SIGNALS

A Publication of Signal Regulatory Solutions

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Welcome

SIGNALS is a newsletter published by Signal Regulatory Solutions, a consulting service dedicated to helping regulators and other organizations continuously improve their operations.

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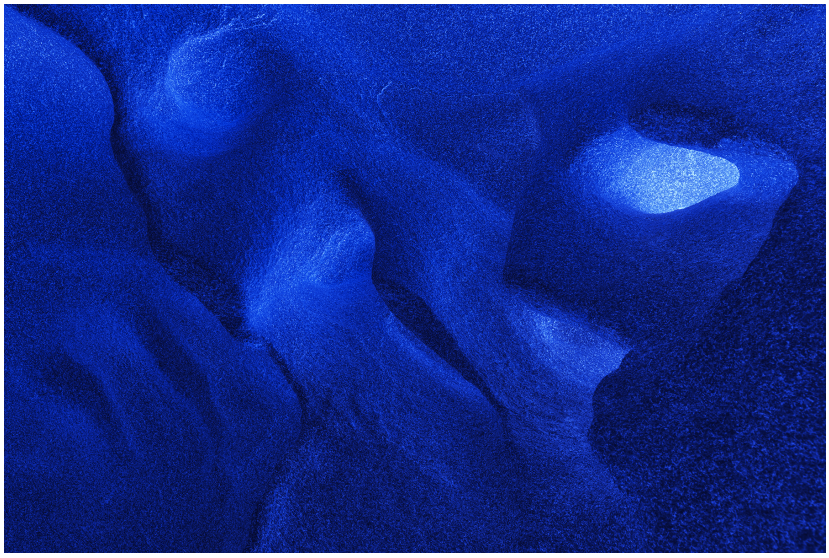
- ✓ Regulatory Modernization
  Continuous improvement of regulatory operations; systems and processes
- ✓ Leadership Development
  Workshops, training and coaching
- ✓ Performance Measurement
  Development of meaningful key performance indicators

This Issue

This issue of SIGNALS explores the regulatory challenges of managing professionals whose health problems are affecting their practices and putting patients and clients at risk.



Professional Regulators: How well are you dealing with professional incapacity?

When we think of professional regulation and the public protection mandate, our minds drift to headline issues such as professional misconduct (failure to maintain the standard, sexual abuse, misappropriation of trust finds, fraud, etc.) and incompetence (lack of knowledge, skill or judgment).

But today, we are going to discuss another area of significant regulatory risk to the public, one that is less clearly understood and less well-managed by regulators: professional incapacity, or the problems posed by professionals whose health conditions may adversely affect their practices and put their clients or patients at risk. Think of the lawyer hobbled by major depression, the accountant with advancing dementia, the nurse with an opioid addiction, or the doctor with bipolar illness. In each case, if the condition is not under adequately control, or the professional's practice not suitably restricted, the public is at risk.

Under the Health Professions Procedural Code of Ontario's Regulated Health Professions Act, 1991, the term "incapacitated",

6 Things You Need to Know about Professional Incapacity

1. Professional incapacity refers to the state of a regulated professional whose health condition may be impairing the ability to practise safely or meet professional obligations, and may pose risk to the public.
2. Many health conditions can lead to professional incapacity, including depression, substance use disorder, bipolar disorder, anxiety disorder, and dementia.
3. Conditions that are minor, under control with treatment, in remission, and/or not relevant to practice may not impair professional capacity.
4. Professional regulators should consider developing a corporate policy regarding professional health, incorporating human rights principles.
5. With a dedicated incapacity program, professional regulators can take a non-punitive approach to working with incapacitated professionals.
6. Special expertise is needed to design and operate incapacity programs for professional regulators.

Want help with your incapacity program?

Signal is here to help. We are experts in designing, reviewing, evaluating and improving professional incapacity programs for regulators. Email Angela Bates: angela.bates@signalregulatory.com

> …means, in relation to a member, that the member is suffering from a physical or mental condition or disorder that makes it desirable in the interest of the public that the member's certificate of registration be subject to terms, conditions or limitations, or that the member no longer be permitted to practise…

Under Ontario's Law Society Act, 1990, the term "incapacitated" means that,

> A licensee is incapacitated for the purposes of this Act if, by reason of physical or mental illness, other infirmity or addiction to or excessive use of alcohol or drugs, he or she is incapable of meeting any of his or her obligations as a licensee.

