the custody and retention of his records, respond to record access requests and follow-up on his patients' laboratory test results. Thus, in the short term, his colleagues must provide follow-up for any tests that he prescribed. They have an ethical but also a moral obligation to assist a colleague. Moreover, section 3.1 of the *Code of ethics* stipulates that a physician must

¹⁹ *Code of ethics of physicians*, s. 29.

²⁰ CCQ, ss. 11 and 24; *Act respecting end-of-life care*, s. 5, pars. 3, 28 and 54.

²¹ *Code of ethics of physicians*, s. 28.

collaborate with other physicians in maintaining and improving the availability and quality of medical services.²²

7.1.5 Quality of practice

Taking into account his capacities and the means at his disposal, a physician must practice his profession according to the highest medical standards and in the interest of his patients. These two obligations call for an increasingly transparent patient-physician relationship.

The disclosure of any incident, accident or complication which is likely to have or which has had a significant impact on the patient's state of health or personal integrity (s. 56) addresses this concern for transparency, the patient's right to information, compliance with the requirement to obtain consent and the absolute necessity of mutual trust in the therapeutic relationship. This section focuses on preventable medical accidents and advocates an overall improvement in care and services. The obligation to inform falls to the physician in charge, usually the attending physician, but it could also fall to a specialist who encounters an unexpected complication while performing a procedure. When uncertainty arises as to who must disclose the situation, the health care team may discuss it and designate someone. The physician must present the information to a patient or his legal representative with empathy and without passing judgment. He also has an obligation to make himself understood and to verify that he has been understood. Disclosure by the physician should help establish a climate of openness and empathy, refocus, as is proper, the relationship on the patient, improve the quality of medical practice and maintain or restore public confidence through transparent practice. In institutions, the physician must follow the rules set by the board of directors in this regard (AHSSS, s. 235.1).

7.1.6 Independence, impartiality and integrity

It is vital that the general public does not doubt the integrity of physicians and that patients feel assured of their physician's loyalty. This means that physicians must not let themselves be deterred or distracted from their obligations by considerations other than the interests of their patients. Thus, physicians must avoid any situation that might present a conflict of interest, either real or apparent.

A physician must always, when different interests are at play, give priority to his patient's interests over his own. This obligation to ensure professional independence concerns a number of aspects of the physician's practice. The

²² See on this topic: [*Départ d'un médecin d'une clinique – Qui est responsable du suivi des patients?*](#) (When a physician leaves a clinic – Who is responsible for patient follow-up?; available in French only), Inquiries Division, last update April 2018.

physician must ensure that a patient is given priority access to medical care strictly on the basis of criteria of medical necessity.

Note also that a physician must respect the patient's freedom of choice by indicating to him, on request, the places where he may receive the diagnostic or therapeutic services when the physician gives the patient a prescription or a referral form to that effect.

A physician may not sell any medication, apparatus or other products presented as having a benefit to health, except the apparatus installed or the medications and products administered by the physician directly. Thus, the physician may not, at any time, obtain a financial benefit other than his fees from the prescription of apparatus, examinations or medications, either directly, indirectly or through an enterprise controlled by the physician.²³ This principle also applies when the physician writes a collective prescription for a group of people or a population. Similarly, a physician who charges disproportionate fees relative to the circumstances and the nature of the services rendered potentially exposes himself to a situation where there is a conflict of interest.

Lastly, a medical expert must also ensure that he acts only as an expert. This means that an attending physician may not act as an expert in a case that concerns his patient.²⁴

Of course, it is impossible to list all real or potential situations of conflict of interest. A physician must therefore reflect on ethical considerations when specific issues arise in his practice. A physician may not allow his title to be used for commercial purposes. He must disregard any intervention by a third party which could influence the performance of his professional duties to the detriment of his patient, a group of individuals or a population. Obviously, he may not allow another natural or legal person to perform, in his name, acts which would mean that he is in contravention of the professional legislation.

7.1.7 Advertising and public statements²⁵

In light of the many questions raised in recent years concerning physician advertising and public statements, the *Code of ethics of physicians* was amended to include a specific division on these subjects. The cornerstone of these new rules is the honesty of the message. A physician may not use advertising that is false, misleading or incomplete. Under the new provisions, certain practices such as the

²³ There is one exception: when the physician has contributed to the development of a product that he prescribes, in which case he must so inform his patient (*Code of ethics of physicians*, s. 73, last paragraph).

²⁴ *Code of ethics of physicians*, s. 66.

²⁵ See on this topic the [rules concerning advertising and public statements](#) presented in this document, and the guide [Le médecin, la publicité et les déclarations publiques](#) (Physicians, advertising and public statements; available in French only).

use of comparative terms, superlatives and supporting testimonials are no longer prohibited, unless they contribute to biasing the information. In addition, a physician must, in any advertising or any other item of identification used to offer professional services, clearly indicate his name and a specialist's title (in family medicine or another specialty) (s. 92).

7.1.8 Records and fees

With respect to accessibility and the rectification of records, which are addressed in sections 94 to 102 inclusively, the patient has the right to examine or obtain a copy of documents concerning him unless the professional is of the opinion that the transmission of these documents could cause serious harm to the patient or a third party. The patient also has the right to have corrected any information in these documents that is inaccurate, incomplete or ambiguous with regard to the purpose for which it was collected or to have deleted any information that is outdated or unjustified by the object of the record.

The *Code of ethics* stipulates that physicians may only claim fees that are justified by the nature and circumstances of the professional services rendered (s. 104). In cases where the patient is paying the fees, the physician must inform the patient in advance of the approximate and expected cost of his services. He must provide his patient with an itemized invoice for his services and any medical supplies, apparatus, medications and products presented as having a benefit to health whose cost is claimed by the physician. The *Code* specifies that the price of any services, supplies and accessory charges for a non-insured service, as well as the price of non-insured medical services or services considered as such, must be displayed for public view in the waiting room of the place where he practices (s. 105).²⁶

He must provide the patient with all the necessary explanations for understanding his account before providing care. Physicians who demand payment in advance for services that are not covered must use the payment solely to cover the cost of these services. In the event of a dispute concerning the amount of an account for professional services, the account may be submitted to the syndic in accordance with the [*Regulation respecting the conciliation and arbitration procedure for the accounts of physicians*](#).

7.1.9 Relations between professionals and relations with the Collège

Ensuring continuity and quality of care for patients imposes certain requirements with respect to relations between physicians and with other professionals. Disparagement, harassment and the like are unacceptable in any form. The

²⁶ See on this topic: [*Indépendance professionnelle et frais réclamés aux patients*](#) (Professional independence and fees charged to patients; available in French only), Inquiries Division, updated January 2019.

attending physician must provide the consulting physician with any information he possesses that is pertinent to the examination, investigation and treatment. For his part, the consultant must promptly reply in writing to the question asked, providing the results of his consultation and the recommendations he considers appropriate. Furthermore, in an emergency, a physician must assist a colleague when asked to do so.

A physician must also collaborate with the Collège and not hinder, intimidate or denigrate its representatives in the execution of their mandate to protect the public. Thus, the physician must make himself available when his presence is required. The Code obliges the physician to inform the syndic of any derogatory act committed, to his knowledge, by any person authorized to practice medicine. He must also report to the Collège any person who is unfit to practice, incompetent or dishonest.

Protecting the public requires that all physicians show the utmost respect for the letter and spirit of the *Code of ethics* in their everyday lives. Public confidence and respect for the profession in general depend on this being a constant concern. While certain rules may appear imprecise, difficult to apply or too demanding, it is important to scrupulously observe them to ensure both the protection of the public and the interests of the members of the professional order. Any physician who has a question regarding his ethical obligations may contact the Collège's Information Centre, which will ensure he receives a response.

7.2 The obligations of physicians under other regulations

In addition to the *Code of ethics of physicians*, medical practice is guided by other important regulations arising from the *Medical Act* and the *Professional Code*, including:

- > the Regulation respecting records;
- > the Regulation respecting periods of refresher training and refresher courses;
- > the Regulation respecting professional liability insurance;
- > the Regulation respecting the standards relating to prescriptions made by a physician;
- > the Regulation respecting professional inspection;
- > the Regulation respecting mandatory continuing education.

7.2.1 The Regulation respecting records

In force since 2012, the *Regulation respecting records, places of practice and the cessation of practice by a physician* contains numerous standards that the

physician must respect in the practice of his profession with respect to, for instance, rooms or offices, records and registers.

Note that this regulation is currently under revision, largely in order to add standards relating to electronic health records.

The medical record

A physician must create and maintain a single medical record per patient per place of practice for any person who consults him, who contacts him directly, who is referred to him or is contacted by him, in whatever place the consultation occurs.

A record must also be created and maintained:

- (1) for any person who participates in a research project as a research subject;
- (2) for any population or portion thereof for a public health intervention.

Furthermore, physicians who practice in a group may create a single medical record per patient.

The medical record is inseparable from the practice of medicine. It attests first and foremost to the person's state of health, the course of the disease and its management by the physician. It is also an indispensable tool for communication between all members of the health care team. As such, it is an essential support document for teaching, research and assessment of the quality of medical acts. It contributes directly to advances in medical science. More specifically, the medical record must provide a detailed account of the patient's condition, all the care provided and any events that concern him. We cannot insist enough on the need for the physician to keep impeccable records, for each of these documents serves many purposes and is a reflection of his professional conduct. For the physician, the record serves as a memory aid, indispensable to the provision and quality of care.

A communication tool

Since the record is an important source of information about a patient, it is used to transmit relevant information, if necessary, to other physicians, to other professionals involved in the patient's care, to other health care institutions or to any other organizations or people concerned.

An assessment tool

Record keeping generally attests to the quality of services a physician provides to his patients and, consequently, to his competence. The medical record is the

preferred tool of the professional inspection committee, especially for assessing the quality of medical acts and professional practice as a whole.

A legal protection function

The record affords a degree of legal protection for the physician and the patient. The more complete it is, the better it can attest to events that occurred.

A teaching and research tool

The record is a valuable document for teaching, research, compiling statistics as well as for establishing and monitoring clinical quality indicators.

Since it is an important tool for communication between professionals, physicians must ensure that their entries in the record are legible and that the use of abbreviations is kept to a minimum.

The Regulation clearly establishes the information and documents that a medical record must usually contain as well as those that must be entered in the record of any person taking part in a research project. It is important that the physician is able to link information and documents filed as part of a research project and the clinical observations made during a person's examination, in the emergency room for example. Indeed, sometimes a person consults for a problem that has resulted directly from instructions followed or medications taken as a participant in a research project.

If, for reasons of convenience, items in a medical record are kept in different places, it is very important to note this on every item in the record and to number each item clearly so that the physician can locate any items he may need in the record. For example, in the case of some psychiatric records, it is essential that a link be made with the medical record, which is perhaps not kept in the same place as the psychiatric record.

Changes to the record

When a physician wishes to correct a note already entered in the record or to change a document, he must produce an additional note dated the day of the correction or a revised report, but must never alter or remove an item already entered in the record.

The computerized record

The use of information technology must respect the usual rules for keeping paper medical records, namely, the authenticity of the record, its content, retention, access and the preservation of confidentiality.

Retention of records

Unless otherwise provided for by law, the physician must maintain a medical record for a period of at least five years after the date of the last entry or inclusion in the record or the date on which a research project ends. After this period, the record is considered inactive and may be destroyed, except for some important items.

In the case of an active record, any document less than five years old must be kept, while any portion dating from more than five years since the last entry or inclusion may be destroyed, except for:

- (1) anatomopathology reports;
- (2) endoscopy reports;
- (3) operative and anaesthesia procedure reports from major surgery.

These three types of documents must be kept for as long as the record is active. They may be destroyed only when the record becomes inactive, that is, five years after the last inclusion or entry.

Genetic tests must be kept for an additional period of ten years, unless they have been given to the person concerned or there is another copy.

It should be noted that when the physician practices in a centre operated by an institution, the rules for retention and destruction are those applicable to the user's record. The user's record refers here to the record belonging to the institution.

Lastly, in all cases, the physician must ensure that security measures to ensure the confidentiality of a patient's personal information are respected when a medical record is destroyed. For example, a record may not be left unshredded in a recycling container outside a clinic or simply left on the premises when a clinic closes.

Transfer of records

1. Cessation of practice

When a physician who practiced outside of an institution within the meaning of the *Act respecting health services and social services* ceases to practice his profession, he must submit for information the name of a transferee or provisional custodian to the secretary of the order within 30 days of the date on which the decision takes effect. However, when the cessation of practice consists of his being struck off for less than one year, the physician must retain custody of his patients' records if he has not already transferred them to a transferee or

provisional custodian and if the Collège does not consider such a transfer to be necessary for the protection of the public. It is important to note that a member who was unable to find a transferee for his records and who cannot retain custody of them must transfer them to the secretary of the Collège.

The term “transferee” refers to a physician or a group of physicians to whom a physician’s effects are transferred at the time of a permanent cessation of practice, whereas the term “provisional custodian” refers to a physician, a group of physicians or the legal representatives of a deceased physician who are entrusted with a physician’s effects before a transferee is appointed or during the temporary cessation of practice.

A physician who ceases to practice his profession but who remains registered on the roll of the order as an inactive member must retain custody of his records unless the Collège considers that their transfer is necessary for the protection of the public. In addition to his requirement to respond to access requests, an inactive member who has custody of his records must, at his patients’ request, transfer their record to a colleague or make a copy of it. In some cases, he will receive test results for his former patients. However, since he no longer has professional liability insurance, he may not provide follow-up. He must take the necessary precautionary measures to ensure that a colleague provides follow-up of his former patients’ results. He may, if he wishes, send his patient’s original medical record to a colleague. If he opts to do this, he must keep a register in which he notes the patient’s name, the name of the physician to whom the record was sent and the date it was sent.

