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Against fear

Dr. Nancy Whitmore on her efforts to change the culture at the country's largest medical regulator

BY TRISTAN BRONCA

The College of Physicians and Surgeons of Ontario (CPSO) has a reputation as a draconian presence looming over the province's doctors. This is true of all provincial regulators but especially true in Ontario. Any patient can submit a complaint against their doctor, on a whim if they've been rubbed the wrong way, and with the exception of those that are obviously frivolous or vexatious, Ontario's college has historically been forced to investigate, dragging the doctor through an abjectly awful and protracted experience.

Some doctors have even suggested that the regulators have contributed to current rates of physician burnout. One of them is Dr. Nancy Whitmore.

Dr. Whitmore is the current registrar of the CPSO and when she took over the post in 2018, she promised a kinder future for doctors. For this she's drawn praise from a number of prominent physicians, including Ontario Medical Association president Dr. Sohail Gandhi. We spoke with her about what that kinder future looks like, whether it has arrived, and the reputation of the college.

Q: What was the culture like at the college before you came on and how has it changed?

Over time, there has been an increasing fear of the college. That's because we're an oversight organization and a lot of what is said about the colleges revolves around a small number of physicians who have had significant issues. But much of the work we need to do is on quality improvements, and part of our role there is to support the profession. It's a very challenging job to deliver medical care. We have redone our vision, mission and values, and we've committed to being accountable, respectful and responsive. When there's a complaint we try to respond with compassion and empathy for the complainant, but also for the physician, because it's a very stressful event for both.

Q: Have you gotten any feedback from physicians about the changes you've made toward those goals?

I communicate with the whole profession through an email I send them every month-and-a-half or so, just to let them know what's going on. We launched a new website. Obviously one of the purposes of our website is to allow patients to complain if there's a concern about care, but we also added a field to give a compliment to a physician. I then send a personal letter to each physician who's received a compliment, to thank them for the care they provided. That has been extremely well-received. We launched that in April, and we now receive about 20 compliments every month.

I think most doctors seize up when they get a letter from the college, but if there's now a possibility that it's good news, that might change.
I spent a lot of time throughout this first year of my work meeting with groups of physicians—including entire medical staff at hospitals, medical leadership—and really listening to what their concerns were. We put out a very detailed questionnaire to the profession about what was working and what wasn't, and we heard back from around 6,000 physicians. We know that most physicians, at some point, will have an interaction with the college over a patient complaint. In some cases those complaints are very, very serious, but the vast majority are related to poor communication.

We sit under regulation so we must respond to every complaint. But early on, I knew there was a big issue with how long it took us to manage a complaint, and the stress on a physician over that entire time frame. So we focused on our complaints process. First and foremost, we started to respond to every complainant. We put a pretty bold line in the sand and said, "We really ought to be able to get back to these individuals within two business days." Prior to that, it was taking us about three weeks. We trained our staff differently, and by October 2018 we were down to four days. Since November we respond to every complaint within two days or less. That has been huge.

When we got that going, we also put in an alternate dispute resolution process. Our contact centre will call a patient and get a sense of their concerns. If it's an appropriate concern for that process, we ask them if they're interested. If they say they are and it's appropriate—each case is approved by myself or my designate—we then make sure the physician is also interested in that route. We've been able to manage probably on average now about 40% of our complaints through that alternate route and most of them in well under 60 days. Prior to that, we were way over a year to manage any concern.

Q: This alternate dispute resolution mechanism came about, I believe, as a result of a report[1] last year that suggested the CPSO needed to speed up the complaints process. Why was it taking so long before?
The other avenue is an investigation. It takes time, and that's how all complaints were being managed before. Plus it's more adversarial. The alternative dispute resolution is more of a conversation.

Most people, when they complain, they complain because they don't want somebody else to experience what they experienced. Alternate dispute resolution is often much better because we can get together—the individual who had a complaint, the physician who was involved, and our own mediator—and, in a very collegial way, work through an issue. And you know the patients feel better heard, they feel their issues are better resolved, and the physicians are getting much more timely feedback.

[1] The report, authored by justice Stephen Goudge, found that the most quickly dealt-with complaints at the CPSO took an average of 97 days to be resolved—more than six times as long as it did for their counterparts in Alberta. The CPSO's investigations were also far more costly than other jurisdictions, yet about 80% of cases resulted in little or no action. Goudge found there was "little apparent benefit to the public in terms of better or safer physician services."

Q: What kinds of complaints are eligible for alternate dispute resolution?
Some of them would be around communications, where a patient may feel the physician didn't adequately listen to their concerns, they felt dismissed. It might be that somebody's elderly mother or father has passed away, and they're concerned about the care their loved one received, and they don't understand why things happened the way they did. So during the mediation they'd walk through the medical record with the doctor to understand the care. Because it may be that there's no one at fault; there was just a misunderstanding. Sometimes the concern will have to do with a physician's staff member who is not treating patients very well. Maybe somebody has a secretary who is rude. Some of them are practice management-related. For example, timely response for filling out insurance forms. It's quite a wide range, but they're all, I would say, solvable problems. At the end we may ask a physician to do a module on communication, or a module on practice management, such as how to run a more efficient office.