The more-recent Chartered Professional Accountants Act of Ontario, 2017, defines the term very similarly to the definition under the Law Society Act.

In each case, the underlying meaning is similar, encompassing professionals with health conditions that may affect their ability to safely and competently practise their profession and meet their obligations.

It is essential here to remember that regulators are not concerned with professionals' health conditions that do not affect practice, because the condition is minor, in remission, under control with treatment, or not relevant to the ability to practise safely.

A broad range of health conditions and disorders can lead to varying degrees of professional incapacity.

Mental health disorders are at least as common - in some cases, more so - amongst regulated professionals as the general population. This category includes conditions such as substance use disorder (e.g., use of alcohol and/or prescription, non-prescription or illegal drugs), depression, bipolar disorder, anxiety disorder, schizophrenia or schizoaffective disorder, delusional disorder, adjustment disorder; personality disorders, post-traumatic stress disorder, and attention deficit hyperactivity disorder.

Neurocognitive disorders, include dementia related to illnesses such as Alzheimer's Disease, vascular disease, traumatic brain injury, and Parkinson's

Disease. As discussed below, this category of health conditions is becoming more common due to the ageing of the professional population.

Physical conditions such as tremor, impaired vision or hearing may affect some professionals' ability to practise safely, depending on the severity of the condition and nature of practice.

Regulators are advised to educate staff to increase general awareness of relevant health conditions. A word of caution here: regulatory staff, even those with health backgrounds, are not acting as clinicians. When dealing with professionals who may be incapacitated, they must avoid using any diagnostic terminology, or worse, trying to arrive at a diagnosis! Staff should be encouraged to use lay terminology to plainly describe their interactions with and observations of potentially incapacitated professionals.

Why do professional regulators struggle to effectively manage professional incapacity?

Reason #1: Legislative limitations

First – not all enabling regulatory legislation explicitly addresses the subject of incapacity. In Ontario, the Regulated Health Professions Act, the Law Society Act and the newer Chartered Professional Accountants of Ontario Act are all examples of legislation that specifically address incapacitated licensees. The impetus behind such legislation is the (badly-named but well-intended) "disease" model of mental health and addictions, which sets out a separate, non-punitive regulatory process for dealing with impaired professionals.

But there remain many examples of regulatory legislation across Canada that do not provide such an option. How do these regulators deal with the issue? Almost invariably, practising while impaired is considered an act of professional misconduct under the respective regulations, and therefore disciplinable. Lacking a defined incapacity process, regulators may believe they have little option but to proceed along this course. While there are times when taking such action may be prudent, it is always best to have more regulatory tools in the toolkit, and having a separate professional incapacity process is ideal.

Reason #2: Lack of staff comfort levels, knowledge and expertise

The residual taboos around – or at least discomfort with -– the subjects of mental health and addictions apply to professionals – even health professionals. This barrier may therefore be the result of lack of subject matter knowledge, unconscious bias, moral judgment, or simple discomfort.

Regulatory staff tend to have some combination of specific regulatory expertise, and/or professional

domain expertise; but they do not generally have occupational backgrounds that equip them to feel competent to deal effectively with impaired professionals. This gap is particularly pronounced when the regulator is small, and unable to afford the luxury of a larger staff with varied expertise.

Bearing in mind the frequent expertise gap in this area, and the fact that incapacity matters do not necessarily enter the regulatory system clearly labelled as such, staff may miss vital warning signs while investigating a conduct or competence issue.

Even where proper identification of incapacity is not in issue, staff may simply not understand how best to communicate with the incapacitated individual.

Finally, the process of an incapacity investigation differs significantly from conduct or competence investigations – and may include steps such as obtaining and reviewing the professional's health records or facilitating an independent medical examination. Again, such work may not be a natural fit for the skill sets of regulatory staff.