It is worth noting that, irrespective of the format used (paper or other format), a physician must ensure that a patient’s record is complete and that it contains in a single place all the relevant information and documents for the patient’s medical follow-up. In all cases, a physician who ceases to practice must:

- > notify the secretary of the Collège of the expected date of the cessation of practice, at the latest 30 days before that date;
- > immediately take the necessary measures to ensure that his records and registers are kept or destroyed in a manner that guarantees their confidentiality and is in compliance with the rules pertaining to confidentiality;
- > take the necessary measures as soon as possible but at the latest within 30 days following the cessation of practice to ensure that the people who have consulted him may reach him in order to have a copy or the original of their medical record transferred to another physician, where applicable, and inform his patients of this within a reasonable period of time and in an appropriate manner;

- > draw up and keep a list of the records transferred for at least 5 years from the day he ceases to practice;
- > within 30 days following the cessation of practice, safely dispose of medications, vaccines, biological products and tissues as well as flammable, toxic or volatile products and substances;
- > make sure that he is able to respond within a reasonable period of time to any requests for access to records and provide for a follow-up mechanism in the event of an extended absence;
- > take the necessary measures to safeguard patients' interests.

2. Transfer agreement

Any agreement concerning the transfer or the provisional custody of records must be made in writing and a copy must be sent to the secretary of the order within 30 days of the date on which it takes effect. A sample agreement is available on the Collège's [website](#).

This agreement may be made on a gratuitous or onerous basis; in the latter case, it may provide for remuneration of the transferee or the provisional custodian by the physician or his successors. However, in all cases where the Collège takes possession of a physician's medical records, an invoice is sent to the latter or to his successors. Indeed, all the fees and expenses assumed by the Collège in the event of a transfer must be reimbursed. These include expenses for administration, retention, management, custody and destruction.

3. Change of place of practice

When a physician who provides clinical follow-up for a patient changes place of practice and considers that the change could compromise this follow-up, he must communicate to the patient, by whatever means he considers most appropriate, the address of his new place of practice as well as his telephone number.

4. Group practice

Physicians who practice within a group and create a single medical record per patient or per population must ensure that the documents and information contained in the record are accessible at all times to all physicians in the group. When one of the physicians who practices within a group leaves the group, the other physicians must, as appropriate:

- (1) continue to assume responsibility for keeping, holding and maintaining the medical record;
- (2) ensure, at the request of the person the medical record belongs to, in the year the physician departs, that the record or a copy of it is given to the latter;

(3) at the request of the person the medical record belongs to, ensure that the record or a copy of it is given to another physician. If the patient gives the name of a physician, the record must be transferred to that physician, but if the patient does not give the name of a physician, the other physicians in the group must transfer the record to the physician of their choice.

In the absence of a request to this effect by the person the record belongs to, when the physicians in the group recognize that the person who is leaving is the physician who has assured the management and follow-up of a person, the group must give that physician, at his request, the original record or the relevant portion of the record. In such a case, unless there is a prior agreement, all the expenses are paid by the physician leaving the group. The other physicians retain the list of records or the list of portions of records given to the physician who is leaving for five years.

5. Questions / Answers

5.1 May a physician store his paper records in a jurisdiction outside of Quebec?

A physician may not store his paper records in a jurisdiction outside of Quebec. However, he may store them at an external company that will keep them in a place that will ensure confidentiality is maintained, make photocopies and do invoicing, in accordance with his instructions. This company must be located in Quebec.

However, a physician may not transfer records to an external company, such as a management or archiving company. Given the nature of the responsibilities that the physician alone can assume, neither the patient concerned, nor any other person, may contact such an external company directly for any requests regarding access to the medical record.

5.2 What is the role of the physician who assumes responsibility for another physician's medical records?

A physician who assumes responsibility for a colleague's medical records must, primarily:

- a) ensure access to the records;
- b) keep a list of the records and registers that were transferred to him;
- c) take the necessary measures to ensure that the records and registers are preserved and destroyed, particularly in a manner guaranteeing their confidentiality;
- d) safely dispose of medications, vaccines, biological products and tissues as well as flammable, toxic or volatile products and substances.

5.3 Do the same rules apply to the transfer of paper medical records and the transfer of electronic medical records?

Irrespective of the format used, the physician must ensure that a patient's record is complete and that it contains in a single place all the relevant information and documents for the patient's medical follow-up. In all cases, a physician who ceases to practice must ensure that he takes the appropriate steps (see topic 1, *Cessation of practice*).

Registers

A physician must, for every place where he practices, create and maintain various registers:

- (1) a register in which are identified all the persons who have consulted him, including those he has examined at home or without an appointment, and in which is entered any surgical or invasive procedure performed during such consultation, excluding injections and infiltrations of medications, as well as the type of anaesthesia administered. Note that when this information is contained in the appointment book or the billing register of the RAMQ, these may take the place of this register;
- (2) a register in which are identified all the persons subject to a surgical or invasive procedure for which there has been a sending of a sample of a part of a human body or an object;
- (3) a register in which are identified any incidents and accidents occurring during or in connection with an invasive medical procedure requiring anaesthesia, sedation or analgesia as well as the measures applied to prevent them;
- (4) a register in which are identified all the persons he examines, treats or whose treatment he supervises as part of a research project;
- (5) a register of benzodiazepines for parenteral use, controlled drugs and narcotics, in the meaning of the *Controlled Drugs and Substances Act* (S.C. 1996, c. 19), in which are entered the nature and quantity of these substances he has in his possession, the identity of all persons to whom he gives or administers these substances, the nature and the quantity of the substances he has disposed of and the method and date of such disposal.

Practice guides and training workshops

Record keeping rules may vary depending on whether the physician is in private practice or practices in an institution. The Collège has also produced a guide that deals more specifically with the writing and keeping of records in consulting

rooms and local community services centres (CLSCs), a guide on record keeping by physicians in general and specialized hospital centres as well as a guide on access to personal information contained in the medical record created by physicians in private practice. The Collège also organizes workshops on record keeping.

7.2.2 The Regulation respecting periods of refresher training and refresher courses

Any member entered on the roll of the order who finds himself in one of the following situations may be required to successfully complete a period of refresher training or a refresher course, or both, following a recommendation by the professional inspection committee or the disciplinary council:

- > a physician has resumed his right to practice medicine 2 years or more after this right had been limited or suspended;
- > a physician has ceased to practice medicine with patients for a period of 3 years or more, unless he had practiced medicine for a period equivalent to more than 12 months during the last 5 years;
- > a physician has begun to practice medicine in a field in which he had never previously practiced or after practicing in another field for 3 years or more;
- > a physician has practiced medicine for a period equivalent to less than 12 months during the last 5 years;
- > a physician has failed a voluntary period of training supervised by a physician in order to refresh his professional practice or update his competencies.

Note that under the *Regulation respecting periods of refresher training and refresher courses that may be imposed on physicians*, a physician must inform the secretary of the Collège des médecins when he changes field or when he starts to practice in a new field.

In the event of a physician's repeated omission or failure to successfully complete one or more required periods of refresher training or refresher courses, he may be struck off the roll of the order or his right to practice medicine may be permanently restricted.

A physician who finds himself in one of the following situations may be required to successfully complete a period of refresher training or a refresher course following a decision of the executive committee:

- > the physician applies for a permit when he stopped practicing for a period of 3 years or longer;

- > the physician has a permit but has not been registered on the roll of the order for 3 years;
- > the physician has a permit but has not been registered on the roll of the order for 2 years and was struck off.

Once the physician's competence has been assessed and based on the results of the assessment, the executive committee may decide to refuse to issue the physician a permit or to register the physician on the roll. It may also register him on the roll of the order but restrict or suspend his right to practice professional activities until he has successfully completed a period of refresher training or a refresher course or both.

7.2.3 The Regulation respecting professional liability insurance

A fundamental principle related to the notion of "professional" is that of liability for any negligence in one's professional practice. Professionals are obliged to provide coverage against their professional liability. This principle is invoked primarily to protect the public, although professionals often perceive the obligation as necessary for their own protection.

More specifically, section 2.01 of the *Regulation respecting the professional liability insurance of physicians* states that a physician who practices his profession for his own account part-time or full-time, either alone or in partnership with other physicians, must hold and keep in force an insurance contract providing coverage against any liability that he or his employees and agents may incur, through error or negligence committed in the practice of his profession.

The coverage may be an insurance policy, a guarantee deposit or another form deemed satisfactory, such as proof that the physician's employer holds an insurance contract that expressly covers this physician, provided the contract respects the conditions imposed in the Regulation.

As for minimal coverage requirements, this coverage must effectively serve the purpose of protecting the public as it applies to persons who consult a physician, in all confidence, for the latter's professional expertise. The coverage must be sufficiently broad in scope to include all acts within the physician's professional field of practice. The Regulation stipulates a minimum amount per claim and for all claims submitted during one period of coverage, including a deductible amount not exceeding a maximum amount.

Holding professional liability insurance that is always valid and in compliance with the Regulation protects both the public and the physician. Neglecting to hold such an insurance policy would mean taking a big risk and committing an offence. The Collège therefore insists that its members comply with the Regulation and provide

proof of this once a year when they complete their annual membership renewal form.

Note also that a physician is deemed to comply with the provisions of the Regulation if he sends the secretary of the order, with his registration on the roll, a declaration that he is a member of the Canadian Medical Protective Association (CMPA) and his membership number.

Furthermore, a physician who practices his profession solely for the account of a private or public agency on a salaried basis is deemed to comply with the Regulation if he sends the secretary of the order, with his registration on the roll, a declaration that his employer holds an insurance contract whose coverage extends specifically to this physician, provided that this insurance contract includes the minimum coverage limits specified in this Regulation.

Lastly, a physician is not required to hold and maintain in force an insurance contract providing coverage against his professional liability:

- (1) if he does not practice any of the activities referred to in section 31 of the *Medical Act*;
- (2) if he practices his profession exclusively outside Quebec.

7.2.4 The Regulation respecting the standards relating to prescriptions made by a physician

Under section 39.3 of the *Professional Code*, the term “prescription” means a direction given to a professional by a physician, a dentist or another professional authorized by law, specifying the medications, treatments, examinations or other forms of care to be provided to a patient or a group of persons, the circumstances in which they may be provided and the possible contraindications. A prescription may be individual or collective.

The *Regulation respecting the standards relating to prescriptions made by a physician* makes the following distinctions:

- > an individual prescription, given by a physician to an authorized person and meant for a patient;
- > a collective prescription, which may be given by a physician or a group of physicians and meant for a group of patients;
- > an external medical protocol, which describes the procedures, methods, limits or standards applicable to a specific condition in an institution.

Individual prescriptions

When writing an individual prescription, whether for a medication, a treatment, an examination or a laboratory test, the prescription must include all of the following information:²⁷

1. Prescriber identification

The prescriber identification must include the physician's name, printed or in block letters, his permit number, the name of the institution or clinic and the telephone number and mailing address he would like professionals to use if they need to contact him about the prescription. It must also include his signature. However, if the prescription is written for a patient during their stay in an institution, a physician is not required to write the name of the institution or clinic or the telephone number and mailing address where he would like to be contacted about the prescription.

2. Patient identification

The prescription must include the patient's name, his date of birth or his RAMQ health insurance number. To avoid confusing people with the same name, other identifiers may also be included, such as address or gender.

3. Date written and period of validity

The period of validity of the prescription starts on the date the prescription is written. Subject to exceptions set out in the Regulation, there is no limit on the time an individual prescription is valid, except for a prescription for medication, unless the physician indicates otherwise. In addition, a prescription's period of validity is not affected by the prescriber's death, striking off the roll or resignation. Indeed, since the prescription was written by an active physician, it remains valid even if any of these events occur, except in the case of a physician who is the subject of a Health Canada advisory, whereby a pharmacist is prohibited, as the case may be, from dispensing, selling or providing any controlled drug, targeted substance, benzodiazepine or narcotic prescribed by that physician.²⁸

4. Documentation in the record and other information

The content of each prescription must be entered in the patient's medical record, irrespective of the format used. To avoid having to write the prescription again, the physician may keep a copy of it that will then take the place of the prescription in his record. A diagonal line must be drawn across the unused portion of the prescription. If he considers it useful, the

²⁷ See the guide *Individual prescriptions written by a physician* published by the Collège in 2016.

²⁸ *Benzodiazepines and Other Targeted Substances Regulations*, SOR/2000-217.

physician may include any contraindications or any other information required by the patient's clinical condition.

5. Legibility

All prescriptions must be completely legible to avoid any confusion or errors. Although it is not mentioned in the Regulation, a prescription may be written in French or English. However, if required by the institution, the prescription must be written in French. Irrespective of whether the prescription is written in French or English, the physician may translate it into another language in another document so that the patient is able to understand it.

6. Prohibition of the promotion of products, services or suppliers

Prescriptions must not contain the name or logo of particular products, services or suppliers of products or services. The same rules apply to a physician who uses a technology tool to write a prescription, including decision support tools. Therefore, prescription pads from laboratories or other suppliers of services and products may not be used, irrespective of whether they are for physiotherapy, audiology, orthotics, etc. A physician must also ensure that technology tools do not allow the dissemination of any form of promotion of particular products, services or suppliers of products or services.

In addition to the information normally required for a prescription, there are specific requirements for some types of prescriptions. For example, an individual prescription for a medication must also contain the following information:

- (1) the full name of the medication;
- (2) the dosage;
- (3) the route of administration;
- (4) the duration of treatment or the quantity prescribed.

Collective prescriptions

A collective prescription must be issued in writing and contain the following information:²⁹

- (1) the date of coming into force;
- (2) the name of the collective prescription and its purpose;

²⁹ Refer to the guide published by the Collège in 2017 [Les ordonnances collectives](#) (Collective prescriptions; available in French only); see also on the Collège's website the section [Questions-réponses sur les ordonnances faites par un médecin](#) (Questions and answers on prescriptions written by physicians; in French only) and the section on INESSS's website on [medical protocols and related prescriptions](#).

