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DU QUÉBEC

Legal, Ethical and
Organizational Aspects of
Medical Practice in Québec

ALDO-Québec

2010 Edition

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Foreword

We are pleased to present the 2010 version of *Legal, Ethical and Organizational Aspects of Medical Practice in Québec (ALDO-Québec)*.

Initially, this document was meant for candidates applying for a permit to practice medicine in Québec. Over the years, however, it has become a reference for all physicians practicing in Québec who wish to round out their knowledge on these topics.

Indeed, from 1988 to 2007 for residents in family medicine, and from 1996 to 2007 for residents in a specialty, successful completion of the ALDO examination administered by the Collège des médecins du Québec was necessary to obtain a permit to practice. Since 2007 however, mandatory training sessions on the content of this document have replaced the examination. This is why we wish to keep it up to date.

We believe that the *ALDO-Québec* document can be thought-provoking for Québec physicians. It will give them a quick grasp of the essentials in the organization of the health care system and the legal and ethical framework of medical practice in Québec. These will also serve as guideposts enabling physicians to better situate themselves and better bear the moral burden of decisions they must make in the interests of their patients.

The *ALDO-Québec* document touches on a host of subjects that are constantly evolving as well as becoming increasingly complex. In recent years, several of these have been the topic of new publications or sections on the website of the Collège. We have taken advantage of the latest updates to that might be useful to consult for more information about a given topic. And over the course of the past year, we have also revised the entire section focused on the practice of medicine outside of institutions.

We thank all those who have contributed to *ALDO-Québec's* ongoing existence and evolution: the editorial committee, the writers, the publishing team and the numerous collaborators who have been with us since the beginning.



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CONTENTS

8 Introduction

PART I

11 THE PRACTICE OF MEDICINE IN QUÉBEC

Chapter 1

11 Organizational Aspects

11	1	Introduction	36	3.1.5	Conditions of Practice in an Institution
			37	-	Appointment
			38	-	Regulations and By-laws
			39	-	Non-compliance with Rules
			39	-	Cessation of Practice in Institutions
			40	-	Remuneration
			40	3.1.6	Examining a Complaint Concerning a Physician
			41	3.1.7	Physicians: Essential Care Providers in Institutions
			42	3.2	Practice Outside an Institution
			42	3.2.1	Introduction
			43	3.2.2	Practice Outside an Institution and the Health Care System
			43	-	Private Practice
			44	-	Networks of Primary Care Services
			44	3.2.3	Practice Outside an Institution and the Health Insurance Plan
			45	-	Persons Insured Under the Plan
			45	-	Services Covered in Québec
			46	-	Physicians Participating, Opting Out or Not Participating in the Plan
			47	3.2.4	Provision of Care Outside Institutions
			48	3.2.5	Different Organizational Models
			48	-	Individual and Group Practice
			48	-	Family Physician Groups
			49	-	Associated Medical Clinics and Specialized Medical Centres
			50	-	Network Clinics
			50	-	Health Care Cooperatives
			50	3.2.6	Common Professional Issues
			51	-	Maintenance of Competency
			51	-	Respect for Patients and Professional Secrecy
			54	-	Access to Care and Follow-Up
			54	-	Professional Independence and Administrative Aspects
			58	-	Responsibilities of the Physician-Employer
			59	3.2.7	Conclusion
			60	3.3	Diversification of the Practice of Medicine
			62	4	A Social Achievement Worth Preserving
11	2	The Health and Social Services System			
13	2.1	The Québec Way			
13	2.1.1	A Culmination			
14	2.1.2	A Point of Departure			
15	2.2	General Characteristics			
15	2.2.1	Canadian Features			
16	2.2.2	Québec Particularities			
17	2.3	General Organization and Medical Organization			
17	2.3.1	General Organization			
17	-	The Organization of the Services			
18	-	Services Provided to the Population			
20	-	Advisory Agencies			
22	2.3.2	Medical Organization			
22	-	The Regional Department of General Medicine			
23	-	The Panel of Heads of Departments of Specialized Medicine			
23	-	University Medicine			
24	-	Distribution and Commitments of Physicians			
24	-	Inter-professional Sharing of Medical Activities			
25	2.4	Conclusion			
26	3	The Professional Practice of Physicians			
26	3.1	Practice in Institutions			
26	3.1.1	Introduction			
27	3.1.2	The Institutions			
28	3.1.3	The Internal Organization of Institutions			
29	-	The Board of Directors			
30	-	The Executive Director			
30	-	Organization Plan			
31	-	The Director of Professional Services			
31	-	The Institution's Resources: Striving for Efficiency			
32	3.1.4	Medical-administrative Organization			
32	-	The Council of Physicians, Dentists and Pharmacists			
35	-	Clinical Departments			
35	-	Clinical Department Head			

Chapter 2 63 Ethical Aspects

63	1	Introduction
65	2	Historical and Legal Context in Québec
65	2.1	<i>Historical Context</i>
67	2.2	<i>Legal Context</i>
67	2.2.1	The Professional Code
68		- Office des professions
68		- Interprofessional Council
69	2.2.2	The Medical Act
69	2.2.3	Permit to Practice
70		- Restrictive Permit
70	2.2.4	Registration
71	2.2.5	Training Cards
72	3	Duties and Obligations of Physicians
72	3.1	<i>The Code of Ethics of Physicians</i>
73	3.1.1	General Obligations
74	3.1.2	Quality of the Professional Relationship
74	3.1.3	Freedom of Choice and Consent
75	3.1.4	Medical Management and Follow-up
75	3.1.5	Quality of Practice
75	3.1.6	Independence, Impartiality and Integrity
76	3.1.7	Advertising and Public Statements
76	3.1.8	Medical Records and Fees
77	3.1.9	Relations between Professionals and Relations with the College
78	3.2	<i>The Obligations of Physicians under other Regulations</i>
78	3.2.1	Regulation respecting the keeping of records, physicians' rooms or offices and other effects
78		- The Medical Record
80		- Other Provisions
81	3.2.2	Regulation respecting the Professional Inspection Committee of the Collège des médecins du Québec
81		- Professional Inspection Committee
82		- Professional Inspection Record
82		- Professional Inspection
82		- Inspection Visit Follow-up
83	3.2.3	Regulation respecting professional liability insurance of physicians
83	3.2.4	The Regulation respecting the standards relating to prescriptions made by a physician
86	4	The Collège des médecins du Québec and other Associations of Physicians
86	4.1	<i>The Collège des médecins du Québec</i>
86	4.1.1	Structures of the Collège
86		- Political Structure
87		- Administrative Structure
88	4.1.2	Functions of the Collège
88		- Verifies Competence of Candidates
		Applying for a Permit to Practice and Issues Permits to Practice
89		- Maintaining Competence and Overseeing Practice
91		- Examining Complaints and Inquiring into the Illegal Practice of Medicine
94	4.2	<i>Other Associations of Physicians</i>
96	5	Obligations of Physicians: Guideposts

Chapter 3 97 Legal Aspects

97	1	Introduction
98	2	The Law and Medical Practice in Québec
98	2.1	<i>The World of Law</i>
98	2.2	<i>The Legal System in Canada and in Québec</i>
99	2.3	<i>Law in the Field of Health</i>
101	2.4	<i>Medical Practice and the Law</i>
102	3	Medical Civil Liability
102	3.1	<i>Introduction</i>
102	3.2	<i>The Evolving Concept of Medical Fault</i>
104	3.3	<i>Scope of Obligations Inherent in Medical Contract</i>
104	3.3.1	Obligation to inform the patient and obtain consent
104	3.3.2	Obligation to provide attentive, prudent and diligent care
106	3.3.3	Obligation to not abandon one's patient
106	3.3.4	Obligation to ensure confidentiality
107	3.4	<i>Rules Concerning Proof</i>
107	3.4.1	Proof of the standard of care
107	3.4.2	Presumption of fact
107	3.5	<i>Period of Time for Prescription</i>
107	3.6	<i>Compensation</i>
108	3.7	<i>Civil Courts</i>
108	3.7.1	Trial
108	3.7.2	Appeal
108	3.8	<i>Professional Liability Insurance</i>
109	3.9	<i>Record-keeping</i>
110	4	The Physician's Obligations under Certain Laws
110	4.1	<i>Civil Code of Québec</i>
111	4.2	<i>An Act respecting the protection of persons whose mental state presents a danger to themselves or to others</i>
112	4.3	<i>Youth Protection Act</i>
112	4.4	<i>Public Health Act</i>
113	4.5	<i>Highway Safety Code</i>
113	4.6	<i>An Act respecting the determination of the causes and circumstances of death</i>
114	4.7	<i>Automobile Insurance Act</i>
		<i>An Act respecting occupational health and safety</i>
		<i>An Act respecting industrial accidents and occupational diseases</i>
115	5	Conclusion