Suggestions for how regulators can improve their management of incapacitated professionals are set out below.

How are professional incapacity issues detected by the regulator?

Regardless of the specific provisions of your enabling legislation, the issue of professional incapacity is clearly pressing from a risk management perspective. But consider, first, the challenges in merely detecting the problem.

Health conditions that may lead to professional incapacity

First – as noted earlier, not every health condition will affect a professional's ability to practise safely. Health conditions may be minor in nature, in remission, under adequate control, or the professional may have self-limited practice.

As well, a health condition may not be relevant to a licensee's ability to practise safely. Consider the difference between a psychologist and a neurosurgeon being diagnosed with a tremor. Depending on the reason for the tremor, the psychologist may continue to practise indefinitely, even if the tremor is not well-controlled. However, the neurosurgeon will likely need to restrict surgical practice immediately, in favour of office and academic work.

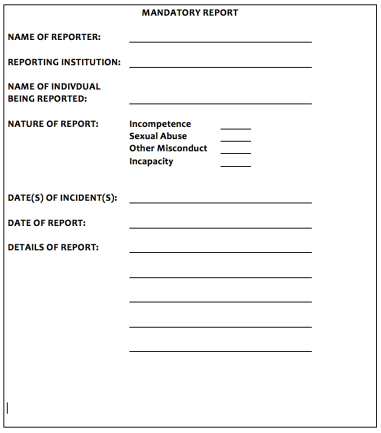
Professional self-management

Professional regulators rely as a first line of defence, on licensees' sense of professional responsibility to effectively manage their own health conditions, via appropriate treatment, and/or self-restriction, or self-removal from practice until they are well again. While ideal, such responsible actions require a high degree of insight, which the individual may lack by virtue of the health condition itself, which is complicated when the affected professional also lacks the financial capacity to reduce practice hours, or to take a leave. This is a surprisingly common problem, even in the generally better-remunerated professions such as medicine and law.

Mandatory reporting of suspected incapacity

Otherwise, regulators rely on others to report professionals with suspected incapacity.

Some individuals, such as employers and facility operators under the Regulated Health Professions Act, have a mandatory obligation to report suspected incapacity of a health professional to the regulator. Even where such an obligation does not apply, other persons such as colleagues, pharmacists, or police, acting in their own professional capacity, may report concerns to the regulator. Occasionally, even health professionals who are treating the affected professional may report suspected incapacity to the regulator, on the basis of a perceived ethical obligation, even breaching confidentiality if consent is not forthcoming.



MANDATORY REPORT

NAME OF REPORTER: _____

REPORTING INSTITUTION: _____

NAME OF INDIVDUAL BEING REPORTED: _____

NATURE OF REPORT: Incompetence ____
Sexual Abuse ____
Other Misconduct ____
Incapacity ____

DATE(S) OF INCIDENT(S): _____

DATE OF REPORT: _____

DETAILS OF REPORT: _____

Based on my own admittedly anecdotal experience, it appears to be much less common for friends, family or even patients to report suspected incapacity of a professional to the regulator. Whether this is driven by lack of knowledge of regulatory responsibility for such matters, or an unwillingness due to other factors is not clear.

Another question meriting exploration is the point at which the professional's problem becomes sufficiently apparent to others to trigger a report. This question relates to the awareness, knowledge, and willingness of those who are required to report.

First – mandatory reporters need to be aware both of their duty to report suspected incapacity and of where the report should be filed. This is an area of surprising uncertainty for many would-be reporters. In some cases, individuals simply fail to appreciate either the duty to report altogether, or else the threshold for triggering the duty.

Second – just as regulatory staff often lack knowledge of common health conditions that can imperil safe practice, so too do employers, facility operators, colleagues, etc.

Thresholds of detection and reporting

Mental health disorders such as depression and bipolar and anxiety disorders have the potential to seriously interfere with safe practice, but employers and colleagues may not feel able to make a judgment call that may result in a licence restriction or suspension. How well do they know the professional? Is the person merely eccentric, or gregarious, as opposed to hypomanic? Are they dealing with personal stressors? The lines are not always so clear.