- (3) the professionals or the qualified persons who can execute the prescription and the professional requirements necessary, if any;
- (4) the circumstances, such as the group of people or the clinical situation targeted;
- (5) the professional activity contemplated by the prescription;
- (6) the indications giving rise to the use of the prescription;
- (7) the intention or the therapeutic target, when the activity consists of adjusting a medication, substance or treatment;
- (8) the medical protocol or the reference to an external medical protocol;
- (9) the contraindications, if any;
- (10) the limits or the situations for which the patient must be directed to a physician;
- (11) the name of the responding physician or a procedure allowing the identification of a respondent at the time when the prescription is individualized, as well as the responsibilities of the responding physician;
- (12) reference tools, if any;
- (13) sources;
- (14) the last prescription review date;
- (15) the name, printed or in block letters, telephone number and permit to practice number of each of the prescribing physicians;
- (16) the form of communication and information that must be conveyed to ensure follow-up by the attending physician;
- (17) the signature of the prescribing physicians and the responding physician if the latter is not a prescriber or, at an institution, of the council of physicians, dentists and pharmacists.

A prescription to initiate diagnostic or therapeutic measures, or drug therapy, must also specify the condition required to initiate and the possible indications or contraindications. A prescription to adjust treatment must include the therapeutic intention and the possible indications or contraindications.

The content of the collective prescription must be revised no later than every 36 months.

7.2.5 The Regulation respecting professional inspection

The *Regulation respecting professional inspection by the Collège des médecins du Québec* sets out the standards applicable to the professional inspection procedure. It specifies the powers of the different actors involved in the procedure and provides guidance on the preparation of the professional inspection file and the different steps involved in a professional inspection.

The person responsible for professional inspection and the professional inspection committee

The Board of Directors appoints the person responsible for professional inspection and the inspectors who will assist him. The Board of Directors also appoints eleven people as members of the professional inspection committee (PIC) and the secretary of the committee, who coordinates its activities. The PIC is composed of an elected director who is not on the executive committee and who acts as committee chair, a director appointed by the Office des professions du Québec who is not on the executive committee and 9 physicians who have been registered on the roll of the order for at least 10 years. The term of PIC members is 2 years and is renewable. A member may not, however, serve more than 4 terms.

The person responsible for professional inspection supervises the practice of the profession in accordance with the general supervision program established by the PIC and approved by the Board of Directors. He periodically draws up the list of physicians who will be inspected, designates the inspector and appoints the experts who may assist him, where applicable. He may deem it advisable to have a medical expert from a discipline similar to that of the physician being inspected accompany the physician inspector on the visit.

Following an inspection, the person responsible for professional inspection receives the report and sends his comments or requests to the member concerned regarding the improvement or maintenance of the quality of his professional practice. However, if the person responsible for professional inspection intends to impose a period of refresher training, a refresher course, both, or another measure provided for in the Regulation, he must inform the PIC of his recommendation. Indeed, only the PIC may impose such a measure on the recommendation of the person responsible for professional inspection. The PIC may also, on the recommendation of the person responsible for professional inspection, restrict or suspend the right to engage in professional activities of a member on whom it has imposed a period of refresher training, a refresher course or another measure provided for in the Regulation until the member has fulfilled this obligation. Furthermore, in the event of repeated omission or failure to fulfil an obligation imposed with restrictions or suspension, the PIC may, after giving the professional the opportunity to make his representations, strike him off the roll or restrict his right to practice permanently.

Professional inspection file

The person responsible for professional inspection creates and maintains an up-to-date file for each physician who is inspected.

A file is also created for each place of practice where a group practice inspection is carried out.

The file contains all the documents and information relating to an inspection, namely, the questionnaires, the physician's observations, the inspection reports, the recommendations of the person responsible for professional inspection, the training period reports and the committee's decisions, where applicable.

A physician may consult and obtain a copy of his professional inspection file for a reasonable fee. Before the physician consults or is provided with a copy of his file, any information that would allow the person who prompted the inspection to be identified must be redacted.

Professional inspection

The inspections carried out by the Collège may concern the professional competence of a single physician or a group practice in an institution.

Before the inspection

With the exception of visits related to a group practice in an institution, every inspection begins with notification to the physician, by the inspector, of a questionnaire, which must be completed and returned to the inspector with the required documents. Furthermore, at least 15 days before the scheduled inspection date, the inspector notifies a notice in writing to the physician, unless notification of this notice could compromise the objective of the inspection. In cases where the physician practices in an institution, a notice is also notified to the director of professional services within the same time period. In the case of a group practice inspection, the notice must be notified at least 60 days before the scheduled inspection date. In this case, the notice must also be notified to the president of the council of physicians, dentists and pharmacists (CPDP), the director of professional services, the head physician of the medical service, the physician in charge or the medical director, as the case may be, for information and posting purposes.

Obligations of the physician who is being inspected

The physician who is being inspected must inform the inspector of any serious reason that prevents him from receiving an inspector or an expert on the scheduled date upon notification of the notice so that another date can be arranged. Furthermore, the physician who is being inspected must be present at

the location of the inspection, must make himself available as required by an inspector or an expert and must provide access to his records and office. In accordance with the rules of professional secrecy, the physician may be assisted by a person of his choice who acts as an observer. When a record, register, medication, substance, apparatus or piece of equipment concerned by an inspection is held by a third party, the physician must, at the request of the person responsible for professional inspection, an inspector or an expert, authorize this person to access it and, where applicable, make a copy of it at no charge.

Assessment tools

The inspector and the expert accompanying him, where applicable, may, as part of an inspection, review records and other documents held by the physician, conduct a structured oral interview, a guided interview or direct observation, or have the physician complete practice profile or competency assessment questionnaires or psychometric tests.

They may also use questionnaires intended for the medical director, director of professional services or department head of the physician's place of professional practice.

Following the inspection, the inspector writes and sends a report to the person responsible for professional inspection. The report includes, in particular, a list of the records examined and his findings and conclusions.

Recommendations of the person responsible for professional inspection and decision of the professional inspection committee

When, after reviewing the inspection report, the person responsible for professional inspection does not intend to recommend that the PIC impose a period of refresher training, a refresher course or any other measure provided for in the Regulation, he notifies the member concerned as soon as possible. The person responsible for professional inspection may also send the member comments regarding the improvement or maintenance of the quality of his professional practice and ask him to take corrective measures, participate in training activities or a follow-up visit.

As mentioned previously, the PIC has the authority to impose a period of refresher training, a refresher course, both, or one of the following measures, on the recommendation of the person responsible for professional inspection: successful completion of a tutoring program, with or without direct observation; participation in workshops organized by the order; structured reading or participation in an administrative follow-up program. The person responsible for professional inspection may, in drawing up his recommendation, take into account an assessment in which failure of a period of refresher training, a refresher course or a tutoring program is noted. Thus, when the person responsible for professional

inspection intends to recommend that the PIC impose one of these measures, he informs the physician, who may submit his observations to the person responsible for professional inspection before the recommendation is made. The person responsible for professional inspection notifies his reasoned recommendations to the PIC, which will also allow the physician to submit his observations before it makes its decision.

In the case of a general inspection of a group practice in an institution, the person responsible for professional inspection sends the physicians concerned and, as the case may be, the head physician of the medical service, the physician in charge, the medical director, the director of professional services or the department head appropriate comments and suggestions regarding the improvement of the quality of the physicians' professional practice. He may also require the physicians concerned to provide a written report on the corrective measures taken and conduct a follow-up visit to verify the adequacy of the corrective measures.

The Collège has published a [leaflet on professional inspection](#) for physicians.

7.2.6 The Regulation respecting mandatory continuing education

Physicians concerned by the Regulation

All physicians registered on the roll of the Collège and who practice medicine within the meaning of section 31 of the *Medical Act* are concerned by the [Regulation respecting mandatory continuing education for physicians](#),³⁰ in force since January 1, 2019, irrespective of how long they have been practicing their profession, their field of activity or their place of practice.

Section 31 of the *Medical Act* defines the practice of medicine and lists the activities reserved to physicians, which include diagnosing illnesses, prescribing diagnostic examinations, determining treatment and prescribing medications and other substances.

However, the practice of medicine involves much more than clinical activities. It also includes other types of activities, such as medico-administrative and medicolegal activities. By way of indication, here are some concrete examples of medical practice:

- > a public health director;
- > a medical specialist in occupational health;
- > a medical specialist in public health and preventive medicine;

³⁰ See also the guide [Les obligations des médecins en matière de formation continue](#) (Physicians' obligations with respect to continuing education; available in French only) published by the Collège in 2019.

- > a physician who is the head of a clinical department in an institution;
- > the director of professional services of an institution;
- > a physician who operates and manages an assisted reproduction centre;
- > a physician who operates a general medical imaging laboratory or a specialized medical centre;
- > a regional director of prehospital emergency medical services;
- > a permanent or part-time physician coroner;
- > a consulting physician (e.g., BEM, SAAQ, Ministry, RAMQ, CNESST);
- > a medical examiner;
- > a medical expert;
- > a physician who is a syndic or inspector at the Collège des médecins du Québec.

Continuing education activities

The Regulation stipulates that every year all physicians must produce a declaration of their participation in continuing education activities. It defines three categories of continuing education activities:

- > recognized professional development activities;
- > recognized practice assessment activities;
- > activities that are not “recognized” but are eligible for inclusion in the annual declaration.

The Regulation also defines the minimum requirements per reference period (5 years), that is, at least 250 hours of continuing education activities, including:

- > at least 125 hours of recognized professional development activities;
- > at least 10 hours of recognized practice assessment activities;
- > no more than 115 hours of activities that are not “recognized” but are eligible for inclusion in the declaration.

The Regulation also establishes an annual requirement for participation in continuing education activities:

- > at least 25 hours of participation in recognized continuing education activities (recognized professional development activities or recognized practice assessment activities).

Thus, physicians must complete a minimum number of continuing education hours per year and per reference period:

- > the reference period is the same for all physicians, irrespective of at what point, during the period, they become an active member or cease to be an active member;
- > the first reference period begins on January 1, 2019 and will end on December 31, 2023.

Lastly, it should be noted that in some cases, a physician may be exempted if he is able to show that he is unable to participate in continuing education activities for a given period.

8. The Collège des médecins du Québec and other associations of physicians

8.1 The Collège des médecins du Québec

The Collège des médecins du Québec is the professional order of physicians in Quebec. Its mission is to promote quality medicine to ensure the protection of the public and contribute to improving public health.

The Collège is one of the orders that make up Quebec's professional system, nearly 30 of which represent professionals working in the health sector. The system was created in the 1970s to supervise professional practice and to ensure the protection of the public. Moreover, the *Professional Code* and the *Medical Act* determine the responsibilities of the Collège and specify the mechanisms required to fulfil them.

Even before these laws were adopted, the Collège used many means to fulfil a professional order's mandate, including mandatory membership for all physicians, a code of ethics and a highly effective disciplinary council. It now has very elaborate mechanisms, a staff of over 100 and a considerable budget that comes entirely from membership dues. Its current structure reflects both its collegial nature and the functions it must fulfil as a professional order.

8.1.1 Structures of the Collège

Political structure

The Collège is first and foremost an association of over 20 000 physicians empowered by law to self-regulate.

Board of directors

On June 8, 2017, the *Act to amend various legislation mainly with respect to admission to professions and the governance of the professional system*³¹ amended the provisions of the *Professional Code* establishing the composition of the board of directors (BD) of a professional order. Thus, by June 8, 2021, all professional orders must be administered by a board of directors composed of a maximum of 15 directors. This number can be increased to 16 if, following an election, the BD does not include at least one elected director who was 35 years of age or under at the time of his election. At term, the composition of the BD of the Collège des médecins will be as follows: 11 elected directors and 4 public representatives, appointed by the Office des professions. Note that the elected

³¹ *Act to amend various legislation mainly with respect to admission to professions and the governance of the professional system*, S.Q. 2017, c. 11.

directors elect a president from among their number by secret ballot; the president's term is four years.

The BD is responsible for the general supervision of the order and the management and supervision of the conduct of its affairs. It is responsible for carrying out the decisions of the order and those of

the members in general meeting and ensures the related follow-up.

The BD must also see to the application of the provisions of the *Professional Code*, the *Medical Act* and the regulations made under this Code and this Act. It exercises all the rights, powers and prerogatives of the order, except those within the competence of the members of the order in general meeting. Unless otherwise provided, it exercises its powers by resolution.

In addition, the BD establishes the statutory committees that every professional order is required to have. The function of these committees is to advise on policy directions in their respective fields.

The BD, in particular:

- (1) sees to the pursuit of the order's mission;
- (2) determines the order's strategic directions;
- (3) rules on the order's strategic choices;
- (4) adopts the order's budget;
- (5) adopts effective, efficient and transparent governance policies and practices; and
- (6) sees to the integrity of internal control rules, including risk management rules, and ensures the viability and sustainability of the order.

Furthermore, the BD, in particular:

- (1) appoints the secretary and the executive director of the order;
- (2) requires any person appointed by the order to develop or apply conditions for the issue of a permit or a specialist's certificate to take training on professional qualifications assessment, training on gender equality and training on ethnocultural diversity management, and makes sure that such training is offered to such a person;
- (3) makes sure that continuing education activities, courses or periods on such subjects as ethics and professional conduct are offered to the members of the order and reports on this in its annual report;
- (4) ensures the fairness, objectivity, impartiality, transparency, effectiveness and promptness of the admission processes adopted by the order and makes

sure that those processes facilitate admission to a profession, in particular for persons trained outside Québec;

Secretary

The secretary of the order is appointed by the BD. The BD may also appoint one or more assistant secretaries of the order and determine their functions.