**PART II
CLINICAL INTEGRATION OF
LEGAL, ETHICAL AND
ORGANIZATIONAL ASPECTS**

117 THEMATIC APPROACH

117	INTRODUCTION
118	A CONSENT
118	1 What is Free and Informed Consent?
121	2 Capacity to Give Consent
121	3 Substituted Consent
123	4 Who May Give Consent?
124	4.1 Minors 14 years of age or over
125	4.2 Minors under 14 years of age
125	5 Exceptions to Obtaining Consent
125	5.1 Emergency Treatment
126	5.2 Confinement in an Institution
128	5.3 Diseases that Must be Treated
129	5.4 Blood Alcohol Test (under certain conditions)
129	Conclusion
131	B PROFESSIONAL SECRECY
131	1 What is Professional Secrecy?
131	2 Professional Secrecy's Regulatory Framework
132	3 The Medical Record
133	3.1 Access to the Medical Record
134	3.2 Restrictions to the Patient's Right of Access to His or Her Medical Record
136	4 Disclosing Information to Third Persons: the Patient's Family
138	5 Disclosing Information to Third Persons: Medical Certificates
140	6 Exceptions to Professional Secrecy
140	6.1 Compelling and Just Grounds
140	6.2 Youth Protection
142	6.3 Public Health Protection and the Diseases that must be Reported
143	6.4 Attestation of Death
145	6.5 Highway Safety
146	Conclusion
147	C END-OF-LIFE ISSUES
147	1 Cessation of Treatment
148	2 Euthanasia and Assisted Suicide
149	3 Futility and Aggressive Treatment
149	4 "Do Not Resuscitate" Order
152	Conclusion
153	D PERSONAL CONVICTIONS OF PHYSICIAN AND PATIENT
153	1 Refusal of Treatment for Religious Reasons
153	1.1 Person of full age
153	1.2 A Minor Person
154	1.3 Validating the Refusal
154	2 Request for Female Genital Mutilation
155	3 Discrimination
156	4 Conscientious Objection

APPENDIXES

Appendix A
Acronyms and Abbreviations

Appendix B
Code of Ethics of Physicians of Québec

Appendix C
References to Legislatives texts

Appendix D
The 35 Medical Specialties in Québec

ALDO-Québec Introduction

In 1988, Québec's four faculties of medicine and the Collège des médecins du Québec decided to produce a document for residents in family medicine, with a view to preparing them for the new examination they would have to successfully pass to obtain a permit to practice. This document addressed aspects of medical practice specific to Québec. These were mainly legal, ethical and organizational in nature, hence the name *ALDO-Québec*, after the French acronym.

Subsequently it became apparent that all physicians practicing in Québec had to be familiar with these aspects, and that residents in a specialty as well as physicians preparing to practice in Québec without having previously trained here, also had to pass this examination. In February 2007, the examination was replaced by mandatory training sessions organized by the Collège within the faculties of medicine themselves, with the view of better incorporation, the ALDO document into the various university curricula.

Since 1991, the *ALDO* document has sought to provide the information deemed necessary for the proper practice of medicine in Québec, that is, the organization of the health care system in Québec, medical ethics, and the many applicable laws.

This objective presents a two-fold challenge. Firstly, the fact that all three aspects of the medical practice environment is constantly evolving, is not insurmountable. A prime example of this is the in-depth revision of the *Code of Ethics of Physicians of Québec*, completed in November 2002, but which did not preclude certain amendments made in 2008 and in 2010. The second challenge is more basic, and that is to select the truly relevant information amidst all the information available on these subjects. One should ask whether all these data need to be known in order to practice well, and to what extent must a physician's practice be dictated by codes, governed by legislation, and controlled by health care systems. In today's world, getting physicians to reflect on these questions is probably just as essential as transmitting the information necessary to respond to them.

The 2004 edition marked an important milestone in the document's evolution. Its content was reviewed, not only for purposes of updating it, but to ensure its pertinence for our physicians. While the sum total of the information deemed essential was still impressive, the revision exercise focused mainly on inducing our readers to think. Thanks to computer resources, updates can now be made on a regular basis, allowing the reflection process to be ongoing.

The document is divided into two main parts: the first is theoretical, and the second presents clinical situation scenarios.

Part I

CHAPTER 1 of Part I deals with **organizational aspects** and includes three broad sections. The first sketches the broad outlines of the road travelled in the area of health in Québec. In the 1970s, the government established a system of social solidarity to deal with disease. By ensuring first the provision of hospital care, then of medical care, the Québec system resembled those in other Canadian provinces and in many industrialized countries of the world. However, it subsequently distinguished itself from the others when public funding and government administration were extended to all social services.

The entire organization of the health care system reflects this policy. Its most striking example is the constantly reaffirmed determination to see the CLSCs as the point of entry to health care services, while acknowledging that physicians in private practice provide most of the primary services. The regional health and social services agencies (ASSS) and the health and social services centres (CSSS) are another revealing example. Since 2005, these are the solutions being applied to better link the local delivery of services to the central bodies. This section presents the **actual organization** of the Québec health care system and the **anticipated organization of medical services**, for it is vital that physicians know how their professional practice fits into this system.

The second section of this chapter touches on the present organization of medical practice. It describes the two main types of professional practice in Québec. **Practice in institutions** is an independent type of professional practice, but it is linked in many ways to the structure and operation of public institutions. Although **practice outside an institution** has a connection to the public health care system, the links are less direct and are not necessarily maintained via institutions. While increasingly prevalent, medical practice without any link to the public system remains a marginal phenomenon in Québec. The relatively new phenomenon of **diversified practice** will also be presented. Running parallel to the common types of practice are the many other forms of medical practice, among them, clinical research, medico-legal assessment, public health, occupational medicine, as well as administrative and commercial practice. Each in its own way presents problems with respect to professional independence.

CHAPTER TWO is of more direct concern to physicians since it deals with **ethical aspects** of medical practice in Québec. Here, medicine is broached from the perspective of professional practice. The medical profession fulfilled a social function and had its own rules long before it was incorporated into health care systems. This was particularly true in Québec, where physicians were obliged as early as 1847 to become members of a professional order. An order whose disciplinary power imposed itself quickly, thanks to a code of ethics that was also quite distinctive. In the 1970s, following the example of other countries and other Canadian provinces, Québec recognized the existence of professional orders and invested them with substantial peer-review powers.

While the present structure and function of the **Collège des médecins du Québec** dates back to a time when professions were little known, their intention essentially remains the same—that physicians themselves ensure the competence and proper practice of the members of their profession. Over time, the **Code of Ethics of Physicians** has become more complex, because this regulation, like many others that complement it, attempts to lay out as precisely as possible the obligations that every physician must fulfil. This is not easy in a context of our new and complex realities. The situation of a public system experiencing a period of restriction of resources is unprecedented. This applies to clinical research, medical entrepreneurship and medicolegal assessment. Therefore, we must be innovative and ask our own questions with respect to the independence of professional practice vis-à-vis the pressing economic and political constraints in the field of health care.

In this context, it must be recognized that the Collège is not the only organization that brings physicians together. The medical federations, for example, play a decisive role in negotiating the practice conditions of physicians. Medical ethics is still very much alive in Québec, and the Collège remains a vital organization for both the medical profession and the public.

CHAPTER THREE deals with the **legal aspects** of medical practice. In Québec, as elsewhere, many laws have a bearing on the practice of medicine. This chapter presents an overview, emphasizing those that impose **special obligations on physicians** and those that frame “**medical civil liability.**” When one analyzes the question of medical civil liability and the risk of lawsuit—a subject of concern to physicians—, one realizes that it goes beyond the strict legal framework. Indeed, transparency, as well as ethical and organizational considerations, often improves the quality of medical practice and, as a result, reduces the risks of lawsuit.

Part II

How should the physician act, given the organizational constraints, the general points of reference established by the legislation, and the guideposts defined by the codes? For every physician, the moral challenge is to answer the question in the heat of the action.

PART II of this document is perhaps the most important in this regard, for it demonstrates that one can and must integrate the various aspects mentioned earlier in order to make enlightened decisions. The best way to understand the legal and moral aspects of one’s professional practice is to look at **practical problems** and, even better, clinical situations. Many questions are examined: **consent, confidentiality, end-of-life** issues and **personal convictions**. While the list is not exhaustive, it does provide practical examples to illustrate the new difficulties confronting physicians and society on a regular basis.

The collaborators in the production of the ALDO document have always been concerned with making it more than just a collection of laws and regulations to be followed to the letter so as to avoid problems. References to legal texts have been added for consultation as needed. Supplemental reading is also suggested, notably a text on professionalism. More recently, references to other documents produced by the Collège have been added to the text, enabling quick access to more exhaustive information.

The primary goal of this document is to provide accurate information to Québec physicians on aspects deemed to be decisive for their professional practice. One hopes that the document will also induce them to participate in a critical reflection process, thereby making the information interesting and useful.

PART I

THE PRACTICE OF MEDICINE IN QUÉBEC

Chapter 1

Organizational Aspects

1 Introduction

It is essential that all physicians practicing in Québec 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. The Québec system differs from those in other Canadian provinces because of the integration of health services and social services thus adding its complexity.

The first section of this chapter sketches the broad outlines of the health and social services system—“Québec-style”. A brief history will illustrate how the Québec health care system compares to other public systems, where needs increasingly exceed resources. This overview will also show how the Québec system differs from others in that its general organization is very centralized, a rather paradoxical feature given that services are essentially provided at the local level. It is evident that the multiple formulas applied to promote decentralization of the system have not managed to eliminate this contradiction. Reorganization on a regional and then local basis now seems to be the advocated solution for better integrating medical and other activities.

The second section attempts to precisely situate the professional practice of physicians within the health care system. The manner in which the medical practice of physicians is integrated has not always been clear in Québec. This is still the case, and the various types of current practice bear this out. To date, the two principal forms of medical practice have been practice in institutions and private practice. However, other formulas situated somewhere between these two are on the rise. These include family medicine groups (GMF), specialized medical centers (CMS), and associated medical clinics (CMA). Once again, these new developments point to the difficulties inherent in wanting to integrate independent professionals into an essentially public system.