Substance use disorders (addictions) pose their own challenges for reporters. Affected individuals may well be in denial about their condition, and may appear to be high functioning for a considerable period. The effects on practice may be subtle at first: a bit of absenteeism, "presenteeism", lateness, or failing to meet deadlines – all of which could be

indicative of any number of problems. Often, the full impact of the disorder on practice may only emerge later, as the professional's condition worsens.

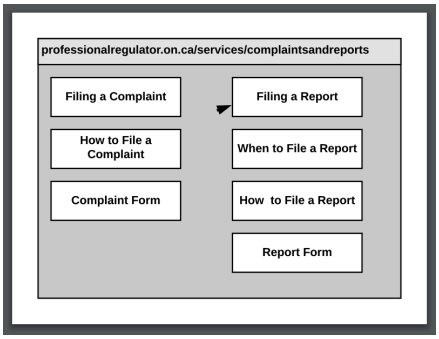
With the demographic surge in professionals now practising into their 60s and 70s, age-related dementia from conditions such as Alzheimer's Disease raises a serious risk to safe professional practice. This is particularly true because such dementia does not tend to strike suddenly; in its earlier phases, affected individuals experience "mild cognitive impairment" (MCI), which may be difficult to distinguish from mere forgetfulness or distractedness, at least for a period.

However, while individuals with MCI can still effectively manage everyday tasks, especially with tools such as reminders and checklists, professional judgment may be subtly affected even in these early stages. For example, experienced physicians develop pattern recognition within their fields, so that they are often able to more quickly diagnose a condition than their less experienced counterparts. However, physicians also need to be able to recognize, process, retain and apply novel information to be effective practitioners. MCI affects this ability, but again, it may take some time for these effects to make themselves apparent to others.

What can regulators do to ensure that individuals and institutions with a mandatory duty to report suspected incapacity comply with that duty?

Regulators should partner with stakeholder groups such as employers and professional associations, in order to improve awareness of professional incapacity generally, and specifically, any duties to report outlined in legislation. This can be accomplished through a variety of mechanisms.

The regulator's website should contain prominent information, clearly written and supported by visual aids such as flowcharts, explaining the problem of professional incapacity, any mandatory report duty, and the advisability of filing voluntary reports where no mandatory duty exists.



The regulator's website should include a prescribed mandatory report form, preferably with data fields that can be completed online, setting out the duty and prompting the reporter to include relevant information.

Finally, potential reporters should be encouraged to contact the regulator's call centre if they are in any doubt.

The regulator may also wish to conduct outreach via webinars and "road shows" for employers and facility operators, or other stakeholders with a duty to report.

If it becomes apparent that an individual or institution failed to comply with the duty to report, it is advisable to follow through on the lapse. Failure to report is a very serious matter, and it is essential that the regulator try to determine and address the cause(s) behind such failure.

What do regulatory incapacity processes look like?

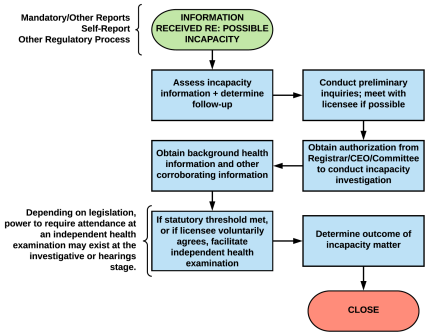
The regulator's enabling statute (and regulations and bylaws) will largely shape the broad outlines of the regulator's approach to dealing with potentially incapacitated professionals.

As noted above, some enabling legislation is silent on the subject of incapacity, except to state that practising while impaired is an act of professional misconduct. In such cases, the regulator may be forced to develop workarounds, such as negotiating appropriate undertakings (including ceasing to practise, restricting practice, and/or health monitoring) to conclude what would otherwise be an incapacity investigation.

Those professional regulators fortunate enough to have an explicit incapacity process in their enabling legislation generally fall into two categories.