The secretary acts as secretary of the order, the BD and the executive committee. He is also the depository of the archives of the order and is responsible, among other things, for:

- > preparing and updating the roll of the Order;
- > seeing to the development and updating of the Collège's regulations;
- > with respect to elections, playing a key role, in particular by supervising the vote;
- > with respect to the annual general meeting (AGM), doing the following:
 - > (1) Before the AGM, sending information about the annual assessment to all members of the order, accompanied by the following documents:
 - a draft resolution amending the amount of the annual assessment, where applicable;
 - budget estimates, including a breakdown of the elected directors' remuneration;
 - a draft annual report.
 - > (2) After sending this information, conducting a first consultation concerning the amount of the annual assessment that will be in force for the next fiscal year.
 - > (3) During the AGM, reporting to the members on the comments received during the first consultation, and the members present are then consulted a second time in this regard.

Executive director

The executive director is responsible for the general and day-to-day administration of the order's affairs. He sees to the conduct of the order's affairs and follow up on decisions of the BD. He plans, organizes, directs, supervises and coordinates the order's human, financial, material and informational resources in accordance with sound management practices. The executive director of the Collège may not exercise any other functions assigned under the *Professional Code* or the *Medical Act* other than that of secretary of the order.

President

The president exercises a right of general supervision over the BD's affairs. He sees, with the senior management of the order, that the BD's decisions are implemented and requires any information he considers relevant to keep the BD informed of any other matter relating to the pursuit of the order's mission. To the extent determined by the BD, he acts as the order's spokesperson and representative. The president also assumes such other responsibilities as are assigned by the BD but may not act as an officer.

The president:

- (1) presides at the meetings of the BD and over the proceedings of the general meeting of members of the order;
- (2) is responsible for the administration of the affairs of the BD;
- (3) sees to the proper performance of the BD;
- (4) coordinates the work of the BD and of the general meeting;
- (5) sees that the directors on the BD comply with the standards of ethics and professional conduct applicable to them.

The president is a director of the BD and has the right to vote. He may not, however, exercise any other functions assigned under the *Professional Code* or the *Medical Act*, including that of executive director.

General meeting

The Collège holds an annual general meeting (AGM) in the fall. During the AGM, an activities report and a financial statement report are submitted.

The AGM is preceded by a consultation period of at least 30 days. Members are invited to comment on the amount of the annual assessment. During the AGM, members may also make additional comments on the BD's recommendation regarding the amount of the annual assessment before the BD, during a subsequent regular meeting, determines by resolution the definitive amount of the assessment.

During the AGM, the members approve the elected directors' remuneration and appoint the auditors responsible for auditing the books and accounts.

Administrative structure

In addition to statutory committees and standing committees, the Collège has a number of divisions that help it fulfil its functions. Working groups are also formed as needed to resolve specific problems.

A division was created for each of the Collège's main functions. Each is composed of physicians employed by the Collège and the necessary support staff. These physicians, like the directors, must abide by specific rules of ethics aimed at preventing any improper use of their powers toward their colleagues.

The Executive Office coordinates the divisions and the various communications and human resources activities. In addition, in the context of the development of draft legislation, it regularly takes part in parliamentary commissions and tables briefs that reflect the Collège's desired policy directions.

8.1.2 Functions of the Collège

Medical Education Division (MED)

The mandate of the Medical Education Division is to ensure that future physicians develop the necessary competence to practice medicine independently and to establish professional education standards for all family medicine and specialty programs. The MED's sphere of activities encompasses undergraduate and graduate medical education and continuing medical education.

More specifically, the MED is responsible for:

- > developing and updating the standards and general and specific policy directions of the Collège des médecins du Québec with respect to physician training;
- > enforcing regulations governing the accreditation of training programs and the accreditation of continuing medical education units for Quebec's four faculties of medicine and medical organizations that offer continuing professional development activities to physicians in Quebec;
- > reviewing applications and issuing permits to practice and specialist's certificates;
- > issuing registration certificates and training cards to medical students and residents;
- > carrying out liaison activities with provincial, national and international bodies;
- > participating in research and development activities in the field of clinical competence evaluation.

The Admission to Practice Committee (APC)

This committee examines all permit or specialist certificate applications and makes recommendations to the Board of Directors. It examines and makes determinations on all restrictive permit and permit renewal applications and on all

applications for recognition of equivalency of a degree or postgraduate training in order to obtain a permit to practice or a specialist's certificate.

The Committee on Medical Education and Accreditation (CMEA)

The main function of this committee is to ensure that under- and postgraduate training prepares candidates adequately for the practice of medicine and to examine any related issues. To this end, it collaborates with the bodies concerned in the development accreditation criteria and monitoring the accreditation of postgraduate training programs, training sites and continuing professional development units in universities. It is also responsible for the entire accreditation process for the CPD units of medical organizations in Quebec.

Practice Enhancement Division (PED)

The mandate of the Practice Enhancement Division (PED) is clear, namely, to oversee and enhance the practice of medicine in order to ensure the protection of the public and contribute to improving the health of Quebecers.

The PED performs the following functions:

- > supports the professional inspection committee and the continuing professional development and remediation committee;
- > assesses the quality of practice of physicians in private practice and in institutions, for instance by the application of three levels of monitoring and assessment;
- > assesses the quality of medical practice in institutions, in particular by promoting quality management;
- > intervenes with a view to improving the competence of physicians in private practice and physicians who practice in institutions;
- > participates, at the Collège and elsewhere, in activities that have an impact on the quality of practice;
- > develops [guidelines and practice guides](#) on regulatory aspects of medical practice and on subjects chosen by the executive committee for their practical interest;
- > assumes the duties of secretariat of the Conseil québécois de développement professionnel continu des médecins du Québec [Quebec council for the continuing professional development of physicians], which is an advisory body that brings together all the parties concerned.

Performance monitoring and improvement system

To fulfil their mandate, the PED and the PIC have, for a number of years, used an intervention model aimed at improving professional practice rather than identifying offending physicians. The model focuses on informing physicians, validating monitoring tools and making a systematic connection between monitoring and activities that would improve practice.

Performance monitoring and improvement system
The performance monitoring and improvement system has three levels of intervention and may be applied to both private practice and practice in institutions.
Level one: monitoring using clinical or administrative indicators
At the first level, the monitoring is done using clinical or administrative indicators. If, for example, the prolonged use of benzodiazepines in older adults is targeted, all the physicians concerned will be monitored using reliable and valid performance indicators. They will then be informed of their practice profile and given information on guidelines published on this aspect of practice.
Level two: further evaluation of certain physicians or institutions
The second level of monitoring includes further assessment of certain physicians or institutions where a specific practice was found to be problematic during the screening process at the first level. Various tools may be used, such as the professional inspection visit, which will be followed, if necessary, by specific recommendations, such as participation in educational activities.
Level three: in-depth assessment of the needs of certain physicians
At the third level, an in-depth assessment of the needs of certain physicians is carried out. Other tools, such as a structured oral interview (SOI) or an assessment period, are used to identify these needs more clearly and propose, to a greater or lesser degree, professional development activities.

All physicians and institutions must cooperate in ensuring that professional inspection visits run smoothly by providing the information and records required for individual and group assessments. If warranted by the findings of professional inspection visits, the PIC may make suggestions to the physician or institution visited. In some cases, the findings may warrant the imposition, by the Board of Directors, of a period of refresher training for a member, possibly with professional practice restrictions during the training period.

In addition, in its concern to protect the public, the Collège implemented an administrative follow-up program in 1999 for physicians who are unfit to practice due to illness. Since 2001, this program has been under the responsibility of a physician in the PED.

The professional inspection committee (PIC)

In accordance with the obligation imposed upon it by the *Professional Code*, the Collège has a professional inspection committee (PIC) whose mandate is to supervise the professional practice of its members and inspect the professional competence of physicians.

The members of the PIC and the person responsible for professional inspection are appointed by the Board of Directors. The person responsible for professional inspection performs his duties in accordance with the inspection programs established by the PIC and approved by the BD. More specifically, the person responsible for professional inspection periodically draws up the list of physicians who will be the subject of a professional inspection. He designates the inspector and appoints the experts who may assist him.

The person responsible for professional inspection or an inspector and the expert accompanying him may, as part of an inspection, review records, conduct a structured oral interview, a guided interview or direct observation, or have the physician complete practice profile or competency assessment questionnaires or psychometric tests. They may also use questionnaires intended for the medical director, director of professional services or department head of the institution or clinic where the physician practices.

The person responsible for professional inspection may recommend that the physician be required by the PIC to fulfil one or more of the following obligations:

- (1) successfully complete a tutoring program, with or without direct observation, with or without restrictions;
- (2) participate in workshops organized by the order;
- (3) do structured reading;
- (4) take corrective measures in order to comply with standards relating to office keeping for physicians or close the place of practice until the physician complies with these standards;
- (5) participate in an administrative follow-up program;

Where applicable, the person responsible for professional inspection ensures the PIC's decisions are followed up with the physician in the manner he deems appropriate.

The syndic and the Inquiries Division (ID)

Examination of complaints and inquiries into the illegal practice of medicine

In order to fulfil its mission – to promote quality medicine at the service of the public –, the Collège has adopted various regulations, including the *Code of ethics of physicians*. To ensure these regulations are enforced, the syndic, assistant syndics and advisors conduct inquiries. In accordance with the *Professional Code*, the syndic is a physician appointed by the Board of Directors of the Collège. His function is to conduct an inquiry following an explicit request or when information is brought to his attention or sent to him indicating that a physician has committed an offence, violating, among others, the provisions of the *Professional Code*, the *Medical Act* or the regulations arising from this Code or this Act, in particular, the *Code of ethics of physicians*.

A physician has an obligation to cooperate in inquiries conducted by the syndic and to provide, without hesitation or deceit, the information or documents requested. The *Professional Code* and the *Code of ethics* impose this obligation and it takes precedence over the maintenance of professional secrecy. The syndic's inquiries are confidential. The disclosure of information obtained during an inquiry is not authorized except for purposes of the disciplinary process. Based on the facts, the circumstances, the gravity of the presumed offence, the available evidence and the record of the physician concerned, the syndic may or may not file a complaint with the disciplinary council. Before resorting to a disciplinary process, the Inquiries Division uses a variety of means to help the physicians concerned practice their profession in accordance with their obligations. The Inquiries Division answers questions and examines requests made to the Collège regarding the professional conduct of physicians or the illegal practice of medicine. Every year, this division receives many requests for information concerning the professional practice of physicians from patients, their family members, physicians, institutions and coroners.

Non-disciplinary interventions

Many cases are settled by means of interventions such as providing assistance or information to the person who made the request. Physicians may submit questions of an ethical or regulatory nature to the syndic for discussion and advice. These questions may, for instance, relate to situations involving confidentiality, the limits of the patient-physician relationship, a physician's departure from a clinic, retirement, advertising, a potential conflict of interest or access to a patient's record.

In general, the problems described in requests that lead to an inquiry are settled using one of the following measures:

- > remarks or recommendations of a preventive nature are made to the physician concerned;
- > the physician's practice is assessed by the Practice Enhancement Division;
- > the physician agrees to undergo an assessment period or complete a training period or any other activity to improve his professional competence;
- > the physician voluntarily restricts his professional practice;
- > the physician is referred to the Quebec Physicians Health Program (QPHP) to resolve certain physical or mental health problems;
- > the physician is referred to the Programme de suivi administratif des médecins ayant des problèmes de santé physique ou mentale susceptibles de compromettre un exercice professionnel de la médecine [Administrative follow-up program for physicians who have physical or mental health problems that may compromise the professional practice of medicine];
- > the physician voluntarily puts his name on the restricted prescribing list for medications managed by Health Canada;
- > the physician stops practicing.

Many of the requests submitted to the Inquiries Division could be avoided if communication were better between physicians and their patients or their family members, or if physicians were more conversant with the laws and regulations. Physicians may also contact the Division's advisory service to obtain the support needed to prevent a situation from worsening.

However, when the solutions proposed are insufficient or inappropriate, disciplinary measures must be taken.

The review committee

A person who has requested an inquiry may request an opinion from the review committee when, at the end of an inquiry, the syndic decides against filing a disciplinary complaint. The number of members on this committee varies and they sit in groups of three. Some are public representatives; their names are on a list compiled by the Office des professions for this purpose. Others are on the Board of Directors or are physicians appointed by the Board of Directors. The review committee may uphold the syndic's decision not to file a complaint with the disciplinary council or conclude that filing a complaint is warranted. In the latter case, the review committee proposes the name of a person to act as syndic to file the complaint. It may also suggest that the syndic or assistant syndic complete the inquiry or refer the case to the PIC.

The disciplinary council

The disciplinary council is composed of three members: the president of the council, a lawyer appointed by the government and two physicians appointed by the Board of Directors. It is a tribunal that is independent of the Collège in the performance of its functions. It hears complaints filed by the syndic or a private complainant concerning physicians who have violated the *Professional Code*, the *Medical Act* and the regulations adopted under these laws, including the provisions of the *Code of ethics of physicians*. The hearings and decisions of the disciplinary council are public. A physician who testifies before this council – which operates under the same rules as a court of law – may be assisted by a lawyer, for he is required to answer all questions, including those that may incriminate him.

Disciplinary penalties

In accordance with section 156 of the *Professional Code*, disciplinary penalties that may be imposed on a physician convicted of an offence are as follows:

- > a reprimand;
- > temporary or permanent striking off the roll of the order, even if the physician convicted of an offence has not been entered on the roll since the date of the offence;
- > a fine that can vary from \$2 500 to \$62 500 for each offence;
- > the obligation to remit to any person entitled to it a sum of money the professional is or should be holding for him;

- > the obligation to transmit a document or the information contained in any document, and the obligation to complete, delete, update or rectify any document or information;
- > revocation of his permit;
- > revocation of his specialist's certificate;
- > restriction or suspension of his right to engage in professional activities.

The disciplinary council may also recommend to the Board of Directors that it require the professional to successfully complete a period of refresher training and/or a refresher course, and that it restrict or suspend the professional's right to engage in professional activities until that requirement is met (*Professional Code*, s. 160).