Q: Are the resolutions here basically the same as they would have been previously, except before they came at the end of a longer and more antagonistic investigation? Or have they also changed?
Generally if it went to our complaints committee, they might give some advice to the physician, but very often there'd be no further action. I think in our alternate dispute resolution process, patients feel that their real feelings were heard, and the physician gets to really respond to how that patient felt. Both tend to feel more satisfied with the outcome.

Q: You've mentioned before that the college investigations are a source of stress for doctors but you suggest that has mostly to do with the length of the investigation. Does it also have something to do with the kinds of things that prompt an investigation? For example, a couple of years ago, doctors were getting in trouble for online comments and many of them felt that was overkill.[2]
If we have somebody make a formal complaint to the college, the way that our regulations sit, unless we can deem the complaint to be frivolous or vexatious, we must investigate it. For example—and I think this set a precedent for the college in terms of frivolous and vexatious complaints—the large number of complaints that were submitted against a physician who was lobbying against guns. We did not put that doctor through an investigation. I think in the past if a physician complained about another physician's online comments, we

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would have to, in most cases, go through an investigation.

Having said that, sometimes we would start a process because we at the college saw something ourselves which caused concern. If in those cases there wasn't a formal complaint, we would have other ways to resolve that. I can tell you under my leadership, there are times where we'll have a medical adviser from the college call a physician who we feel is perhaps behaving in a way on social media that we would prefer they not, and have a direct conversation and recommend that stop. When we can resolve it that way, that's what we do.

[2] Following the most heated period of the Ontario physician contract negotiations of 2016, the college investigated at least 13 doctors for comments they made online. Only two were dismissed, eight were cautioned, and three faced fines and suspensions. One doctor, who was cautioned for using profanity in Spanish in reference to another doctor, felt the process was disproportionately harsh—"like using a small thermonuclear weapon to kill a fly," in his words.

Q: I know it was before your tenure but, in hindsight, do you wish the college would have handled those complaints about online conduct differently?

I mean, it's always difficult in hindsight. I don't know the issues of the day, and what exactly was happening or how they were managed. I just think that if there's a way to be less adversarial and more supportive, it's better. At the college we try to focus ourselves on the public interest, and as a rule on physicians when it relates to their delivery of care to patients. So we want to be careful when we're concerned about a physician's behaviour that's completely unrelated to their practice.

Q: It's not lost on me that the CPSO seems to be trying to strike a balance between public pressure, applied through the media and government, to crack down on bad behaviour, while trying to manage its relationship with doctors. Do you think you've been able to strike that balance, or have there been trade-offs?

Striking a perfect balance is always a challenge, but that's been our aim. That balance of really focusing on the very important, serious issues so that the regulator can take action in that small number of cases where we really need to, and to take care of the other issues that are potentially distracting us from that very important work. So if there's a cluster of complaints that are truly frivolous and vexatious we call them such, and we don't use our resources on that. Then we use a much more nimble and appropriate type of resolution

process for these more—I don't like the word "minor" complaints—but the types of complaints that can be resolved in that way.

If it's a question of whether patients are being served the same, better or worse, I would say it's for sure not worse. I would argue that patients are being better served because we are providing timely service, and I think that's really, really important. When you're not taking years to resolve an issue, if there is something to learn, we learn it right away and we apply an improvement. Otherwise, by the time we figure out what the problem was, it's two years past.

Q: That report I mentioned earlier, about expediting the complaints process, noted about 40% of Canadian doctors practise in Ontario, but the CPSO deals with more than half of the country's total discipline-related matters. Then there's the matter that the CMPA spends more money defending Ontario doctors than it spends in all other provinces combined. Why is that?

Some of the other provinces have less red tape in their regulation, fewer rules, and they allow the college a little bit more latitude to decide what is serious and needs a full investigation, and what can be managed in a different way. We have less of that flexibility. We're actually working with government to reduce some of that red tape.

Having said that, we have early data now that would tell you we no longer represent more than our 40% with regards to CMPA, because by moving away from this very serious full-out investigation for everything, there is less CMPA time spent with physicians. If we look at our time to complete a complaint in the first quarter of 2018 and we compare it to the first quarter of 2019, we've made major reductions. The 80th percentile was 320 days, and we're down to 200, so that's pretty remarkable. We've cut the number of open complaints in half. We have reduced the length of time it takes us to release a decision from our complaints committee from just about six months down to just over five weeks.

It's going to take a little longer for us to see a full change. But there's no issue with patient safety as a result of the changes of our complaints process in Ontario.