The practice of medicine in an institution is an independent type of practice. But as it is linked to institutions in the public system, this type of practice obliges 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* (LSSSS).

In contrast, medical practice outside public institutions is often designated as “private practice”. However, barring a few exceptions, it also is an integral part of the public health care system, if only because medically required services are publicly funded. Here again, many formulas from CLSCs to family medicine groups (GMF), from regional medical manpower plans (PREM) to special medical activities (AMP), have been put in place to better integrate this type of practice into the public network. To date, the results have been mitigated, so much so that one can rightly ask whether a healthy tension between the professional independence of physicians and the very centralized organization of the health care system is not just another characteristic of the “Québec way”.

The organizational aspects of medical practice in Québec pose an additional challenge to physicians. Indeed, what we see is that physicians are working in increasingly varied spheres. Clinical research, medico-legal assessment, 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 Québec Way*

The health and social services system is a pillar of social policy in Québec. To the individual it offers a guarantee of security in case of health problems. To the community at large it represents an instrument of social justice and progress.

By way of information, every year over 80% of the population, or six million persons, consult a physician; approximately 675,000 patients are admitted to general or specialized hospital centers within health and social services centers (CSSS); over 400,000 surgical procedures are performed in these centers; finally, thousands receive various services of a preventive, curative or palliative nature, as well as rehabilitation or social integration services.

The Québec 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. It seems unnecessary to recall every milestone in the history of medical services and, in a more global sense, of health and social services in Québec. Suffice it to mention the salient facts:

- 1886 The Public Health Act was enacted; its mandate was to check the spread of infectious diseases and to improve sanitary conditions;
- 1921 The Québec Public Charities Act was adopted. The government would henceforth intervene in the area of helping the needy, an area heretofore restricted to the Church and to groups doing good works;
- As of
1926 Clinics were set up, making for immense progress in matters of public health. These would also serve as models for other societies;
- 1936 The first Ministry of Health was created to settle the thorny question of hospital deficits and to improve the overall administration of hospitals.

In Canada, as in all industrialized countries, the end of World War II launched a period of progress in the area of social policy. This was the beginning of the thirty-year boom period, from 1945 to 1975, three decades marked by economic prosperity unprecedented in our history. As for Québec, it would have to wait until the early 1960s and the end of the Duplessis era to experience that same effervescence. Indeed, Québec would be transformed by teeming cauldron of social ferment. This was the period 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 decisive effect on the development of health services—hospital insurance (1957). The federal government drew its inspiration from the Marsh Commission (1943), considered to be Canada's social charter, and from the policies of Great Britain and the Beveridge Report (1942), which led to the implementation of the British health care system, the National Health Service (1948).

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

In Québec, a series of measures were enacted, in particular the *Hospital Insurance Act* (1960) providing free hospital services to the user, the *Act respecting the Québec Pension Plan* (1965) and the *Social Aid Act*, all of which represented the Québec government’s first incursion into the field of professional practice. In matters of health, social services and social development, however, the lack of a global perspective was still a matter of deep concern. Conclusions would emerge from two important task forces—the Boucher Committee (1963) studying public assistance, and the Castonguay-Nepveu Commission (1966-1972) mandated to inquire into health and social services. The first recommended that the public sector take over assistance activities from the church and other charitable works groups. It insisted that Québec adopt an integrated economic and social policy, and it defined its broad parameters. As for the Commission, it submitted to the government a global and generous vision of social security based on three pillars: health, social services and income security. It also proposed the implementation of innovative services that would take into account these concerns.

2.1.2 A Point of Departure

In the early 1970s, the Québec government gave itself 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).

The new ministry of social affairs was responsible for implementing the overall policies of the government in matters of health, social services and income security, and for defining the rules for the administration and operation of the institutions. The *Health Insurance Act* instituted free medical services for the user. 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 the mode of organization of this new public system, namely the mission of institutions, the role and responsibilities of the institutions’ committees, the role and responsibilities of the new regional bodies (Regional Boards of Health and Social Services), the powers of the Minister, etc.

The Québec of the 1970s was one great beehive of activity, a going concern. But quickly, the new organization would run into obstacles that would affect its development in the subsequent thirty years.

- The costs of services continued to increase rather than decrease as had been predicted after the required period of investment given that the population should be healthier. Thus, the problem of hospital deficits, in particular, remained unresolved.

- The new institution, the CLSC, which was to be the cornerstone of primary care services, did not fulfill its promise for a variety of reasons: hesitation on the government's part, lack of resources, unfavorable climate in certain CLSCs, resistance on the part of physicians to practice there, etc. In this context, medical clinics and hospital emergency rooms became the real first line.
- The coordination of efforts had its deficiencies; the dividing lines between institutions and between professionals were impediments to the effectiveness and efficiency of services.
- The centralized decision-making progress 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 an inquiry commission chaired by Dr. Jean Rochon; its mandate was to find solutions to the problems of funding and operating the system. Fifteen years later, another study commission 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 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 in matters of coordination, and the funding problems. Reforms are still under way to tackle these very problems. Two other task forces were set up in recent years to re-examine the problem of funding. One, chaired by Mr. Jacques Ménard, tabled its report in July 2005; the other, chaired by Mr. Claude Castonguay, the very father of health-insurance in Québec, published its report in February 2008. These two reports identify an increase in health expenditures in excess of government revenues, inevitably leading to a financial impasse. To offset the impasse, they propose using additional revenues, either in the form of a specific tax or private funding sources (user's contribution, insurances, etc.). The mixed aspect of medical practice is at the heart of the debate. They also note that there is more room for improvement in the efficiency and effectiveness of the public system, whose adaptability and flexibility are still weighed down by a cumbersome bureaucracy that seems resistant to streamlining.

2.2 General Characteristics

In many ways, the Québec health and social services system is similar to those in other Canadian provinces. Everywhere in Canada, access to medical services and hospital services is subject to the same rules, and the general organization of services is similar. In other important aspects, however, the Québec system has its own peculiarities. These similarities and differences stem from the very origins of the system and from its recent developments.

2.2.1 Canadian Features

Health is an area of provincial jurisdiction. However, since the middle of the 20th century, the federal government has used its spending power to gradually establish a truly Canadian health insurance system and to impose its vision on the system's development. From this perspective we can understand this government's great exercises in planning, notably the Hall Commission in the early 1960s, the National Forum on Health in the 1990s, and the Romanow Commission in the early years of this century.

The Government of Canada has also used legislation to gradually imprint its own vision. The *Hospital Insurance and Diagnostic Services Act* (1957) was a first step. It came hand-in-hand with equal cost-sharing between the central government and the

provincial governments. This was also the case with the *Medical Care Act* (1966), aimed at inciting the provinces to promulgate a similar law and thus cover medical costs. This measure represented a decisive step in establishing a universal health-insurance plan. The legislation set four conditions for the provinces: the services must be universal (at least 95% of the population must be covered); comprehensive; portable (access provinces); and publicly administered.

These principles would be reiterated, adapted and strengthened in the *Canada Health Act* (1984). We know that it was adopted to counter the over-billing of medical services in certain provinces, particularly in Ontario and Alberta. Above all, it laid the groundwork for the “Canadian health insurance plan”.

Today, everywhere in the country, the provincial plans must respect the following five principles:

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

These principles apply to medical services and hospital services. From the Canadian perspective, they do not apply to other service sectors. Furthermore, while the federal government’s share of the funding has steadily decreased over the years—in 2004, it covers no more than 16% of the costs, compared to 50% in the mid-1970s—the principles stipulated in the *Canada Health Act* have retained all of their political legitimacy given that they have the support of a very large segment of the population.

Discussions on these principles have nonetheless been reopened by a decision of the Supreme Court issued in June 2005 in the Chaoulli-Zélotis case, which ruled that it should be possible to resort to private insurance to obtain medically required care, when waiting times in the public system are “unreasonable”.

2.2.2 Québec Particularities

Since its creation, the public system in Québec has always brought health services and social services together under one administration. Québec is the only province to maintain this kind of integration. This has the advantage of better responding to the needs of populations that require a lot of services, particularly the elderly who have lost their independence, and the handicapped.

Québec is also the only province to have established a general drug insurance plan. The other provinces have various selective programs serving specific populations, and these give rise to access problems. Before this plan was instituted in 1997, 20% of the Québec population had no public or private drug insurance.

Québec is also the province that has paved the way for decentralization in Canada. Since then other provinces have followed suit, taking it even further. Finally, in response to the Supreme Court ruling, Québec is the first province to legislate certain organizational changes likely 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 waiting times.

Indeed, in December 2006, the Québec government amended its *Act respecting health services and social services* and other legislative provisions to establish a central

management mechanism in hospital centres giving access to surgical procedures and allowing the use of private facilities and private insurance if access to three procedures (knee and hip arthroplasty and cataract surgery) is not available within a reasonable waiting time. Bill 33 established the legal framework whereby certain medical services usually provided in an institution may be provided outside an institution, that is, in specialized medical centres (CMS), some of which may be completely private (non-participating physicians), or in associated medical clinics (CMA), where physicians participating in the public system would have entered into agreements with these establishments. All centres providing services determined by regulation would meet three requirements:

1. obtain an operating permit from the government;
2. name a medical director responsible for ensuring the quality of medical services;
3. within three years of issuance of the permit, be accredited by an organization recognized for this purpose.