In cases of sexual misconduct in particular, the disciplinary council imposes the following penalties on a professional found guilty: striking off the roll for at least five years, unless he convinces the council that striking off for a shorter time would be justified in the circumstances, and a fine. When determining the penalties to be imposed, the council takes into account:

- > the seriousness of the facts of which the professional was found guilty;
- > the professional's conduct during the syndic's inquiry and, if applicable, during the processing of the complaint;
- > the measures taken by the professional to facilitate his reintegration into the practice of his profession;
- > how the offence is related to what characterizes the practice of the profession; and
- > the impact of the offence on public trust in the order's members and in the profession itself.

The disciplinary council may also recommend that a professional found guilty of sexual misconduct be required to undergo training, psychotherapy or an intervention program to allow him to improve his behaviour and attitudes and facilitate his reintegration into the practice of the profession (*Professional Code*, s. 160).

The disciplinary council must, on rendering a decision imposing provisional striking off the roll or provisional restriction or suspension of a professional's right to engage in professional activities, decide whether a notice of the decision must be published in a newspaper having general circulation in the place where the professional has his professional domicile and in any other place where the

professional has practiced or could practice. The notice must include the name of the professional found guilty, the place of his professional domicile, the name of the order of which he is a member, his specialty, if any, the date and nature of the offence committed by him and the date and a summary of the decision.

If the council orders the publication of a notice, it must, in addition, decide whether publication expenses are to be paid by the professional or by the Collège, or apportioned between them.

Note that either party may appeal the disciplinary council's decision before the Professions Tribunal.

The illegal practice of medicine

The Inquiries Division also has a mandate to protect the public against the practices of any person who engages in medical activities by the unauthorized use of the title of physician or by claiming to be authorized to practice the medical profession. In response to complaints from the public, health professionals or other sources, the Inquiries Division may, after investigation, institute legal proceedings for the unauthorized use of a title or illegal practice of medicine.

Accounts conciliation procedure

A client who has a dispute with a physician concerning the amount of an account for professional services may apply for conciliation by the syndic. The care and services that may be the subject of such a procedure are services that are not insured by the Régie de l'assurance maladie du Québec (RAMQ), such as cosmetic treatments, services that are not medically required, the completion of forms or independent medical evaluations.

The syndic or the person who is assisting him then informs the physician of the client's request. His role is to try to reach an agreement that is acceptable to both the client and the physician. Requests for conciliation are processed in accordance with the *Regulation respecting the conciliation and arbitration procedure for the accounts of physicians*.

8.2 Other associations of physicians

For a very long time, there have been voluntary associations of physicians that pursue three broad objectives:

- > scientific objective: maintain and promote the quality of professional practice;
- > union objective: defend the rights and working conditions of members;
- > social objective: offer assistance and support services to their members and promote certain causes.

At the scientific level, various agencies, such as the Royal College of Physicians and Surgeons of Canada (RCPSC) for specialists as well as the College of Family Physicians of Canada (CFPC) and its Quebec chapter, the Collège québécois des médecins de famille (CQMF) for family physicians, ensure that the competence of their members is standardized and recognized. They also, in their respective fields, participate in the accreditation of training programs offered across the country. There are also associations in Quebec which, in addition to having scientific objectives, offer support to their members, such as Médecins francophones du Canada [French-speaking physicians of Canada] and the Association des conseils des médecins, dentistes et pharmaciens du Québec (ACMDPQ) [Association of councils of physicians, dentists and pharmacists of Québec].

At the union level, general practitioners were the first to create regional associations which came together to form the Fédération des médecins omnipraticiens du Québec (FMOQ) [Quebec federation of general practitioners]. The FMOQ has regional associations and two provincial associations: the Association des médecins omnipraticiens œuvrant en établissements psychiatriques [Association of general practitioners working in psychiatric institutions] and the Association des médecins de CLSC du Québec [Quebec association of CLSC physicians].

Shortly afterwards, medical specialists formed provincial associations that brought together physicians in the same specialty. These associations form the Fédération des médecins spécialistes du Québec (FMSQ) [Quebec federation of medical specialists].

Physicians in training followed suit and created the Fédération des médecins résidents et internes du Québec (FMRIQ) [Quebec federation of medical residents and interns], which later became the Fédération des médecins résidents du Québec (FMRQ) [Quebec federation of medical residents]. As soon as they were formed, the medical student associations in each of Quebec's four faculties of medicine came together to create the Fédération médicale étudiante du Québec (FMEQ) [Quebec federation of medical students].

The federations of physicians play a very important role in the organization of medicine in Quebec by negotiating agreements with government authorities. Indeed, the FMOQ and FMSQ have been recognized as organizations representing physicians and, as such, they negotiate payment methods and pay scales for physicians. In fulfilling their mandate, they also have an influence on the conditions of medical practice. The federations have done much to enhance the professional status of their members, in particular through their ongoing involvement in continuing professional development activities. Quebec physicians are not obliged to belong to a union association. However, under the Rand formula, they are obliged to pay an assessment, which is deducted at source by the Régie de l'assurance maladie du Québec.

With respect to assistance and support for physicians, the medical federations also offer a number of services to their members, such as investment funds and insurance plans. The Canadian Medical Protective Association (CMPA) acts as a mutual professional liability insurance company, covering most physicians in Canada.

The existence of associations of physicians also made it possible to establish the Quebec Physicians Health Program (QPHP) in 1990. Intended for physicians in difficulty, the program is the result of a joint initiative of Médecins francophones du Canada, the Collège des médecins and the medical federations. The QPHP's mission is to assist physicians who have personal problems or suffer from a mental illness or from dependence. It assesses each situation and directs the people concerned to the appropriate resource. A growing number of medical students, medical residents and physicians are receiving assistance under this program. It is important to distinguish this program, aimed at helping physicians in difficulty, from the administrative follow-up program run by the Collège's Practice Enhancement Division, whose aim is first and foremost to protect the public through risk management with regard to fitness to practice.

SECTION 3 – LEGAL ASPECTS

9. Overview

This section highlights the essential role of the law in providing a framework for Quebec's health care system and medical practice.

In Quebec, medical practice is subject to various legal provisions, because the latter concern the health sector more specifically, because they provide a framework for professional relations, or because they apply to all citizens. First, this section presents an overview of the many laws that may have a bearing on the practice of medicine; it then focuses on medical civil liability and concludes with a presentation of certain laws that impose very specific obligations on physicians.

These legal provisions share a common purpose: to create a framework that supports the provision of the best possible health care services while ensuring respect for each and every person.

10. The law and medical practice in Quebec

10.1 The law and the health sector

Many provisions in the *Civil Code* have a bearing on the health sector, especially those intended to protect the integrity and inviolability of the person and to establish the right to life. The *Civil Code* addresses many subjects related to health, including care; consent to care and the circumstances in which one may use a substitute or disregard it, particularly in the case of minors, incapable persons and those whose condition presents a danger to themselves or to others; respect for a person's privacy; respect for a person's right to have access to records concerning him; as well as transplants, research projects and ethics committees.

It also sets out rules of civil liability, contractual or extracontractual. Insofar as the relationship between the patient and the physician constitutes a contract, certain sections of the *Civil Code* have a bearing on medical practice. Indeed, the *Civil Code* governs all contracts established between two persons and fixes their conditions, so that each party is responsible for complying with his obligations and for damages resulting from noncompliance. Because hospitals and professions come under provincial jurisdiction, Quebec legislates on health. In 1971, the National Assembly adopted framework legislation concerning the organization of the health care system in Quebec, namely, the *Act respecting health services and social services* (AHSSS). With the objective of improving the health and well-being of individuals and populations, this Act established the principles and guidelines for the organization of health and social services.

Amended many times since, the AHSSS still determines the mandates and methods of organization of public institutions, community groups and coordinating agencies. For example, it provides for the creation of a council of physicians, dentists and pharmacists (CPDP) in every institution as well as mechanisms for granting or revoking hospital privileges. It also establishes a list of "users' rights", including the right to choose one's physician, to have access to one's medical record and to have access to appropriate care given the resources available.

The *Professional Code*, adopted in 1973, is also a legal framework, in this case for the professional system in Quebec. It defines the criteria for recognition of a profession, determines the powers of a professional order and provides for the mechanisms an order may use to supervise the professional practice of its members in order to ensure the protection of the public. Thus, a professional order must have a professional inspection committee, a code of ethics, a syndic with broad powers to conduct inquiries and a disciplinary council authorized to examine complaints when a member violates a provision of its code of ethics.

The *Medical Act* defines the practice of medicine, establishes requirements regarding registration and the subsequent issue of a permit to practice, and sets out the organizational structure of the Collège des médecins du Québec.

One legal source of particular importance is Quebec's *Code of ethics of physicians*. This regulation, adopted pursuant to the *Professional Code*, is the fundamental guide to good medical practice.

Other laws that have a bearing on the health sector include the *Act respecting the protection of persons whose mental state presents a danger to themselves or to others*, the *Youth Protection Act*, the *Public Health Act* and the *Highway Safety Code*.

Taken together, these particular laws, be they provincial or federal, are often referred to as “statutory” law.

10.2 The law and medical practice in Quebec: possible remedies

This overview of the various laws that have an impact on the field of health shows why a medical act can have legal consequences.

- > In some circumstances, engaging in medical activities can go against the public order or a standard deemed essential to life in society, such as a *Criminal Code* provision. For example, a physician once faced criminal charges for refusing to provide care for a homeless person in the emergency room. The man died without receiving the appropriate care. Or again, before the Supreme Court ruled that the *Criminal Code* provision prohibiting abortion was invalid because it was discriminatory, legal action could be taken against a physician for performing an abortion. If a physician is found guilty of a crime, the court must, within the guidelines fixed by law, impose a sentence meant to punish, to serve as an example, to express social disapproval and to protect society. In criminal matters, the Crown has the burden of proof “beyond a reasonable doubt”, and the accused is not compellable, that is, he is under no obligation to testify.
- > The practice of medicine may also be subject to any of numerous federal or provincial laws that determine a physician's conduct in a specific instance. This applies, in particular, to the physician's “statutory” obligation to report to the director of youth protection situations in which a child might be in danger because of his parents' negligence or incapacity. In the event of a violation, these laws have criminal penalties attached to them, usually in the form of a fine.
- > A physician's behaviour may also contravene the *Code of ethics of physicians* and lead to the imposition of a penalty by a disciplinary council

composed of a majority of peers. A physician may be found guilty of a breach of ethics even if the offence he committed did not have any adverse consequences. The ethical and disciplinary process has no compensatory function. Justice in this case is dedicated to protecting the public rather than punishing the physician. Depending on the severity of the physician's offence, it may warrant imposition of a reprimand, a fine, practice restrictions or temporary or permanent striking off the roll. The disciplinary council may also recommend that the professional order require the physician to complete a period of refresher training. Lastly, the physician is compellable and may be obliged to testify. A preponderance of evidence is the degree of proof required.

- > When a wrongful act has caused injury to a patient or his family, the *Civil Code* provides for a compensation regime: the professional or civil liability regime. The *Civil Code* requires the victim of a medical error to establish that a fault was committed, that an injury was sustained and that there is a causal relationship between the fault and the injury. The physician is compellable. The burden of proof lies with the claimant, except in particular circumstances, and the degree of proof required is a preponderance of evidence.
- > If, in addition to having committed a wrongful act and caused an injury, the physician has illegally and intentionally violated a fundamental right as provided for in the *Québec Charter of Human Rights and Freedoms*, such as the right to physical integrity, the court may impose exemplary damages.
- > A complaint may also be filed against a physician in accordance with the complaint examination procedure provided for in the *Act respecting health services and social services* (AHSSS).

These remedies, at the civil as well as the disciplinary and administrative levels, may be exercised by all patients or their legal representatives, either consecutively or concurrently.

11. Medical civil liability

11.1 Context

The relationship between the physician and his patient is subject to obligations. A physician who fails to fulfil his obligations may be the subject of a civil liability remedy, the basis for which can be found in sections 1457 and 1458 of the *Civil Code*:

“**1457.** Every person has a duty to abide by the rules of conduct incumbent on him, according to the circumstances, usage or law, so as not to cause injury to another.

Where he is endowed with reason and fails in this duty, he is liable for any injury he causes to another by such fault and is bound to make reparation for the injury, whether it be bodily, moral or material in nature.

He is also bound, in certain cases, to make reparation for injury caused to another by the act, omission or fault of another person or by the act of things in his custody.

1458. Every person has a duty to honour his contractual undertakings.

Where he fails in this duty, he is liable for any bodily, moral or material injury he causes to the other contracting party and is bound to make reparation for the injury; neither he nor the other party may in such a case avoid the rules governing contractual liability by opting for rules that would be more favourable to them.”

Medical civil liability is first and foremost a system of reparation for an injury due to a fault. Therefore, the victim must first prove the existence of a medical fault in order to win his case before the courts.

Section 1457 of the *Civil Code* establishes the three elements essential to a civil liability lawsuit:

- > a fault, which can be defined as a failure to fulfil a pre-existing obligation, a duty or to abide by a rule of conduct;
- > an injury, for the law in civil liability seeks to make reparation for the injury. If there is no injury to make reparation for, there is no basis for legal action, at least not in civil liability;
- > a causal relationship between the fault and the injury.

Thus, the patient must prove before the civil courts that the physician committed a fault by failing to fulfil a medical obligation, that the fault caused him injury and that there is a causal relationship between these two elements. If the patient wins his case, the physician is then obliged to compensate him. If, in addition to having committed a fault and caused injury, the physician has illegally and intentionally violated a right protected by the *Québec Charter*, such as the right to physical integrity, the court may impose exemplary damages, also called punitive damages.

Note the particular situation of a person who acts as a “good Samaritan”. Under section 1471 of the *Civil Code*, a person who comes to the assistance of another person is exempt from all liability for injury that may result from it, unless the injury is due to his intentional or gross fault.