Some regulators, such as those empowered under the Regulated Health Professions Act, are able to carry out distinct incapacity investigations, which may include steps such as:

- obtaining the professional's background health information (on consent)
- obtaining other relevant documentary information (e.g., criminal charges)
- interviewing others with information about the professional's behaviour;
- where there is risk to the public, restricting the professional's practice, or suspending the professional's certificate of registration, on direction of the appropriate statutory committee; and
- facilitating an independent medical or psychological examination(s), which may be compelled on the direction of the appropriate statutory committee; if the professional fails to attend, the professional may be suspending until he or she submits to the examination.



If the matter cannot be resolved satisfactorily at the investigative level, it can be referred for a closed hearing before a hearing panel, to determine whether the professional is incapacitated.

Other regulators, such as the Law Society of Ontario, may follow the same steps as above, except that medical or psychological examinations may only be conducted on a voluntary basis at the investigative level. If the professional is not cooperative with a voluntary examination, only a hearing panel may compel such an examination.

Generally, then, the work of managing incapacity matters falls somewhere between investigative and hearing committees and processes, which in turn dictates the rules of evidence, and powers of the committee.

In addition, professional regulators are always free to prosecute a professional for practising while impaired, and to investigate and prosecute for misconduct that may be related to the professional's health condition. These are decisions within the discretion of the staff and/or committees empowered under the relevant legislation; but they should always be made in

accordance with the regulator's policy or approach to incapacitated licensees, and the precepts of procedural fairness. See discussion below re: What can regulators do to enhance their own management of incapacitated professionals?

What are "diversion" programs, and how do they work?

An additional factor to consider is whether there is access to an appropriate diversion program for incapacitated professionals.

Often, professionals have access to a member or employee assistance program through their employers, associations or regulators (MAPs or EAPs). These programs provide fully-confidential support and assistance to professionals, including counselling and referrals. However, they do not have any reporting relationship whatsoever with regulators, and do not generally provide ongoing monitoring of the professional's health status. Thus, while it may provide some reassurance to the regulator if the professional indicates they have enrolled with a MAP or EAP, the regulator will have no way of immediately knowing whether the professional has undergone assessment or treatment under the MAP's recommendations and whether they have progressed or experienced a significant relapse.

Some regulators are fortunate to have access to full diversion programs, often operated by the professional association. These programs provide not only the basic MAP/EAP services, but may also provide:

- in-depth health assessment;
- assistance with facility admission;
- referrals to psychiatrists, addictionists, psychologists, counsellors, and group programs;
- forensic urine/blood/hair analysis; and
- ongoing monitoring.

In Canada and the U.S., for example, most provincial and state medical regulators are able to refer incapacitated physicians to physician health programs (PHPs) operated by their respective medical associations.

The added advantage to such diversion programs is that while the regulator and the PHP operate separately, and confidentially, they will likely have an agreement (or relapse reporting protocol). These ensure that physicians referred to the PHP by the regulator are monitored by the experts (the PHP), with some minimal information reported back to the regulator, such as brief annual progress reports, and reporting of certain relapses or breaches of monitoring agreements. This relieves the regulator of the burden of trying to directly monitor a professional's health status, and provides some privacy of health information to the monitored professional.

Where the regulator has sufficient confidence in the diversion program, it may be able to bypass full incapacity investigations and hearings if the professional has enrolled in the

program. This represents a considerable cost savings for the regulator, as well as a more private approach for the professional.

What are the health information privacy and human rights implications for regulators when dealing with potentially incapacitated professionals?

Whenever professional regulators deal with licensees who may be incapacitated, a number of obligations arise from external statutory sources.

First, regulators will often collect health information relating to the affected professional, including background health records and independent medical examinations required during the regulatory process. As such, regulators should consider whether they are health records custodians for the purposes of health information privacy legislation. Such information is accorded a higher level of privacy, even above the confidentiality obligations outlined in the enabling regulatory statute. Consult with the regulator's privacy officer, or external privacy counsel, to develop procedures for appropriately managing such information.