2.3 General Organization and Medical Organization

2.3.1 General Organization

— The Organization of the Services

With respect to the organization of services, the public system operates on three levels: a central level, a regional level, and a local level.

Power sharing between the levels has been transformed 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 the course of 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 called regionalization in a true sense. 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 to 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.

Recently, a new trend has taken over: the government has chosen to bring the decision-making centers even closer to the action. To make the local services networks more effective, all of the establishments in a given territory were grouped together under one board of directors, creating a new type of institution called the health and social services centre (CSSS).

The roles and responsibilities of the health and social services system's three levels are now divided as follows:

▪ The Ministère

The ministère de la Santé et des Services sociaux (MSSS) fulfils a two-fold mandate:

- 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 fulfill its mandate, the MSSS must act at several levels:

- developing policies in matters of health and social services, their implementation and evaluation;
- approving regional priorities stemming from ministerial policies;
- coordinating the provincial public health program and instituting measures to protect the health of the population;
- equitably distributing human, material, financial and information resources among the regions of Québec;
- establishing the necessary management frameworks for the effective and efficient use of these resources;
- establishing policies and orientations relative to the network's manpower;
- ensuring inter-regional coordination of services;
- ensuring inter-sectorial activity;
- assessing the effects of policies in matters of health and social services.

- **Health and Social Services Agencies (ASSS)**

After an administrative transition phase, the health and social services agencies replaced the regional boards. Since 2003, these agencies have assumed strictly regional functions, namely:

- specialized services funding;
- health services and social services planning and coordination;
- functions entrusted to it under the *Public Health Act*, that is, the promotion and protection of public health, and prevention.

- **Health and Social Services Centres (CSSS) and Local Services Networks (RLS)**

The local services networks (RLS) bring together all service-providers in a given territory to ensure access to a complete range of services, including the care management and support of persons who need services, particularly those most vulnerable. Two basic principles underlie the operation of these local services networks:

- responsibility toward the population, which is entrusted to all the care-providers;
- prioritizing of services.

In practice, a local body called a health and social services centre (CSSS) overseen by a board of directors, is responsible for bringing together the resources, coordinating the activities and establishing the partnerships essential to the operation of the networks, particularly those with physicians, regional institutions and university institutions.

- **Services Provided to the Population**

With respect to services provided to the population, the health and social services system maintains its objective to fulfill five missions, defined according to the categories of services offered by the five types of institutions originally composing it. As a result of the groupings and mergers aimed at creating real services networks, one

institution may now fulfill many missions. The notion of “centre” therefore refers to a mission and not to a physical space.

- **The local community service centre (CLSC)** offers everyday health and social services of a preventive and curative nature, as well as rehabilitation and reintegration services.

Over the years, the CLSCs have concentrated their efforts on services to children and youth (well-baby clinics and post-partum follow-up, immunization clinics, health services in schools), on the one hand, and to the elderly, on the other. In 2004, home care and assistance counted for half of all the CLSC’s activities.

- **The residential and long-term care centre (CHSLD)** provides, on a temporary or permanent basis, a substitute living environment as well as necessary services (rehabilitation services, nursing services, psychosocial services, medical services and pharmaceutical services) to the elderly who have lost their independence and to handicapped persons who cannot stay in their natural environment despite the support of their family.
- **The hospital centre (CH)** offers diagnostic services as well as general and specialized medical care in the physical health and mental health sectors.
- **The rehabilitation centre (CR)** provides adjustment, rehabilitation and social reintegration services to persons who need them because of physical or intellectual handicaps, behavioral, psychosocial or family problems, or alcoholism and other drug dependencies. It also provides accompaniment services and family support to the persons involved.
- **The child and youth protection centre (CPEJ)**, or youth centre, as it is commonly called, provides, in its region, services of a psychosocial nature, emergency social services included, to youth whose situation requires it under the *Youth Protection Act* or the *Young Offenders Act* (Canada). The youth centre also provides child placement services, family mediation, medico-legal assessments to the Superior Court on child custody, adoption and, finally, research into biological history.
- **The Health and Social Services Centre (CSSS)**. Since 2005, a new type of institution called the health and social services centre (CSSS) has been established at the heart of every local services network. It groups together, under one board of directors, one or more CLSCs and CHSLDs and, in the majority of cases, the hospital centre in a territory.

The CSSS acts as a base for the local services network, ensuring accessibility, continuity and quality of services for the population in its territory. The CSSS has a responsibility to promote health and well-being; to receive, assess and direct persons to the services required, and to assume care for the most vulnerable. As an institution, the CSSS must also provide a range of general health services and social services, as well as certain specialized services. In order to cover all of the needs of its population, it must also enter into service agreements with other partners (medical clinics, GMFs, community organizations, rehabilitation centres, youth centres, university-hospital centres, etc.).

The CSSSs were established to improve the follow-up care given to persons, since the CSSS, along with the family physician, will become reference points for people, in case of health problems or psychosocial problems. Here, they will receive the appropriate services or be directed to another service-provider in the local network.

- **Advisory Agencies**

Many agencies report directly to the Minister of Health and Social Services. These advisory agencies perform a variety of functions: consultative (Comité de la santé mentale du Québec); administrative (Régie de l'assurance maladie du Québec); concerted action (Office des personnes handicapées du Québec); etc. Four of these are particularly important for medical practice: the Institut national de santé publique du Québec, the Commissaire à la santé et au bien-être, the Agence d'évaluation des technologies et des modes d'intervention en santé, and the Conseil du médicament.

▪ **Institut national de santé publique du Québec (INSPQ)**

This agency's main function is to support the Minister of Health and Social Services and the health and social services agencies in matters of public health.

The creation of INSPQ makes it possible to coordinate public health expertise in Québec. Fulfilling its mission assumes:

- pooling and sharing of expertise;
- research development;
- transmission and best use of knowledge;
- international exchanges.

INSPQ offers a variety of activities and services:

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

INSPQ has many sites in Québec where it conducts its activities.

▪ **Commissaire à la santé et au bien-être (CSBE)**

The position of Commissaire à la santé et au bien-être was created in 2006, its objective being to provide a relevant perspective in matters of public debate and government decision-making applicable to health and well-being. Certain functions devolving to the Commissaire were once exercised by the Conseil de la santé et du bien-être (CSBE) and the Conseil Médical du Québec. The Commissaire took over from these two agencies charged with advising the Minister of Health and Social Services. The mandate was also broadened and includes essentially the following functions:

- evaluating and assessing the results achieved by the health and social services system;
- consulting with citizens, including experts and other players in the health and social services system;
- informing the Minister of Health and Social Services, the National Assembly and all citizens in order to promote a better understanding of the big issues in matters of health and welfare;
- recommending improvements.

- **Agence d'évaluation des technologies et des modes d'intervention en santé (AETMIS)**

The Agence d'évaluation des technologies et des modes d'intervention en santé (AETMIS) is an independent organization reporting to the Minister of Health and Social Services.

Its mission is to advise the Minister and to support, by way of assessment, the decision-makers in the health sector. Its assessments focus on the introduction, acquisition and use of health technologies and on ways and means of dispensing and organizing services.

Promoting assessment, transferring knowledge, training and outreach activities to disseminate Québec expertise are also at the heart of its mission.

- **Conseil du médicament**

The Council's mandate is to assist the Minister in updating the lists of medications covered by the general drug insurance plan and to promote the optimal use of medication. To this end, the Council may:

- conduct or support reviews on the use of medication;
- propose the development and implementation of strategies to educate, inform and sensitize professionals and the public, or contribute to these;
- see to it that problems related to medication use are evaluated and measures put in place to prevent and correct them.

Another function of the Council is to make recommendations to the Minister on pricing and price-trends in medications, and on all other questions the latter submits to it.

Shortly after the tabling of the task force's report on funding for the health care system, in February 2008, the Minister of Health and Social Services followed up on one of its recommendations and gave a mandate for a proposed Institut national d'excellence en santé et services sociaux (INEES), which would be formed by merging AETMIS and the Conseil du médicament. As well as assess technologies and methods of intervention, including clinical effectiveness and cost-effectiveness of medications, this agency would develop clinical practice guides and protocols, review the basket of services covered by the public health system, and identify performance indicators for the health care system. A bill to that effect was tabled in 2009 and adopted on June 10, 2010 (Bill 67).

2.3.2 Medical Organization

The collaboration of physicians is obviously essential to the development of health services networks. Certain structural mechanisms have therefore been established to ensure that the practice of physicians is in keeping with regional priorities. Unfortunately, medical services deemed unanimously to have priority, such as emergency services, proved to be unavailable in certain regions. Legal measures were adopted in recent years to remedy these situations. They require, that physicians respect the medical staffing plans of institutions and regions, that they take part in special activities deemed to have priority, failing which the terms of their agreement with the Régie de l'assurance maladie can be changed. Other legislative provisions have also been adopted to promote interdisciplinary work and a better sharing of responsibilities pertaining to medical activities.