11.2 The evolving notion of medical malpractice

No law or regulation clearly defines the notion of medical malpractice. Therefore, we must look to case law and doctrine. Until the mid-20th century, the notion of medical liability was almost nonexistent in case law. In 1930, the Supreme Court stated the following: [Translation] *“As the authors have said, in serious cases of surgery, only honor stands between the physician’s conscience and his patient. Between the two there is no judge but God.”*

Changes came about gradually. The rules of civil liability were applied to medical practice in cases of “serious, gross and inexcusable” negligence. In 1948, the Superior Court established, while referring to physicians as men of art, that: [Translation] *“Men of art may not be sued when they perform a professional act except to the extent that they commit gross negligence in and of itself, apart from any academic controversy.”*

In 1957, the principle of medical civil liability was established by the Court of Appeal: [Translation] *“The general rule is therefore that professional negligence is a fault like any other.”*

Civil liability encompasses two categories: contractual liability and extracontractual liability. The distinction between these two categories is whether or not a contract is formed between the parties. Medical liability is based on the same principle. In short, the formation of a contract will depend on the presence of a mutual agreement between these two individuals. In this way, a person who is brought unconscious to the emergency room and who must have surgery immediately establishes an extracontractual relationship with the surgeon. On the contrary, a person who goes to his ophthalmologist for follow-up has a contractual relationship with his ophthalmologist.

While the distinction between the two regimes results in some unique features, in particular with respect to presumption, the physician and the patient are

essentially bound by the same rights and duties, whether their relationship is contractual or extracontractual. On the one hand, the patient is obliged to cooperate in the investigation and treatment. For his part, the physician has traditionally been required to fulfil four main obligations, which form his medical obligation as a whole. Established by the Court of Appeal in 1965, these obligations had been recognized previously in case law and doctrine and can be summarized as follows:

- > the obligation to inform the patient and obtain his consent;
- > the obligation to provide care;
- > the obligation to provide follow-up;
- > the obligation to ensure confidentiality.

Therefore, each time a patient takes legal action against his physician for professional liability, he must prove that the physician's fault consisted in a breach of one of these obligations. Essentially, a breach occurs when a person fails to meet professional standards.

Consequently, it must be determined whether the physician behaved as a normally prudent, competent and diligent physician would have in the same circumstances. Using objectivity as the criterion, a family physician is compared with another family physician, or a medical specialist is compared with a physician practicing in the same specialty. Case law shows that, in assessing the situation, one must think back to the time when the events occurred and take into account what was known then or what should have been known then, and not what became known after the fact. The physician should not be judged using a "retrospectoscope", that is, accused retrospectively of having performed or not performed a given act.

Furthermore, one must have recourse to expert witnesses – physicians known for their expertise – who will provide their opinion on the act the physician is accused of. Did it meet practice standards or was it an uncommon practice but still recognized by the profession and in keeping with scientific knowledge?

The judge renders his decision after hearing the witnesses of fact and expert witnesses of both parties, and after examining all the relevant documentation, such as the medical or hospital records and articles from medical journals submitted as evidence. He determines if a fault was committed, if this fault caused an injury and if there is a causal relationship between the two. The judge must also evaluate the injury sustained and quantify it in dollars.

If the judge finds there is a fault, an injury and a causal relationship, he will order the defendant to pay the claimant the sum of money required to compensate him fully. Either party may appeal this decision in order to contest the liability, the amount granted, or both.

In closing, it should be noted that physicians are generally held to an obligation of means, not an obligation of results. This means that they must use the appropriate means available to them to make the right diagnosis, treat the illness appropriately and provide follow-up. They must make every effort to diligently provide care to the patient. They may not, however, guarantee the outcome of their work. This is why they are only held to an obligation of means. In contrast, other professionals, such as engineers or architects, are held to an obligation of results.

11.3 The scope of obligations under the medical contract

11.3.1 The obligation to obtain the patient's consent and provide information³²

The obligation to obtain consent

The obligation to obtain the patient's free and informed consent is directly related to recognition of the right to freedom and self-determination of individuals, a principle established in many legislative texts. Section 1 of the *Charter of Human Rights and Freedoms* and section 7 of the *Canadian Charter* protect the right to life, liberty, integrity and security of the person. Section 10 of the *Civil Code* states that every person is inviolable and is entitled to the integrity of his person. In addition, section 4 of the *Code of ethics of physicians* stipulates that a physician must practice his profession in a manner that respects the life, dignity and freedom of the individual.

This is therefore an appropriate obligation in the context of the administration of medical care, as provided for in section 11 of the *Civil Code*:

“11. No one may be made to undergo care of any nature, whether for examination, specimen taking, removal of tissue, treatment or any other act, except with his consent. Except as otherwise provided by law, the consent is subject to no other formal requirement and may be withdrawn at any time, even verbally.

If the person concerned is incapable of giving or refusing his consent to care and has not drawn up advance medical directives under the Act respecting end-of-life care (chapter S-32.0001) by which he expresses such consent or refusal, a person authorized by law or by a protection mandate may do so in his place.”

Moreover, reiterated in section 9 of the *Act respecting health services and social services*, the obligation to respect consent to or refusal of care, once this decision is voluntary and informed, is an unambiguous duty under Quebec and Canadian

³² See also [7.1.3 Obtaining consent to care](#).

law. Thus, when a patient makes a fully informed decision, even though it may lead to his death, the physician may not disregard it, unless specifically authorized to do so by law (*Civil Code*, s. 10).

The legislation and the professional practice standards arising from the legislation provide for exceptions to obtaining consent in specific situations, such as decision making in an emergency situation, diseases for which treatment is compulsory, psychiatric examinations and confinement in an institution. Furthermore, court authorization may be requested where the person who may give consent for a minor under 14 years of age or for a person of full age who is incapable of giving consent is prevented from doing so or, without justification, refuses to do so, or if a minor over 14 years of age refuses to consent to care.

The obligation to provide information

Of course, consent will only be free and informed insofar as the patient was given sufficient relevant information about his condition, the treatment options and their respective benefits and risks. The *Code of ethics of physicians* is particularly clear in this regard:

“A physician must, except in an emergency, obtain free and enlightened consent from the patient or his legal representative before undertaking an examination, investigation, treatment or research.” (s. 28)

“A physician must ensure that the patient or his legal representative receives explanations pertinent to his understanding of the nature, purpose and possible consequences of the examination, investigation, treatment or research which he plans to carry out. He must facilitate the patient’s decision-making and respect it.” (s. 29)

Giving the patient accurate information is not required solely to obtain his consent to the proposed care, but also every time his health or physical integrity are concerned.

Case law recognizes the principle whereby good medical practice means providing the necessary information, not only at the start of the relationship but also throughout the follow-up period. The *Code of ethics* reinforces this requirement by obliging physicians to demonstrate transparency when a complication or an accident occurs:

“A physician must, as soon as possible, inform his patient or the latter’s legal representative of an accident or complication which is likely to have or which has had a significant impact on his state of health or personal integrity.” (s. 56).

The *Code of ethics* reiterates an obligation already recognized in case law, as illustrated by the Superior Court ruling in the *Kiley-Nikkel v. Danais* case in 1992. In this case, a woman discovered an unusual mass in her left breast and decided to consult a surgeon, who suspected a malignant tumour. A few days later, the patient was admitted to hospital where she consented to a biopsy and, if necessary, a mastectomy. While the patient was under anesthesia, the pathologist who received the biopsy confirmed the presence of a malignant tumour. Based on this report, the surgeon immediately performed a mastectomy. Two days later, a more in-depth analysis of the biopsy showed that it was non-malignant granulomatous mastitis, not a cancerous lesion. However, the surgeon concealed this crucial information from his patient, who did not learn the truth until six years later. In this case, the Court recognized both the pathologist's fault due to his medical error with respect to the analysis of the biopsy and the surgeon's fault for failing to disclose the second diagnosis to the patient, who then lived in fear of a recurrence of her cancer during all those years.

11.3.2 The obligation to provide attentive, prudent and diligent care

Section 7 of the *Act respecting health services and social services* confirms every person's right to receive appropriate care:

“Every person whose life or bodily integrity is endangered is entitled to receive the care required by his condition. Every institution shall, where requested, ensure that such care is provided.”

In this context, the physician, whose primary duty is to protect and promote the health of the people he treats, has the obligation to provide attentive, prudent and diligent care.

Like the other components of medical obligation, the obligation to provide care must not be assessed in relation to the outcome. The fact that the physician did not cure the patient obviously does not lead to a presumption of medical error. Moreover, the physician's conduct must not be analyzed from the standpoint of what would have been ideal. As mentioned previously, the physician's obligation is one of means. Thus, in his professional activities, the physician is required to use means as appropriate as those a competent physician with the same training would have used in the same circumstances.

The physician may also be held liable for care provided by people who were directly under his authority, such as a student or a nurse acting under the physician's direct supervision in an operating room, for example. The physician may be sued as “principal” for the fault of his “temporary subordinate”, somewhat like an employer being sued for a fault committed by an employee. The subordinate may also be sued personally. However, if the hospital staff is not under the physician's immediate authority, as in the case of a nurse providing

professional services on a unit, the physician would not be liable for any fault on the nurse's part. The nurse is herself liable, as is the hospital as the employer.

There have been cases where several physicians have been sued jointly. Section 1478 of the *Civil Code* allows the judge to apportion liability and to determine the share of the compensation to be paid by each defendant. This apportionment applies to them only and does not deprive the claimant of the right to execute the entire judgement against one of the defendants.

In addition, since the coming into force in 2007 of the *Regulation respecting the practice of the medical profession within a partnership or a company*, physicians in Quebec may practice their profession within a limited liability partnership (LLP) or a joint stock company (Inc.). Physicians who practice within a limited liability partnership or a joint stock company are not held jointly liable for the obligations of the partnership or company or of another professional as they pertain to fault or negligence committed by the latter, their subordinates or their representatives in the practice of their professional activities within the partnership or company, if they did not participate in those acts. However, the physician's professional liability toward the patient remains unchanged.

11.3.3 The obligation to provide follow-up

Failure to comply with the obligation to provide follow-up is sometimes described by lawyers as a fault by omission. Case law and doctrine establish that physicians must remain reasonably available to their clients, taking each patient's condition into account.

Moreover, the obligation to provide follow-up is specified in the *Code of ethics of physicians*:

“A physician who has undertaken an examination, investigation or treatment of a patient must provide the medical follow-up required by the patient's condition, following his intervention, unless he has ensured that another physician, another professional or another authorized person can do so in his place.

A physician who signs a collective prescription or a prescription to adjust a medication or a medication therapy must ensure that the prescription includes measures for the medical management or follow-up, if required.” (s. 32)

“A physician who refers a patient to another physician must assume responsibility for that patient until that other physician takes responsibility for the latter.” (s. 33)

Physicians must fulfil this obligation wherever they practice. They must be particularly vigilant in activity sectors where there is risk involved, such as walk-in clinics or emergency rooms, or when they cease to perform certain activities (*Code of ethics*, ss. 35, 36 and 37).

In addition, section 13 of the *Code of ethics* prohibits physicians from taking part in a concerted action of a nature that would endanger the health or safety of a clientele or population.

With respect to case law, the Superior Court, in the *Steinberg v. Mitnick* case (2016 QCCS 4749), specified that the physician's obligation to provide follow-up includes the duty to provide information and treatment:

[Translation] "A physician must inform the patient of his test results and propose the treatment that is indicated to improve his health to him. Simply instructing his assistant to contact a patient to schedule a follow-up appointment does not release the physician from his obligation to provide follow-up. However, if the patient is informed that he requires medical follow-up and fails to or neglects to make an appointment with the physician, he may not allege wrongful conduct on the part of the physician, for he has made it impossible for the latter to provide follow-up."

11.3.4 The obligation to ensure confidentiality

The patient's right to professional secrecy is recognized by the *Charter of Human Rights and Freedoms*, the *Civil Code of Québec*, the *Professional Code* and the *Medical Act*.

Furthermore, under section 20 of the *Code of ethics*, a physician, in order to maintain professional secrecy:

- > must keep confidential the information obtained in the practice of his profession;
- > must refrain from holding or participating, including on social networks, in indiscreet conversations concerning a patient or the services rendered him or from revealing that a person has called upon his services;
- > must take reasonable means with respect to the persons with whom he works to maintain professional secrecy;
- > must not use information of a confidential nature to the prejudice of a patient;
- > may not divulge facts or confidences which have come to his personal attention, except when the patient authorizes the physician to do so or

when the law authorizes or orders the physician to do so, or when there are compelling and just grounds related to the health or safety of the patient or of others;

- > may not reveal a serious or fatal prognosis to a patient's family if the patient forbids him from so doing;
- > must, when providing professional services to a couple or a family, preserve each member's right to professional secrecy;
- > must take reasonable measures to preserve professional secrecy when the physician uses, or persons working with the physician use, information technologies;
- > must record in the patient's record any communication to a third party, with or without the patient's consent, of information protected by professional secrecy.

Once the patient-physician relationship is established, any information disclosed by the former comes under the rule of professional secrecy. And even when the relationship ends, the physician must continue to comply with his obligation.

However, there are some exceptions to this rule. Under the *Code of ethics*, a physician may communicate information about a patient to a third party when the patient or the law authorizes him to do so or when there are compelling or just grounds related to the health of the patient or of others.

Indeed, certain laws authorize or oblige the physician to disclose to the director of youth protection or public health director information considered essential to the protection of the health or safety of certain persons or of the population. Section 60.4 of the *Professional Code* allows the communication of confidential information without the consent of the person concerned when there are reasonable grounds to believe that there is a serious risk of death or serious injury threatening a person or an identifiable group of persons and where the nature of the threat generates a sense of urgency. It stipulates, however, that the information may be communicated only to the people exposed to the danger, to their representative or to the people who are likely to come to their aid. The physician may only communicate such information as is necessary to achieve the purposes for which the information is communicated.