As well, regulators who deal with potentially incapacitated professionals should be aware of the requirements of human rights legislation within their jurisdiction. The kinds of mental health conditions, substance use disorders, dementia and movement disorders we have referred to here are disabilities under human rights legislation, which is likely applicable to the professional regulator. Again, regulators should consult with counsel with human rights expertise to help design procedures to ensure that incapacitated professionals are properly accommodated by the regulator, regardless of which regulatory process is germane (e.g., incapacity investigations, misconduct or incompetence investigations, quality assurance processes, trusteeship processes, etc.).

What can regulators do to enhance their own management of incapacitated professionals?

Determine the regulator's policy regarding professional health and incapacity

A regulator's approach to health conditions affecting regulated professionals, and more specifically, the subject of professional incapacity is not a black-and-white matter. The subject is considerably more complicated, touching on risk management, professional responsibility, individual moral beliefs, and professional and institutional norms and culture.

At the corporate level, regulators should consider developing a policy statement, or at least a corporate position regarding the regulator's approach to dealing with professionals with mental health (or other health issues) generally, and specifically, those that may affect professionals' ability to practise safely. The policy should specifically incorporate applicable human rights principles, such as the duty to accommodate disability.

See for example, the recent respective mental health task force reports of the Law Society of British Columbia, and the Law Society of Ontario.

All professional regulators must ensure that they have a coherent, fair, sympathetic approach to dealing with incapacitated professionals, regardless of whether they are fortunate enough to have the right legislative mechanisms.

When formulating policy

In formulating its policy, the regulator should consider the following.

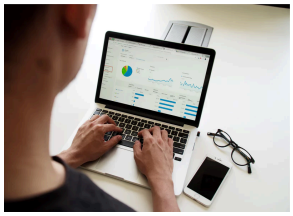
- Should professional regulators, which have traditionally operated more reactively, concern themselves with promoting the health of regulated professionals generally? Or should the regulator focus only on managing information about possible incapacity of a specified professional received by the organization?
- What are the specific risks to the public posed by professional incapacity?
- Does the regulator prefer to use an enforcement/deterrence approach, or an ameliorative ("disease" model) approach emphasizing rehabilitation, or elements of both?
- What is the dividing line between enforcement and rehabilitation? At which point is misconduct excusable on the basis of a relevant health condition that might explain the misconduct?
- How can the regulator embed human rights principles into all of its regulatory processes, so that individuals with disabilities are properly accommodated?
- What involvement, if any, should the regulator have in subsidizing and/or facilitating the developing of a members' assistance program? Or a true diversion program?
- Which kind of monitoring processes (almost never specified by legislation) should the regulator undertake to ensure an incapacitated professional is adhering to treatment and any practice restrictions?

When implementing or reviewing an incapacity program

When implementing or reviewing its incapacity program, the regulator may wish to consider these questions.

- Does the regulator have a separate, defined process for dealing with incapacitated professionals?
- If so – have operational procedures been documented? Are related correspondence and memorandum templates available to staff, to support their work?
- Is there sufficient expertise on staff (or available to staff) and educational resources respecting common mental health conditions, substance use disorder and dementia?
- Have staff and committee members received sufficient training in the incapacity policy and procedures, along with commonly-encountered health issues?

- Does the regulator have legal opinions on file to provide guidance on interpretive issues, such as the definition of “incapacitated”, thresholds for commencing an incapacity investigation, referring an incapacity matter for hearing, or imposing interim restrictions or suspensions on licenses where appropriate?
- If the regulator does not have access to a separate legislated incapacity process, what steps can the regulator take to nonetheless deal with incapacitated professionals in an empathetic manner? For example, it may be possible to accept an undertaking to undergo treatment, or to cease practising or resign, whichever is most appropriate in the circumstances.



A final word regarding incapacity data management and analysis

Many regulators track the sources of information leading to incapacity investigations; these organizations should definitely consider conducting regular analyses of such information, and sharing it with other regulators in their network in order to gain a greater understanding of the drivers of incapacity reporting. More broadly, all regulators should regularly conduct analysis of their incapacity-related information beyond mere activity reports.

NOTE: This newsletter is intended to provide general information only, and is not intended to provide legal or medical advice to professional regulators. Regulators should consult with their own legal and medical experts when designing their incapacity programs, policies and procedures.