The Regional Department of General Medicine

A regional department of general medicine (DRMG) was formed in each region. It brings together all general practitioners in the region, regardless of their place of practice. This department performs the following eight functions, within the Agency:

- makes recommendations on the number of general practitioners required in the region;
- defines and proposes regional plans for the organization of primary care medical services;
- defines and proposes an access network for 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 centers and for the home-care program;
- makes recommendations on the kinds of general services conducive to priority programs in the region;
- makes recommendations on the particular medical activities required in the region;
- evaluates the extent to which objectives on general care have been achieved;
- advises the regional agency on new projects concerning primary care medical services;
- assumes all other functions assigned to it by the regional agency for 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 an executive committee composed as follows: three members elected by their colleagues, who in turn choose three to nine other members (depending on the region's profile) to represent the various practice profiles of general practitioners in the territory. The president and executive director of the health and social services agency (ASSS), or a physician designated by the latter, also sits on the committee.

The 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 a region, act as department heads within an institution. In the context of powers entrusted to the agency, and respecting the responsibilities of institutions, the panel exercises the following eight functions:

- makes recommendations on aspects of the regional medical staffing plans and ensures the setting up of plans approved by the Minister and decided upon by the ASSS;
- proposes an organization plan, divided by specialty, and specifies for each CSSS the specialized care likely to best meet the needs of the population (including specialized services provided in private practice), and ensures implementation of the agency's decision regarding the plan;
- proposes an accessible network of specialized medical care that may include management of the regional clientele, regional on-call services, and the conclusion of inter-institutional agreements; also ensures implementation of the agency's decision regarding this network;
- evaluates the achievement of objectives applicable to the organization plan and medical staffing plan;
- give its opinion on any project concerning the dispensing of specialized medical services, necessary facilities or equipment, and telemedicine;
- give its opinion on some projects related to medication use;
- gives its opinion on the implementation of service corridors proposed by the Integrated University Health Network (RUIS);
- carries out all other functions entrusted to it by the president and executive director of the agency and applicable to specialized medical services.

The panel is administered by an executive committee formed as follows: three members elected by their colleagues, from three different clinical fields (from among those specified by law); these in turn appoint five to seven other members. The president and executive director of the ASSS, or a physician designated by the latter, also sits on the committee. If there is a medical school in the agency's territory, a member appointed by the dean must be added to the committee, as well as a medical resident as observer.

University Medicine

In 2002, the MSSS announced the creation of four integrated university health care networks (RUIS). These networks must ensure that ultra-specialized care is integrated into educational, research and technologies assessment activities, and that training is evenly spread out in the university and community institutions to which they provide professional support. They must also set up service corridors, give onsite support in the regions, and respond to the needs of local services networks. Finally, the university health care networks have a responsibility to advise ministerial authorities.

The integrated university health care networks rely on partnerships between affiliated hospital centers, their research centers and their faculties of medicine. For purposes of consultation and training, a close partnership links every university health care network with the regions and may even include backup support for the medical workforce. This mandate includes professional development activities for physicians practicing in the regions and on-site training.

Distribution and Commitments of Physicians

In recent years, various legislative amendments have been made concerning medical activities and the distribution and commitments of physicians. Thus, the requests of physicians who wish to practice in an institution or open an office in a precise location are now examined in relation to medical manpower plans. These plans are used to determine the status and volume of activity of physicians practicing in institutions as well as the places of practice of physicians in a given region (regional medical manpower plans or PREM). With respect to family physicians, according to the new rules governing the practice of special medical activities (AMP), the possibility of opting into an agreement on these activities is now extended to all family physicians in a given region. The list of special medical activities (AMP) has also been reworked. Services deemed to have priority status are as follows, in order:

- emergency services in designated institutions;
- care to persons hospitalized in short-term care units of a hospital centre;
- on-call duty in a residential and long-term care centre (CHSLD) or in a rehabilitation centre, or as part of a CLSC home maintenance program;
- obstetric medical services in a centre operated by an institution;
- primary care services to vulnerable clientele;
- any other priority activity determined regionally and authorized by the Minister.

It also puts an end to the differential remuneration given to physicians in their first years of practice. Now, a periodic review of physicians' commitments to PREM and special medical activities (AMP) will serve to ensure that medical services deemed to be a priority are available everywhere.

Inter-professional Sharing of Medical Activities

In the last few years, interdisciplinary work has also been considered a preferred means of maintaining access to quality medical services despite limited medical manpower. The *Act amending 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 laid out a sharing of reserved activities for professionals in the orders contemplated. The same model was used as the basis for reform proposals in the field of mental health and human relations, for which legislative amendments are still expected.

The diagnosis of illness and the determination of medical treatment remain activities restricted exclusively to physicians. Other acts, such as the use of techniques and administration of treatments entailing risks of injury are shared with one or several professionals competent to perform them; some of these acts will be performed following the issuance of an individual or collective medical prescription. These activities are clearly defined in the *Professional Code* or in specific legislation affecting the professional orders concerned. For example, a pharmacist will be allowed to begin or adjust a medicinal treatment if he or she has a medical prescription for this purpose.

Furthermore, nurses holding a certificate in a nursing specialty, pursuant to a regulation of the Ordre des infirmières et infirmiers du Québec, are authorized to perform certain activities restricted to physicians in accordance with the Collège des médecins du Québec authorizing regulation^{1,2} This type of sharing is what is meant by the term “advanced practice.”

2.4 **Conclusion**

The health and social services system is an imposing and complex organization. Approximately 10% of the collective wealth of the community at large is dedicated to it. For the government, this represents over 40% of its program spending. Furthermore, about 7% of Québec’s manpower works in the system.

The establishment of a public health and social services system, coupled with the constant improvement in living conditions, has translated into incalculable gains in the area of health and well-being. This is why, despite the criticisms leveled against it, the health and social services system is still seen as a major achievement and a vital developmental lever.

¹ COLLÈGE DES MÉDECINS DU QUÉBEC, [Lignes directrices sur les modalités de la pratique de l’infirmière spécialisée](#), Montréal, Collège des médecins du Québec, 2006.

² COLLÈGE DES MÉDECINS DU QUÉBEC, [Lignes directrices Étendue des activités médicales exercées par l’infirmière praticienne spécialisée en soins de première ligne](#), 2008.

3 The Professional Practice of Physicians

3.1 *Practice in Institutions*

3.1.1 Introduction

Medical practice in institutions represents a considerable portion of the clinical activities of general practitioners and specialists in Québec. Many factors explain this situation: the complexity of health problems; the sophisticated technologies used in modern medicine; the necessary input of other health and social services professionals; the need to bring these professionals and resources together into functioning entities; and the need to hospitalize and provide accommodation for a great many patients so as to ensure the continuity and quality of their care.

One can expect that, in future, an even greater number of physicians will practice in a variety of health care facilities. Under a new provision of the *Act respecting health services and social services* (LSSSS), all general practitioners must commit themselves to devoting part of their practice to special medical activities (AMP), notably in the emergency room or with patients admitted to a hospital centre or to a residential and long-term care centre (LSSSS, ss. 360 and 361). Physicians who do not make this commitment could see a reduction in pay 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 (sec. 361.1). The terms and conditions of a physician's participation in special medical activities (AMP) are specified by agreement with the Federation of General Practitioners of Québec (FMOQ) or the Federation of Medical Specialists of Québec (FMSQ), whichever is applicable.

Almost all health care institutions in Québec are public. Professional medical practice in these institutions is governed by several pieces of legislation, notably:

- *An Act respecting health services and social services* (LSSSS) and the ensuing *Organization and Management of Establishments Regulation* (ROAE);
- The *Professional Code* and the various regulations ensuing from it, among them *The Code of Ethics of Physicians*;
- *The Medical Act*;
- *The Health Insurance Act* and the agreements concluded with the medical federations pursuant to this law.

In their relations with health institutions, physicians enjoy a special position because of their status as independent workers. They are neither members of the personnel of these institutions (LSSSS, sec. 236); nor executives, nor employees. Physicians are not subject to the provisions of the *Labour Code* or the *Labour Standards Act*, which apply to other health workers (*Health Insurance Act*, sec.19). Medical residents are considered employees of the institution and are subject to the above laws. But they still maintain their professional independence as medical doctors and are thus subject to the *Code of Ethics of Physicians of Québec*.

Physicians are independent professionals, and the agreements concluded between the ministère de la Santé et des Services sociaux (MSSS) and the Quebec Federation of General Practitioners, and the Quebec Federation of Medical Specialists reaffirm this independence, notably by ensuring the freedom to provide therapy and freedom to choose their place of practice, as well as respecting the personal and private nature of the

physician-patient relationship, an important aspect of which is professional secrecy. The freedom to provide therapy means that physicians have the right to decide on the medical care required, to prescribe the appropriate treatments and their mode of administration (Agreement on health and hospital insurance between the MSSS and the FMOQ, Art. 7.04). Institutions must respect this professional independence, within the framework of their mission and their resources (Agreement on health and hospital insurance between the MSSS and the FMOQ, Art 8.01).

While the special status enjoyed by physicians has its guarantees, it also has its obligations. Physicians must respect 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 health care team with constant concern for the quality of care given to their patients. When physicians practice in institutions, they, of necessity, have close relations with the health care network. Hence, the importance of knowing its structures, the internal organization of its institutions and the elements creating an even more specific framework for medical practice.

3.1.2 The Institutions

Since 1991, the *Act respecting health services and social services* (LSSSS) 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 many centres. “The function of institutions is to ensure the provision of continuous and accessible quality health and 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 and financial resources effectively and efficiently and cooperate with other key players.” (LSSSS, sec. 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 an operating permit issued by the MSSS.