Section 21 of the *Code of ethics* specifies the items that must be entered in the medical record to document and justify such a breach of professional secrecy. Provided physicians satisfy these requirements, they cannot be accused of anything in terms of ethics or professional liability. However, the physician could be held liable if an unfortunate event resulted from a failure to alert the people in danger or the appropriate authorities.

It is important to qualify one key point with respect to confidentiality in the context of a dispute. Case law has established that the patient waives professional secrecy with respect to the professionals who provided services related to the dispute when he institutes legal proceedings against his physician. The latter is released from the obligation to maintain professional secrecy. Insofar as the confidential information is relevant, the physician may even use it for his defense.

Lastly, when it comes to professional secrecy and information technology, the physician must follow these general rules:³³

- > The physician must separate his professional life and his personal life when he uses information technology.
- > The physician must always use his judgement as to the content and quality of the information sent using information technology.
- > The physician is responsible for weighing the benefits and risks of exchanging information with a patient or colleague using technology.
- > The physician must therefore be aware of the issues raised by the use of information technology.
- > The physician must inform his patient of the benefits but also the risks of using information technology.
- > Even with his patient's agreement or consent, the physician remains responsible for maintaining professional secrecy and the confidentiality of the information he sends. Thus, even if the patient has consented to email communication, depending on the nature of the information the physician needs to send, he may sometimes have to adapt the method he uses to communicate with his patient to the situation.
- > The patient is responsible for the content of the information he sends his physician.
- > The physician must use the appropriate medium for the method of communication and the nature of the information he is sending his patient.
- > The physician must agree with his patient on the methods of communication and the safeguards that he will be using depending on the nature of the information. This agreement must be documented.

³³ See the guide published by the Collège in 2015: [*The physician, telemedicine and information and communications technologies.*](#)

- > The physician and the patient always must be aware that when they use social media, the information sent is public (can be accessed by anyone), permanent (in time) and universal (no geographic limit).

The Collège believes that communicating sensitive information electronically (or even over the telephone) is not appropriate. “Sensitive subjects” include, in particular, mental health disorders, cancer problems, drug abuse and alcoholism, sexually transmitted or blood-borne infections, the communication of a new diagnosis or a new treatment or a highly emotionally charged diagnosis or treatment.

Furthermore, in general, the physician should always agree with his patient in advance as to what information will be shared electronically. The physician must obtain informed consent to the exchange of emails and texts before the first communication with the patient.

In the case of exchanges with physician colleagues or other health professionals, the rules vary depending on whether the physician is consulting a colleague or making an informal request to one or more colleagues by email or other non-secure application. When a physician responds to a colleague’s request for a consultation, he should use only secure email, for such requests usually include the patient’s name and health insurance number. In the case of an informal request, the physician must ensure that he does not disclose information or distinguishing features that could be used to identify the patient, that he does not share photographs with distinguishing features that could be used to identify the patient, that he sends only the information required and, lastly, that he asks the colleague to destroy any photos or information sent for the purposes of the consultation.

Moreover, as mentioned in the guide published by the Collège in 2015, perhaps of all the technology tools used, social media raise the greatest number of issues for physicians, since it is virtually impossible to ensure the confidentiality of communications. In general, a physician should not use social media to give an opinion outside his area of expertise or to disseminate defamatory comments or information. Needless to say, the rules of confidentiality apply at all times.

Websites are acceptable and useful for providing public information, such as the clinic schedule, the services offered and addresses and contact information. But it is important to avoid copyright infringement and beware of the risk of providing hyperlinks to sites or information that is not recognized scientifically.

11.4 Rules concerning proof

11.4.1 Proof of the standard of care

The burden of proof lies with the claimant. Therefore, it is up to the patient to prove – usually by presenting expert evidence – that the physician has failed to comply with the accepted standard of care and has therefore committed a fault. The patient must demonstrate that the physician being sued did not give the same quality of care as would be expected of another physician with the same training in the same circumstances. The physician being sued may also produce his own expert witnesses.

Unlike criminal law, where “proof beyond a reasonable doubt” is required, a “preponderance of evidence” is the degree of proof required in professional civil liability. This means that the judge must be convinced that the existence of a fact is more probable than not. Concretely, the judge must be 50% + 1 convinced of the existence of the fact. Note that this burden is not of the same order as that of expert scientific evidence.

11.4.2 Burden of proof reversal

In some circumstances, a burden of proof reversal may be warranted with respect to both fault and causal relationship. Sections 2846 to 2849 of the *Civil Code* give the claimant a benefit of this kind when the court deems the presumptions to be “serious, precise and concordant”. The classic example is leaving a compress or an instrument in the site of a surgical procedure. It then falls to the physician to make reasonable explanations establishing that he did not commit a fault.

11.5 Prescriptive period

Any legal action must be brought within a certain time period. Failing this, the right expires and the action is “prescribed”. Actions in medical civil liability are subject to a legal prescription of three years (*Civil Code*, s. 2925). If the victim, his representative or family members do not respect this time period, the right claimed expires.

The period runs from the day the moral, bodily or material injury appears for the first time (*Civil Code*, s. 2926). Sometimes, this date will be concomitant with the commission of the fault. However, the injury may appear subsequent to the commission of the fault.

Furthermore, under section 2904 of the *Civil Code*, prescription may be suspended if the victim is able to show that it was “impossible in fact for them to act”. For example, a claimant could argue that it was impossible for him to act if

he shows that he was not aware of the wrongdoing that led to his injury, in particular in a case where a physician knowingly conceals it from him.

11.6 Compensation

In civil liability, it is clearly established that the amount granted to a victim must compensate for the loss he has sustained and the profit of which he has been deprived (*Civil Code*, s. 1611). This amount, called damages, is exigible in the form of capital payable to the victim, unless otherwise agreed by the parties (*Civil Code*, s. 1616). In medical liability, damages are paid to compensate for monetary losses and non-monetary losses resulting from the bodily injury. Once the physician has been found liable, damages may be granted to both the victim and to victims by extension, provided it is proven that the losses in question are an immediate and direct consequence of the physician's wrongdoing. Furthermore, the victim by extension must ensure that he does not claim the same amounts that he is claiming as an heir in cases that involve the patient's death.

Non-monetary losses include physical pain, moral suffering and inconveniences experienced by the victim, loss of enjoyment of life and loss of life expectancy. For victims by extension, non-monetary losses are the loss of moral support and suffering caused by the loved one's death or severe disability. This particular category of damages is one approach adopted by the courts to ensure complete reparation of the injury caused. It can be difficult to quantify these losses. Thus, in three landmark cases in the late 1970s, the Supreme Court of Canada ruled that, barring exceptional circumstances, the maximum compensation that could be granted in this situation should not exceed \$100 000. Given the rate of inflation in the last 25 years, the maximum today would be much higher.

Monetary losses include the cost of past and future care, the cost of home adjustments, where applicable and, above all, the loss of the victim's earning capacity or the loss of financial support for a family member. To assess the loss of earning capacity or financial support, one must calculate the sum of money equivalent to the amount the victim would have obtained during his active working life or the sum equivalent to the portion of this sum a family member would have received from the victim. It is up to the first judge who rules on liability to determine the amount based on actuarial evidence submitted by the parties.

Lastly, if the judge believes that, at the time of the ruling, there is not enough information on the course of the victim's physical condition, he may grant the victim the right to apply to the court again for a reassessment of his condition and to claim additional damages within a period of no more than 3 years after the ruling (*Civil Code*, s. 1615).

11.7 The civil courts

11.7.1 Action at first instance

A civil liability action can be brought before three different courts at first instance, depending on the amount claimed by the claimant (excluding interest):

- > Small Claims Court: amount not exceeding \$15 000. In this case, the parties do not have the right to be represented by a lawyer;
- > Court of Québec: amount over \$15 000 but not exceeding \$85 000;
- > Superior Court of Québec: amount of \$85 000 or more.

If a claim is submitted to the Court of Québec and one of the parties requests a change that will increase the amount under dispute or if one of the parties submits a counterclaim for an amount that exceeds the \$85 000 cap, the Superior Court then becomes the court that has jurisdiction to hear the dispute. That said, it is worth noting that the new *Code of Civil Procedure* provides for a periodic increase of the Court of Québec's jurisdictional threshold. The \$85 000 cap will therefore be raised at some point.

11.7.2 Appeal

The decision of the Small Claims Court is final and cannot be appealed. However, it is not eternal. The right that results from a decision is no longer valid if it is not exercised within 10 years of the date of the decision.

In the case of the other two courts, the Court of Appeal hears, by right, appeals in civil matters against decisions of the Court of Québec or appeals against decisions of the Superior Court if the sums involved exceed \$60 000. If not, the appeal may only be heard by leave.

The Supreme Court will agree to hear, by leave only, an appeal against a decision of the Court of Appeal that would be in the national interest or constitute a new and eminently important case. Decisions of the Supreme Court are final.

11.8 Professional liability insurance

Under the terms of the *Regulation respecting the professional liability insurance of physicians*, a physician must hold and keep in force an insurance contract for this purpose or provide proof that his employer holds an insurance contract whose coverage expressly includes that physician and that the amount of the coverage is for the minimum amounts fixed in the Regulation. Membership in the Canadian Medical Protective Association (CMPA) also meets the Regulation's requirements:

“3.01. A physician is deemed to comply with the provisions of this Regulation if he sends the Secretary of the Order, with his registration on the Membership Roll, a declaration that he is a member of the Canadian Medical Protection Association and his membership number.”

Physicians can choose between the following options:

- **Protection offered by the CMPA** — This protection is “event” based: the CMPA will defend a physician if he was a member when the event occurred.
- **Protection offered by an insurance company** — The company will assume the physician’s defence, based on the claim submitted, if it is the physician’s insurer on the date the action is brought.

In the event of a lawsuit, a physician must immediately seek help from his insurer. Indeed, it is the insurer’s responsibility to defend the physician and, if it is demonstrated that the physician committed a professional fault, to compensate the victim within the limits provided for in the insurance contract, where applicable. The physician should not try to settle the dispute himself and run the risk of adversely affecting his case and subsequently being refused coverage.

Note that the CMPA may refuse to pay compensation to a victim if the physician’s fault was the result of a completely intentional act unrelated to a medical activity. This is what we learned from the *Shannon v. Canadian Medical Protective Association* decision. In this 2016 decision, the Court of Queen’s Bench of New Brunswick did a lengthy analysis of the CMPA and recognized the Association’s authority to deny protection in cases of sexual misconduct.

Moreover, the insurance contract must stipulate that the coverage provided by the insurer must extend to any claim filed against the physician for the five years following the year in which he no longer has an obligation to maintain liability coverage or in which he ceases to be a member of the order.

Exceptions

Under section 3.03 of the Regulation, a physician is not required to hold and maintain in force an insurance contract providing coverage against his professional liability:

- (1) if he does not exercise any of the activities stipulated in section 31 of the *Medical Act* under any circumstances;
- (2) if he practices his profession exclusively outside Québec.

According to section 31 of the *Medical Act*, the practice of medicine consists in assessing and diagnosing any health deficiency in a person in interaction with their

environment, in preventing and treating illness to maintain or restore health or to provide appropriate symptom relief.

The following activities in the practice of medicine are reserved to physicians:

- (1) diagnosing illnesses;
- (2) prescribing diagnostic examinations;
- (3) using diagnostic techniques that are invasive or entail risks of injury;
- (4) determining medical treatment;
- (5) prescribing medications and other substances;
- (6) prescribing treatment;
- (7) using techniques or applying treatments that are invasive or entail risks of injury, including aesthetic procedures;
- (8) providing clinical monitoring of the condition of patients whose state of health is problematic;
- (9) providing pregnancy care and conducting deliveries;
- (10) making decisions as to the use of restraint measures;
- (11) deciding to use isolation measures in accordance with the *Act respecting health services and social services* and the *Act respecting health services and social services for Cree Native persons*; and
- (12) administering the drug or substance allowing an end-of-life patient to obtain medical aid in dying under the *Act respecting end-of-life care* (chapter S-32.0001).

11.9 Record keeping

We cannot overemphasize the importance of creating good medical records in private practice and of entering all the required notes in records in institutions. Not only are these records essential to care, but they are the best means of establishing the facts in the event of a dispute. A decision rendered by the Court of Appeal in the *Bérubé* case (J.E. 2003-769, C.A.), states:

[Translation] “I am in agreement with the appellant’s legal counsel when he pleads that we must rely primarily on the notes in the medical record and, unless there are clear and plausible explanations, we must consider that what was not noted, was not in principle done.”

12. Physicians' obligations under certain laws

As explained previously, physicians practice their profession in a legal environment. Like all other citizens, they are subject to the rules (laws and regulations) society has imposed on itself and they must practice medicine while respecting certain rights, such as the right of every person to integrity and inviolability, to privacy and to professional secrecy. Physicians are sometimes permitted, however, to override these rights in order to care for and protect the individual or the population.

It is therefore important to first present an overview of the main legislation that provides for exceptions to fundamental rights which, in turn, imposes particular obligations on physicians.

12.1 The *Civil Code of Québec*

Section 10 of the *Civil Code of Québec* establishes the right of every person to integrity and inviolability.

Surgical procedures, medical care, experiments and confinement in an institution violate this right. However, since they are necessary for the person's well-being, the legislator provides a framework and establishes strict conditions for these violations. Justified violations are permitted if the person consents to them or if they are provided for by law.

An entire division of the *Civil Code*, that is, sections 11 to 25, is devoted to care and focuses on two themes: consent and the nature of the care. The term "care" encompasses every kind of examination, specimen collection, treatment or procedure of a medical, psychological or social nature, required or not by the person's physical or mental health.