Q: There seems to be a greater demand for transparency in Ontario than in other jurisdictions across Canada. So far, the only explanation I've heard is, "the provinces each have their own laws, and then the colleges do their best to abide by their rules." Why hasn't there been a push for the same standards across the country? Why aren't all the colleges obligated to live up to the same standard of transparency?

So there are two pieces. One, as others have told you, has to do with legislation. Some of those rules are defined by government and we don't have the ability to decide whether we will or won't abide by them.

Having said that, in Ontario, we also sort of stepped ahead of that. We felt that certain types of serious issues should be part of the public record. For example, if we know a physician has a criminal conviction, that should be public-facing. We see a general trend over time toward more transparency, and I would say in Ontario, both in its regulation as well as at the college itself, we probably are on the front end of being more transparent with the public.

But each province is really very, very different. Even if you look at the sexual abuse regulation, it was very different in Ontario than in all of the other provinces up until very recently. In Alberta there is something fairly similar with regards to automatic licence revocation for a minimum of five years, whereas other provinces might say "yes, the standard of care should be the same," but have only a one- or two-year licence revocation or suspension as a penalty.

Q: Last year there was a *Toronto Star* investigation about doctors crossing jurisdictions, where certain disciplinary findings did not make it into the record of the regulators, or that the regulators had on record but withheld from the public. Do you think the CPSO will have

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to disclose more information—sometimes sensitive information—about doctors in the future?
I think right now we are very transparent. Where we are right now is perhaps where other regulators will move to be. When the *Toronto Star* did that work, I mean, we were clearly the most transparent about what was on the public register.[3] If you look up a physician in Ontario, you can see if they've had a number of different issues and the number of issues we've disclosed has increased over time.

[3] The *Star* did indicate that "The Ontario college's physician profiles are the only ones we found in Canada that include information about discipline imposed in other jurisdictions" but that only applied to decisions imposed after September 1, 2015. And while the *Star* reporters said the CPSO "is arguably the most open medical regulator in the country" they said it was a "fortress" compared to certain U.S. medical regulators.

If you look at it historically—like 10 to 20 years ago—there could have been issues that didn't make it onto the record, and then a physician might have gone to another jurisdiction. Although that is probably good for selling newspapers, that's pretty rare now. Now there's a very good transfer of information across jurisdictions, there is a lot of cooperation and mandated exchange back and forth. Because if a physician leaves Ontario and goes to get a licence in another jurisdiction, not only will that jurisdiction know whatever that physician declares, but they will also be directly in contact with us, as their previous regulator, and we'd be sending them a very detailed report.

I think it could be different in some developing countries, where they don't have a robust medical regulation framework, where physicians could potentially have a very serious issue in one jurisdiction and go to another jurisdiction. But I really don't think there's as much of that as the newspapers would like to think. If we look across North America, as well as Europe, Australia, New Zealand, you'll find very strong medical regulatory environments.

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Q: Have you ever faced a complaint, or come close to facing a complaint? I feel like every doctor has been in a situation where a patient leaves and they're worried about getting a letter. . . . I'm wondering if you would care to commiserate.
I'm an obstetrician-gynecologist by training and I've been in practice for over 30 years. I don't practise presently and I haven't in the previous 10 years prior to taking this role. I mostly did medical administration in the hospital sector. I'm lucky in that I've never had a patient complain to the college.

I know I sit in a small group of individuals, but I can tell you that I've had many, many encounters with physicians, whether they be friends of mine, or in my role as chief of staff or department chief at the hospital, colleagues of mine, where I've seen another doctor deal with a complaint. These are great physicians doing great work, and it just completely discombobulates them. It's an incredibly stressful event. There's angst, and I think there's a sense that, you know, their licence is at risk the minute they get a complaint. The data would not support, in any way, that their licence is at risk, but the anxiety, the stress of that event is very, very real.

So I do commiserate with them. I understand it. I think I really do. I understand the complexity of practising medicine. I understand how difficult it is to be up in the middle of the night, providing the best care you possibly can in a very complex system with a lot of stressors.

I'm also married to a physician. One of our three daughters is currently a resident. I have lots of touchpoints as to what that's like. I think it's important that we do the best job we can to serve in the public interest, protect the public, and at the same time, support the physicians who are doing great work.

Q: What would you like the CPSO's reputation to be among doctors, and do you think that its current reputation is close?
I would like us to be recognized as a fair and effective medical regulator. You know, I would like us to be recognized for really thinking about those values of accountability, responsiveness, professional excellence, communication and compassion.

Are we there yet? No, I don't think we're there yet. I think we'll always be, you know, "the regulators." That will always be a challenge. But I do think that we are moving in that direction and being able to understand what we need to focus on, and how we can work with the profession to ultimately do a better job. Right now we are in the process of building a whole new quality improvement program from our assessment program which will operate in a much more collaborative way. We're doing lots of things that are moving us in the right direction. **MP**

Edited for length and clarity.