The notion of centre refers to the mission of an institution and not to a physical place--for which the term, facility, is used. The *Act respecting health services and social services* establishes five types or categories of centers, whose names are rather explicit in terms of the services offered or the populations served:

- the local community service centre (CLSC);
- the hospital centre (CH);
- the child and youth protection centre (CPEJ);
- the residential and long-term care centre (CHSLD);
- the rehabilitation centre (CR).

Each type of centre has a specific mission, which defines and limits the kind of services offered there (LSSSS, ss. 79-93. See also Section 2.3.1).

A new type of institution was created in 2005: the health and social services centre (LSSSS, s. 99.4). As an institution, the CSSS must offer a certain range of services. But its main responsibility is to ensure that all of the needs of a population are covered. The CSSS is responsible for bringing together the resources in the territory, coordinating their activities, and establishing partnerships essential to the operation of each services network.

Physicians' private offices are not institutions within the meaning of the Act (LSSSS, sec. 95). They are, however, one of the partners with which the CSSS can conclude agreements to better meet the needs of the population.

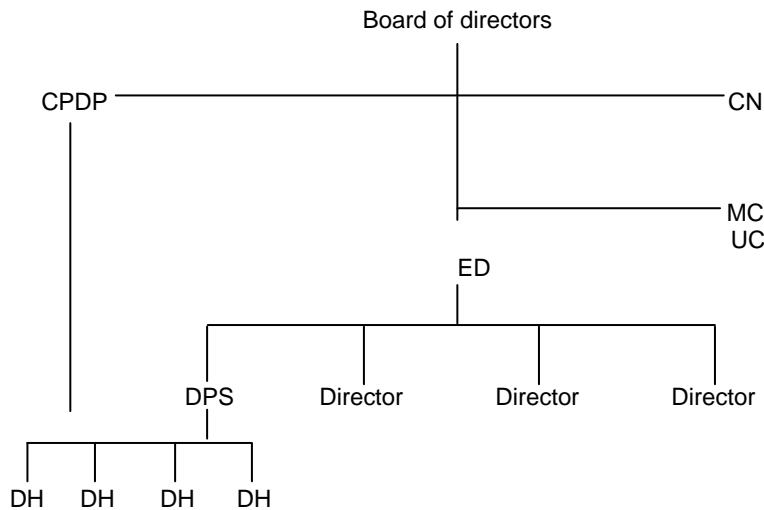
A new legal framework has in fact been created so that resources outside of institutions can be called upon in order to increase access to certain services without compromising the quality of these services (See Section 3.2.5 on the subject of specialized medical centers and associated medical clinics).

3.1.3 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, an executive director, management personnel (which includes a director of professional services), a council of physicians, dentists and pharmacists, a council of nurses, a multidisciplinary council, a users' committee, and a council of midwives, if need be. Each of these bodies performs its functions in all centers operated by the institution.

The following organization chart shows more specifically the organizational structure of a CSSS.

Organization Chart I-1.1
General and medical-administrative organization of institutions and centres



Note: The department head answers to the CPDP on the quality of medical practice in his or her department; he or she is accountable to the DPS for the management of his or her department's resources.

- Key:**
- CPDP: council of physicians, dentists and pharmacists
 - CN: council of nurses
 - MC: multidisciplinary council
 - ED: executive director
 - DPS: director of professional services
 - DH: department head
 - UC: users' committee

The Board of Directors

Until recently, a board of directors was formed to administer the affairs of a particular centre or institution. But to improve the continuity of care and integration of services, legislative amendments were made whereby one board of directors could administer several centers, even several institutions, within a given territory (LSSSS, sec. 119-128).

The composition of this one board of directors may vary, depending on whether the institutions concerned provide rehabilitation or residential services, community health services, or operate a hospital centre. Essentially, it is composed of:

- representatives elected by the population;
- one or two representatives of the users' committee;
- a representative of physicians, dentists and pharmacists;
- a representative of the nursing staff;
- a representative of the multidisciplinary council;
- one or two representatives of the remaining personnel members;
- persons representing foundations and landlords of premises, if applicable, or faculties of medicine, if applicable;
- persons designated by the agency to represent the other institutions in the region and appointed by the Minister to represent the other regions served, if applicable;
- persons designated by the above-mentioned, one of whom will represent the community organizations in the territory;
- the executive director of the institution (LSSSS, sec. 129-133).

A specific board of directors must, however, be formed to administer an institution which operates a university hospital centre, a university institute or an affiliated university centre (LSSSS, sec. 126).

The board of directors manages the affairs of all the institutions it administers and exercises all powers within these, as designated in the list of principal powers of the board (LSSSS, ss. 170–181).

Box No. I-1.1

The principal powers of the board of directors of an institution

The principal powers of the board of directors of an institution are as follows:

1. Manages the affairs of every institution it administers.
2. Establishes the priorities and orientations of the institution.
3. Ensures that these priorities and orientations are respected and are in compliance with the staffing plans approved by the agency.
4. Ensures the pertinence, quality and effectiveness of the services provided.
5. Ensures respect for users' rights and promptness in processing their complaints.
6. Ensures economical and efficient use of human, material and financial resources.
7. Ensures the participation, motivation, enrichment, maintenance of professional standards and development of human resources.
8. Appoints the executive director and senior management officers.
9. Appoints physicians and dentists, assigns a status and grants privileges to them and determines the obligations attached to such privileges.
10. Allocates financial resources to each of the institutions it administers.
11. Concludes service contracts.

12. Appoints the local service quality and complaints commissioner and creates a watchdog committee responsible for ensuring follow-up on complaints and recommendations.

The Executive Director

The executive director of a public institution, under the authority of the board of directors, is responsible for the administration and operation of all institutions which the board administers (LSSSS, sec. 194). In addition to his or her other functions, he or she must “see that the clinical activity taking place in the centre is coordinated and supervised.” (LSSSS, sec. 195).

Organization Plan

“Every institution must prepare an administrative and scientific organization plan. This plan describes the administrative structures of the institution, its divisions, services and departments as well as its clinical programs.” (LSSSS, sec. 183).

As for medical activities, the organization plan of the institution must:

- indicate, on the recommendation of the council of physicians, dentists and pharmacists or the medical service, which department or service is responsible for the medical acts of a clinical program (LSSSS, sec. 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 (LSSSS, sec. 183.1-183.4);
- provide for the creation of clinical departments and services in hospital centres (LSSSS, sec. 184), among them, a clinical department of general medicine which must be under the responsibility of a general practitioner (LSSSS, sec.185);
- provide for, in CLSCs, CRs and CHSLDs, 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 (LSSSS, sec. 186);
- must specify the general practitioner staffing plan; another part must specify the specialist staffing plan. Each of these parts must indicate respectively the number of general practitioners and specialists, by specialty, who may practice their profession in each department or service. Once approved by the ASSS, these parts of the organization plan will constitute the medical staffing plan of the institution (LSSSS, ss. 184 and 186). The CPDP, including the university concerned, if 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;
- provide for a central mechanism to manage access to specialized and superspecialized services in the institution’s clinical departments (LSSSS, sec. 185.1)
- The organization plan must be reviewed every three years.

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. A DPS may be appointed by any other institution (LSSSS, sec. 202).

Under the authority of the 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.” (LSSSS, sec. 203). In performing his duties (see box), he supervises the activities of clinical department heads and acts as interface between the administration and the medical organization of the institution.

Box I-1.2

Functions of the DPS (LSSSS, sec. 204)

1. Directs, coordinates and supervises the activities of the 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 of such.
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 all centres 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. Transmits the necessary information concerning organ and tissue donors, if need be.

The Institution's Resources: Striving for Efficiency

Every institution has a certain quantity of human and material resources to help it accomplish the missions of the centres it operates. The MSSS, through the ASSS, allocates its overall budget for this purpose. The extent of an institution's resources and the budget at its disposal have an effect on the kind of medical services physicians can provide there. For example, a CLSC has no operating room, and CHs do not, as a rule, provide home care. Capital and operating budgets, which determine the total expenses authorized, restrict the sphere of activity of institutions.

Given the government's limited financial capacity and out of a concern for equity in resources allocation, the government authorities and administrators of the health and social services network must reconcile the search for efficiency in the use of its resources with the quality of services, accessibility being one aspect. As medical activities have a direct effect on the effectiveness and quality of services offered in a health institution, physicians are being asked by the board of directors where they practice, through the CPDP and the DPS, to take part in improving the system's efficiency.

3.1.4 Medical-administrative Organization

The medical-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 physicians, dentists and pharmacists practicing in an institution. The lines of authority are established by the *Act respecting health services and social services* and its applicable regulations, which impose obligations on physicians and on the medical-administrative organization, as well as on the institution's administration.

The Council of Physicians, Dentists and Pharmacists

Every institution operating one or more centers where at least five physicians, dentists or pharmacists practice must form a CPDP (LSSSS, sec. 213).

The CPDP includes all physicians, dentists and pharmacists practicing in all centres operated by an institution. Its essential function is to ensure the quality of services provided by its members and, in this capacity, it is directly responsible to the board of directors. The CPDP also has responsibilities with respect to medical activities (see box).