Consent to care must not only be obtained, but it must be free and informed, meaning that the person gives it without undue coercion or pressure after having received sufficient information. The person consents on his own behalf. Exceptionally, a third party may authorize a violation of the integrity of a person under his charge or protection. This is called a substituted consent to care, in particular for a minor under the age of 14, a minor 14 years or older depending on the nature of the care and the circumstances, or an incapable person of full age. Note that the fact that a person is legally incapable does not necessarily rule out their being able to refuse or consent to care. Indeed, the incapacity may sometimes be limited to the administration of property. In other cases, the incapable person may understand the scope of the care and its effects. He may therefore voluntarily consent to or refuse care. In emergency situations, consent to care is not required if the person's life is in danger or his integrity is threatened and his consent cannot be obtained in due time. It is required, however, where the

care is unusual or has become futile or where its consequences could be intolerable for the person.

Consent is usually expressed verbally. However, section 24 of the *Civil Code* stipulates that consent must be given in writing if the care is not required by a person's state of health or if it involves alienation of a part of a person's body or an experiment. However, it may be withdrawn verbally at any time.

Confinement in an institution and mandatory psychiatric examination are exceptional care measures. They deprive the person of his physical freedom and require him to undergo an examination that violates his right to integrity and inviolability. This is why the legislator considered it appropriate to dedicate an entire division to them. Sections 26 to 31 of the *Civil Code* provide a rigorous framework for these interventions and establish the general law in this regard which, moreover, is addressed in other laws, such as the *Act respecting the protection of persons whose mental state presents a danger to themselves or to others*.

Note that dangerousness is the criterion adopted in the legislation for this type of protective supervision. A number of factors are analyzed when assessing the danger a person presents. The legislator therefore requires that an expert psychiatric assessment be carried out in order to evaluate and determine the level of dangerousness. The *Civil Code*, however, authorizes preventive confinement of a person when the danger is serious and immediate.

12.2 *The Act respecting the protection of persons whose mental state presents a danger to themselves or to others*

The protective measures set out in the *Act respecting the protection of persons whose mental state presents a danger to themselves or to others* (APPMS)³⁴ complements the more general provisions of the *Civil Code* with respect to the psychiatric examination and forced confinement. All these legislative provisions are intended to protect everyone, in particular by authorizing, in the absence of consent, a psychiatric assessment or confinement of a person who presents a danger to himself or others owing to his mental state.

The Act provides for three types of forced confinement: preventive confinement, temporary confinement and confinement in an institution.

Since they are measures that involve deprivation of liberty and allow an exception to the principle of the inviolability of the person, they must be applied in a strict and prudent manner. Preventive confinement, an emergency measure when there are reasons to believe the danger is grave and imminent, is the only type of confinement that may take place without the person's or his proxy's consent or

³⁴ CCQ, ss. 26 and 27.

the authorization of the court.³⁵ Section 7 of the APPMS reiterates the notion defined in the *Civil Code* with respect to preventive confinement when the danger is grave and imminent. However, it specifies that the power to impose preventive confinement is given to physicians in institutions only and may not exceed 72 hours. Once this period has expired, the person must be released unless the court has ordered an extension of the confinement so that the person may undergo a psychiatric examination. The Act also stipulates that a peace officer may be called upon to bring the patient, against his will, to the institution (s. 8).

Note that preventive confinement does not authorize a psychiatric assessment or treatment against the person's will. In the event of refusal, a court order will be necessary to require the person to undergo treatment.

As soon as the person has been taken in charge by the institution, or as soon as he seems able to understand the information, the institution must inform him of the place where he is being confined, of the reasons for the confinement and of his right to contact his close relatives and an advocate immediately (APPMS, s. 15). It must also give him, if placed in authorized confinement, a document consistent with the schedule to the Act regarding his rights and recourses. In addition, the person under confinement must be immediately informed by the institution of the end of the confinement (APPMS, s. 18).

When the court has authorized confinement for more than 21 days,³⁶ the person under confinement must be examined periodically to ascertain whether continued confinement is necessary. The institution in which a person is under confinement must inform the court without delay of the conclusions of each of the psychiatric examination reports and of the end of the confinement (s. 20).

12.3 The *Public Health Act*

The purpose of this Act is to protect the health of the population and to establish conditions favourable to the maintenance and improvement of the health and well-being of the general population. The objective of some of the measures in this Act is to enable public health authorities to engage in health monitoring activities and to give them the necessary powers to take action in cases where the health of the population is threatened.

Thus, under section 82 of the Act, the physician must report to the public health director any infection, disease or intoxication on the list of reportable diseases. Furthermore, a physician who suspects the presence of a threat to the health of the population, other than a reportable disease, must notify the public health director in his territory (s. 93). It should be noted that this reporting is mandatory

³⁵ CCQ, s. 27, pars. 2, 28 and 31; APPMS, ss. 2 and 3.

³⁶ CCQ, ss. 28 to 31; APPMS, s. 10.

and that physicians who neglect to do so are committing an offence and are liable to a fine.

Reporting procedures and the list of reportable diseases are updated regularly. There is now only one [report form](#): the AS-770. This form is also used for reporting sexually transmitted infections, which is now nominal. To promote screening for sexually transmitted and blood-borne infections (STBBIs) in vulnerable populations, there are, however, integrated services that provide screening on an anonymous basis.

Physicians must send their reports to the public health director in their territory in the 48 hours following the consultation. Diseases under extreme surveillance must be reported immediately by telephone or fax to the national director of public health as well as to the public health director in the territory.

12.4 The Highway Safety Code

Under the *Highway Safety Code*, the physician has a discretionary obligation to report to the Société de l'assurance automobile du Québec (SAAQ) [Quebec automobile insurance board] the state of health of a patient he considers unfit to drive a road vehicle. In this situation, it is advisable for the physician to speak to the patient and give him his opinion on his state of health and the risk it represents when driving. However, if the physician has reason to believe that his patient will not obey the driving ban and presents a serious risk to public safety when driving a vehicle, he may inform the SAAQ of this.

Note that this type of reporting constitutes a legally authorized departure from the rules of professional secrecy; therefore, the physician does not need to obtain the patient's permission. Furthermore, the law protects him against being sued for damages for having reported the situation.

The *Regulation respecting the health of drivers* establishes the standards used to determine a driver's fitness to drive and the restrictions necessary given his state of health. When there is doubt about a patient's ability to drive a vehicle, the physician should recommend that the patient undergo an exhaustive assessment of his driving ability.

The Collège has produced a guide on the topic entitled [L'évaluation médicale de l'aptitude à conduire un véhicule automobile](#) (Medical assessment of fitness to drive a motor vehicle; available in French only) (March 2007).

12.5 The Act respecting the determination of the causes and circumstances of death

This Act stipulates that a physician who certifies a death for which he is unable to establish the probable causes or which appears to have occurred as a result of negligence, in obscure or violent circumstances, must immediately notify a coroner or peace officer. It also establishes that the coroner must be notified when a death occurs in a reception centre, rehabilitation centre, adapted work centre, correctional facility, penitentiary, security unit within the meaning of the *Youth Protection Act* or police station.

The same applies to the death of a person placed under confinement in a health institution, a child in the custody of the holder of a permit issued by the Ministère de la Famille, des Aînés et de la Condition féminine [Ministry of families, seniors and the status of women] and a person in the care of a foster family or a family-type resource. However, in all cases, the Act stipulates that the director of the place in question or the person in authority there must notify the coroner. The physician should nonetheless remain vigilant and make certain that these deaths are also reported to the coroner.

12.6 The Automobile Insurance Act, the Act respecting occupational health and safety, the Act respecting industrial accidents and occupational diseases

The purpose of these acts is, in particular, to give rights and remedies to people who are victims of injuries of a physical or psychological nature caused by a motor vehicle accident or injuries “arising out of or in the course” of their work.

A physician who takes charge of a worker who has suffered an employment injury, work accident or motor vehicle accident must, within the prescribed time period and based on the patient’s condition, produce the required reports and certificates. These reports by the attending physician are necessary, for they enable patients to assert their rights and obtain compensation.

Diligence is called for when assessing this particular kind of patient. The physician must first determine whether the patient’s condition is due to an occupational disease or injury, a work accident or a motor vehicle accident and then collect all the information needed to complete the forms to be sent to the administrative agencies responsible for enforcing these laws.

12.7 Communication of information to law enforcement authorities

The Collège has published a [memory aid](#) (in French only) that physicians and police officers can use to quickly identify which of Quebec's various laws apply to the situation and to find out the associated reciprocal obligations with respect to the communication of personal information and professional secrecy.

CONCLUSION

Quebec has inherited a complex legal system. On the one hand, constitutional laws have established the federal and provincial governments' fields of jurisdiction. As a result, the practice of medicine in Quebec is subject to federal legislation, in particular criminal law, and to various Quebec laws, including the *Professional Code*, the *Medical Act* and the *Civil Code*. On the other hand, while public law in Quebec is British in tradition, private law comes from French law, with a British influence. Lastly, Quebec and the federal government have both adopted a charter of rights that guarantees the citizen of certain fundamental rights and makes other laws subject to the requirements of the charters. They have also adopted several other laws that have a more or less direct bearing on the practice of medicine.

Finding one's way through this legal and legislative maze is not easy for physicians. Indeed, the same medical act can bring into play the application of:

- > a provision of the charter that protects, for example, the integrity of the person. A violation of this provision may result in a conviction with damages and, when the fundamental rights violation is "illegal and intentional", a conviction with exemplary damages;
- > the *Code of ethics of physicians* if the act violates a standard of conduct that physicians have imposed on themselves, which in turn may lead to disciplinary measures, the primary purpose of which is to protect the public;
- > civil liability if a wrongful act also caused injury to another;
- > a penalty in the form of a fine imposed by the court if, in the practice of his art, the physician disregarded a provision of a particular law or a regulation.

While they are different, these mechanisms are part of a body of legislative measures that assures the population of quality care. While civil liability is primarily intended to compensate patients who have sustained an injury, this mechanism is also linked to professional obligations and medical ethics in the same way as medical ethics are linked to laws that have a bearing on the practice of medicine.

Provided these laws and regulations are also perceived as references, whose purpose is not to hinder but to guide, they should, in practice, facilitate decision making for physicians and patients alike. Indeed, these decisions should take into account societal choices, the professional obligations of physicians, the rights and expectations of patients as well as the interests and convictions of all.

LIST OF ACRONYMS AND INITIALISMS

ACMDPQ	Association des conseils des médecins, dentistes et pharmaciens du Québec [Association of councils of physicians, dentists and pharmacists of Québec]
AHSSS	Act respecting health services and social services
AMC	associated medical clinic
AMHSSN	Act to modify the organization and governance of the health and social services network, in particular by abolishing the regional agencies
APC	Admission to Practice Committee
APPMS	Act respecting the protection of persons whose mental state presents a danger to themselves or to others
BD	Board of Directors
CFPC	College of Family Physicians of Canada
CHSLD	centre d'hébergement et de soins de longue durée [residential and long-term care centre]
CISSS	centre intégré de santé et de services sociaux [integrated health and social services centre]
CIUSSS	centre intégré universitaire de santé et de services sociaux [integrated university health and social services centre]
CLSC	centre local de services communautaires [local community services centre]
CMA	Canadian Medical Association
CMEA	Committee on Medical Education and Accreditation
CMPA	Canadian Medical Protective Association
CNESST	Commission des normes, de l'équité, de la santé et de la sécurité du travail [Labour standards, pay equity and occupational health and safety board]
Collège	Collège des médecins du Québec [Quebec college of physicians]
CPDP	council of physicians, dentists and pharmacists
CPEJ	centre de protection de l'enfance et de la jeunesse [child and youth protection centre]
CQMF	Collège québécois des médecins de famille [Quebec college of family physicians]
CSSS	centre de santé et de services sociaux [health and social services centre]
DPS	director of professional services
DRMG	département régional de médecine générale [Regional department of general medicine]

FMEQ	Fédération médicale étudiante du Québec [Quebec federation of medical students]
FMG	family medicine group
FMOQ	Fédération des médecins omnipraticiens Québec [Quebec federation of general practitioners]
FMRIQ	Fédération des médecins résidents et internes du Québec [Quebec federation of medical residents and interns]
FMRQ	Fédération des médecins résidents du Québec [Quebec federation of medical residents]
FMSQ	Fédération des médecins spécialistes du Québec [Quebec federation of medical specialists]
HC	hospital centre
HIA	Health Insurance Act
ID	Inquiries Division
Inc.	joint stock company
INESSS	Institut national d'excellence en santé et en services sociaux [National institute for excellence in health and social services]
INSPQ	Institut national de santé publique du Québec [National public health institute of Quebec]
LLP	limited liability partnership
MED	Medical Education Division
MSSS	Ministère de la Santé et des Services sociaux [Ministry of health and social services]
OMIR	Organization and Management of Institutions Regulation
OPQ	Office des professions du Québec [Quebec office of professions]
OQLF	Office québécois de la langue française [French language board of Quebec]
PED	Practice Enhancement Division
PEM	plans d'effectifs médicaux en médecine de famille et en spécialité [medical staffing plans in family medicine and in specialties]
PIC	Professional Inspection Committee
PREM	plans régionaux d'effectifs médicaux [regional medical staffing plans]
QHR	Québec Health Record
QPHP	Quebec Physicians Health Program
RAMQ	Régie de l'assurance maladie du Québec [Quebec health insurance board]
RC	rehabilitation centre
RCPSC	Royal College of Physicians and Surgeons of Canada

RUIS	réseau universitaire intégré de santé [integrated university health network]
SAAQ	Société de l'assurance automobile du Québec [Quebec automobile insurance board]
SERTIH	Service d'évaluation des risques de transmission d'infections hématogènes [Service for the assessment of the risk of transmission of hematogenous infections]
SMA	specific medical activity
SMC	specialized medical centre
SNP	specialized nurse practitioner
STBBI	sexually transmitted and blood-borne infection

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