Box I-1.3

The Responsibilities of the CPDP (LSSSS, sec. 214)

1. Control and assess the quality and pertinence of the medical, dental and pharmaceutical acts performed in the centre.
2. Assess and maintain the professional standards of the physicians, dentists and pharmacists practicing in the centre.
3. Make 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 status to be granted to him or her.
4. Make recommendations on the qualifications and competence of a pharmacist who applies for appointment and on the status to be granted to him or her.
5. Give its opinion on the disciplinary measures the board of directors should impose on physicians, dentists or pharmacists.
6. Make 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. Make recommendations on the obligations which may 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 on-call 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. Develop the terms and conditions 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. Give 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 the resources and the administrative sanctions to be included therein.
10. Make 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. Carry 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." (LSSSS, sec. 214). It must submit an annual report of 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 executive director of the institution by giving its opinion on the administrative aspects of various questions (see box) concerning the organization and provision of care.

Box No. I-1.4

Matters on which the CPDP advises the executive director (LSSSS, sec. 215)

1. The measures to be taken 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 questions 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." (LSSSS, sec. 216).

In hospital centers 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 when necessary (ROAE, ss. 97 and 106; LSSSS, ss. 46 and 48). Committees of this kind, which are not obligatory in other institution categories, make for a better distribution of CPDP tasks.

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 (ROAE, sec. 98). It is composed of at least five physicians, dentists and pharmacists designated by the CPDP, the executive director

and the DPS of the institution or, when no DPS has been appointed, a physician designated by the executive director (LSSSS, sec. 217).

The **qualifications committee** is responsible for studying the applications for the appointment of physicians, dentists and pharmacists and recommending to the executive committee the granting of status and practice privileges, as well as renewing them or not every two years. It is responsible for opening and keeping a professional file on each member of the CPDP (ROAE, sec. 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 makes judgments on the quality and appropriateness of the medical, dental and pharmaceutical care given to users; it studies preoperative and postoperative diagnoses, as well as surgical procedure cases where there was no excision; it examines the records of patients who presented with complications and cases of death that have occurred in the hospital centre. It reviews periodically the treatment prescribed for nosocomial infections and for the centre's most common ailments (ROAE, sec. 103).

The **pharmacology committee** sees to it that medications are properly used in the institution and makes recommendations to the executive committee in this regard. It ensures that control mechanisms are put in place, among them, the retrospective study of records, notably records of patients having presented with adverse reactions or allergies. It advises the department head on the selection of medications to be prescribed in the institution and on the rules concerning their use. It assesses requests to use medications for research purposes or for situations of particular medical necessity (ROAE, sec. 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 or her competence, diligence, conduct or compliance with the rules or by-laws of the institution or the CPDP. As required, this committee follows the accepted procedure for the study of complaints concerning physicians, dentists and pharmacists. Essentially, the disciplinary committee hears the professional concerned, as well as his or her counsel, if there is one. After examining the complaint, the disciplinary committee presents its report to the executive committee, which then takes the appropriate measures. When it recommends that a disciplinary measure be applied, the executive committee forwards the file to the board of directors (ROAE, ss. 106-109).

Given the nature of the activities of the various committees of the CPDP, the files and minutes of the meetings of the CPDP and each of its committees are confidential. Thus, nobody may read them except those duly authorized to do so (LSSSS, sec. 218).

Clinical Departments

The organization plan of an institution, in addition to outlining the clinical departments, services and programs, must provide for their formation (LSSSS, sec. 183-184).

In a hospital centre, physicians are grouped together in various departments according to their specialty or type of work, and each department may include several services, each with a specific area of activity. Thus, the department of general medicine may include an emergency service, an extended care service, a family medicine service and a geriatric service. The department of surgery may include a general surgery service, an orthopedic service and a urology service. A physician is usually attached to one department only, but he or she may practice in several services in the same or different department. All hospital centers, except for those designated by regulation, must have a clinical department of general medicine under the responsibility of a general practitioner (LSSSS, sec. 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 facilities have now adopted a program-based mode of management, meaning that all of their clinical activities are grouped according to subject matter. Finally, 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 (LSSSS, sec. 183).

In CLSCs, CHSLDs and 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 (LSSSS, sec. 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 (ROAE, ss. 78.1-81).

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

Clinical Department Head

The head of a clinical department of medicine must be a physician. He or she is appointed by the board of directors after consultation with the physicians practicing in the department, with the DPS and the CPDP (LSSSS, sec. 188). The clinical department head, under the authority of the DPS (LSSSS, sec. 189), directs the activities of all physicians in the department. Furthermore, he or she is accountable to the CPDP, for supervising the manner in which medicine is practiced in his or her department and for establishing the rules for medical care (sec. 190). In CLSCs and CHSLDs where there is no DPS, the head of the medical service reports to the executive director. According to the responsibilities he or she assumes, the clinical department head is accountable to the DPS or the CPDP (see box). The legislator has also entrusted the department head with the task of supervising, in collaboration with the director of nursing services, the medical activities of nurses and other professionals in his or her department who are competent to perform these by regulation of the Collège des médecins du Québec (sec. 190-1.1).

Box No. I-1.5

Responsibilities of the Clinical Department Head, Depending on the Authority under which he Acts:

Under the authority of the DPS (LSSSS, sec. 189):

1. Coordinates, subject to the responsibilities discharged by the CPDP, the professional activities of physicians in his or her department.
2. Manages medical resources.
3. Draws up, for his or her department, rules governing the use of medical resources and material resources used by physicians, and ensures that the central access management mechanism operates as it should.
4. In the case of the clinical head of the radiology department, the clinical head of the medical biology laboratories department, and the clinical head of the pharmacy department, manages the resources of his or her department.
5. Draws up a duty roster.
6. Ensures an appropriate distribution of medical services in his or her department.
7. Ensures compliance with the rules governing the use of resources.

Under the authority of the CPDP (LSSSS, sec. 190):

1. Supervises the manner in which medicine is practiced in the department.
2. Supervises, subject to the responsibilities discharged by the director of nursing services, the medical activities performed by nurses and other professionals in the department who are competent to perform them.
3. Draws up, for his or her department, rules governing medical care and rules governing the use of medication, taking into account the necessity of providing adequate services to users and the organization and available resources of the institution.
4. Gives his or her 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 duties of his or her department head vis-à-vis the physicians in the service; nonetheless, he or she still answers directly to the department head for all duties performed as head of the service.

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

3.1.5 Conditions of 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 (LSSSS, ss. 237-243 and 251);
- produce a document in which he or she acknowledges having read the resolution (LSSSS, sec. 243);
- hold a valid professional liability insurance policy (LSSSS, sec. 258);
- fulfill the obligations attached to his or her appointment (LSSSS, sec. 242);
- observe the by-laws of the institution and the CPDP (LSSSS, ss. 242 and 249).

Appointment

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

Box No. I-1.6
Steps Leading to a Physician's Appointment to Practice in an Institution
(LSSSS, ss. 237-248)

1. The physician makes an application for appointment to the executive director of the institution.
2. The 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 studies the application for appointment.
4. The CPDP makes a recommendation to the board of directors.
5. The board of directors checks with the Agency to ensure that the appointment complies with the regional medical staffing plan (PREM).
6. The board of directors approves or refuses the application for appointment. It then communicates its decision in writing to the physician, giving its reasons.
7. The physician whose appointment has been approved attests in writing to having read the content of the resolution.

When approving the appointment of a physician, the board of directors must set out the status and privileges of this physician, the period for which they are granted, and the nature and scope of the medical activities he or she may engage in at the centre. In addition, the resolution of the board of directors must ensure that the physician makes a commitment to fulfill the obligations attached to the enjoyment of his or her privileges, which are determined following the recommendations of the CPDP (LSSSS, sec. 242).

All appointments must comply with the medical and dental staffing plan defined in the institution's organization plan. The board of directors must, before accepting a physician's application for appointment, receive the approval of the agency. The latter ensures that the medical staffing plan of the institution justifies the appointment. An appointment granted when the complement of the medical staffing plan has already been reached may be withdrawn (LSSSS, ss. 239, 240, 240.1 and 240.2).

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

The physician's **status** determines his or her membership and level of participation in the CPDP (active member, associate member, advisory member, honorary member). A physician, dentist or pharmacist is granted a status based on the extent of the activities he or she performs for the institution (ROAE, ss. 87-96).

Privileges are granted to a physician or dentist in terms of the hospital centre's organization and manpower plan. Privileges determine the nature and scope of medical acts that a physician may perform in a department (ROAE, s. 86).

The **obligations** attached to the enjoyment of privileges concern the physician's participation in activities related to the centre's requirements, notably (LSSSS, sec. 214):

- participation in clinical activities, including on-call duties;
- participation in teaching and research activities, as necessary;
- participation in professional, scientific, medical or administrative committees;
- participation in medical activities pursuant to an agreement between institutions (LSSSS, ss. 108-109). In this case, the agreement must be made known to the physician and be valid at the time of his or her application for appointment or renewal of appointment.

The privileges granted to a physician are usually for a period of two to three years. Except on notice to the contrary, the application for renewal of the appointment is made automatically and on the same terms as the last application (LSSSS, sec. 237). An application for renewal "may be refused by the board of directors only on the basis of criteria of qualifications, scientific competence or the conduct of the physician [...], having regard to the specific requirements of the institution and fulfilment of the obligations attached to the enjoyment of privileges" (LSSSS, sec.238).

Regulations and By-laws

The regulations and by-laws a physician must observe in an institution are notably as follows:

- The regulations of the *Act respecting health services and social services*;
- The regulations of the *Professional Code*, among them, the *Code of Ethics of Physicians*;
- The regulations of the CPDP;
- The rules of the institution;
- The *Regulation respecting the standards relating to prescriptions made by a physician*.

The CPDP regulations govern the functioning of the council itself and member participation in its activities. The rules of an 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 (LSSSS, sec 189).

Among these rules, two of them 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 coming into effect, these rules must be approved by the board of directors, acting on prior advice received from the CPDP on the subject. They must also provide for administrative sanctions in cases of non-compliance (LSSSS, 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, as well as the organization and available resources of the institution.

These are usually drawn up by the clinical department head, under the authority of the CPDP (LSSSS, sec. 190). The pharmacy department head or the pharmacist may also, under the authority of the CPDP, draw up rules for the use of medications (ROAE, sec. 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 these (LSSSS, sec. 207), and the council of nurses (CN) must make recommendations concerning such rules (LSSSS, sec. 192).

These rules come into effect after having been approved by the board of directors, on the recommendation of the CPDP (LSSSS, ss. 189, 192, 214). The LSSSS also stipulates that physicians practicing in the various departments must be subject to the same set of rules. Thus, in identical clinical situations, two departments may not adopt two different rules. It is up to the CPDP to recommend a single set of rules (LSSSS, sec. 190). Note that certain of these rules may concern specialized nurse practitioners.

The rules of an 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 (LSSSS, sec. 189).

Non-compliance with Rules

A physician who does not comply with certain rules and regulations is liable 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 [conditions of his or her appointment]. The disciplinary measures must be imposed in accordance with the procedure prescribed by regulation [...]. The executive director must send a copy of the decision to the professional order concerned" (LSSSS, sec. 249).

When the board of directors decides to apply a disciplinary measure against a physician, it must communicate its decision to the latter, 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 (ROAE, sec. 109). The physician concerned by the disciplinary measure may contest the decision before the Administrative Tribunal of Québec (LSSSS, sec. 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" (LSSSS, sec. 189). However, they cannot be considered as affecting 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 reasons justifying the decision and ensures that it is applied. The physician concerned by such a decision may contest the decision before the Administrative Tribunal of Québec (LSSSS, sec. 205).

Cessation of Practice in Institutions

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 supervising the cessation of practice in an institution are also in place.

A physician may cease to practice in an institution by choice or if his or her appointment is not renewed. If a physician decides to cease practicing in a centre, he or she must give prior notice of at least 60 days to the board of directors. Once received by the board of directors, this notice is irrevocable (LSSSS, sec. 254). However, the board may authorize the departure of a physician before the 60 days have expired (LSSSS, sec. 255).

When a physician ceases to practice in a centre without the authorization of the board of directors or before the 60 days have expired, 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 (LSSSS, sec. 257). Furthermore, the Collège des médecins is notified in writing if the board of directors judges that the departure affects the quality or accessibility of medical services.

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

Remuneration

Like the LSSSS and its regulations, the agreements and their appendices with medical federations fix the conditions of medical practice relative to health insurance and hospitalization insurance. Thus, the agreements prescribe payment methods and pay-scales in institutions and elsewhere. They also determine certain conditions of practice in institutions for physicians paid a fixed honorarium or a salary and for physicians paid a per diem payment. Physicians and institutions are bound by these agreements.

The methods of remuneration are specified in the agreements. Fee-for-service, flat rate, mixed payment, hourly rate, fixed honorarium and salary are the main methods of payment of physicians. The conditions for applying each of these payment methods are also defined in the agreements, depending on the institution in which the physician practices, his or her 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 (LSSSS, sec. 259 and 505).

3.1.6 Examining a Complaint Concerning a Physician

Every institution must establish a procedure for examining complaints filed by users (LSSSS, ss. 29-59). A special procedure applies for the examination of a complaint filed by a user against a physician or a medical resident (LSSSS, ss. 41-59).

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, but who will be responsible for applying this procedure. Note that this physician may also examine a complaint filed by someone other than a user (LSSSS, sec. 44).

The medical examiner assigned with a complaint filed against a physician or a medical resident must choose the appropriate steps to be taken from among the following possibilities:

- examine the complaint pursuant to the LSSSS (ss. 45-50);
- forward it to the CPDP for “study for disciplinary reasons by a committee formed for this purpose”;
- forward it to the authority determined by regulation, if it concerns a medical resident;
- dismiss it if he judges it frivolous, vexatious or in bad faith.

In cases of examination of a complaint concerning a physician, the latter must collaborate with the medical examiner and the members of the disciplinary committee, if there is one.

The medical examiner must “transmit his or her conclusions in writing to the user and the physician concerned, together with the appropriate recommendations, and inform the user of the conditions and procedures” at his or her disposal (LSSSS, sec. 47).

The user who does not agree with the conclusions sent to him by the medical examiner or said to have been sent to him by the medical examiner may make a written or verbal request for a review of his complaint before the review committee (LSSSS, sec. 53). The review committee is composed of three members appointed by the board of directors of the local authority. The committee chairperson is chosen from among the elected or co-opted members of the board of directors. The two other members are appointed from among the physicians, dentists and pharmacists practicing in the same network, on the recommendation of the CPDP, the local authority or other institutions in the territory or, in the absence of such council, after consultation with the physicians, dentists and pharmacists concerned (LSSSS, sec. 51).

When the medical examiner sends a complaint to the CPDP to be examined for purposes of discipline, 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 the application of a disciplinary measure, the executive committee of the CPDP must then send the file to the board of directors (ROAE, ss. 106-109).

If the user’s complaint concerns administrative or organizational problems that involve medical, dental or pharmaceutical services, it must be examined by the local service quality and complaints commissioner (LSSSS, sec. 45).

3.1.7 Physicians: Essential Care Providers in Institutions

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

3.2 *Practice Outside an Institution*

3.2.1 Introduction

Traditionally in Québec, we distinguish two ways of practicing medicine — practice inside an institution and private practice. However, the dividing line between private office and public institution has become more and more permeable for a variety of reasons which are not pertinent for discussion here.

Family physicians do not only work from their office. They are being called upon to provide various forms of care and services in medical institutions to a greater and greater extent. In addition, increasingly specialized care is migrating outside of institutions and into treatment facilities that can no longer be simply qualified as doctors' offices. New organizational models somewhere between institutions and private offices have been growing in number for several years, with their sole common characteristic being that the care is being dispensed outside of the institutional setting.

In this section, we will strive to present a global vision of medicine being practiced outside of institutions in Québec and to offer a clear interpretation of its evolution. In so doing, we will emphasize certain aspects that, regardless of the organizational model, we believe raise various issues with respect to the quality of physicians' professional practice.

In the face of these issues, current laws and regulations do not always offer the coherent answers we would hope for. As we will see in the following chapters, the requirements of the *Code of Ethics* apply to all physicians regardless of their place of practice (Chapter 2, Section 3.1). Moreover, new administrative rules were adopted in 2007 with respect to the types of associations possible for physicians, whether they practice within or outside of an institution. In addition, the rules pertaining to advertising were also revised in 2010. For its part, private practice must satisfy the obligations established in a regulation governing the operation of offices that was updated in 2005 (Chapter 2, Section 3.2). In modifying certain provisions of the *Act Respecting Health Services and Social Services* (LSSSS) and the *Act Respecting Health Insurance* (LAM) in 2006 and 2009, the Québec government established a governing framework for two new bodies — specialized medical centres (CMS) and associated medical clinics (CMA). However, now that a number of interventions previously restricted to institutions can be carried out outside of these settings, several questions have emerged and remain unanswered.

Among all the requirements imposed within an institution, which are still pertinent? For example, do we need to obtain written consent before embarking on any surgery, invasive procedure or research project? By calling for written consent when treatment is not medically required, the *Civil Code* only offers a partial response (see Chapter 3, Section 4.1). Practice outside an institution raises numerous new questions which the Collège is attempting to answer, be it in the *Code of Ethics*, in its regulations, in the guidelines, or in the practice guides³. As you will see in this section, vigilance must always be the order of the day for physicians.

³ COLLÈGE DES MÉDECINS DU QUÉBEC. [La rédaction et la tenue des dossiers par le médecin en cabinet de consultation et en CLSC : guide d'exercice](#), Montréal, Collège des médecins du Québec, September 2006.

COLLÈGE DES MÉDECINS DU QUÉBEC. [La tenue des dossiers par le médecin en centre hospitalier de soins généraux et spécialisés : guide d'exercice](#), Montréal, Collège des médecins du Québec, December 2005.

With respect to the more practical aspects of practice outside of institutions, we recommend consulting the documents published by medical federations (FMOQ and FMSQ) and medical associations (CMA, CFPC, RCPSC). The [Québec Federation of General Practitioners \(FMOQ\)](#) Web site offers several training modules designed for medical residents and focused on such subjects as the choice of a location to practice, possible modes of compensation, billing, financial planning and insurance, specific medical activities (AMP) and required medical manpower plans (PREM). For more information about the new organizational models, it would be useful to consult the [Ministère de la Santé et des Services sociaux \(MSSS\)](#) and [Régie de l'assurance maladie du Québec \(RAMQ\)](#) Web sites. However, given the extremely rapid pace with which this area is evolving, the best way to remain informed is often to follow the news.

3.2.2 Practice Outside an Institution and the Health Care System

We often draw a distinction between practice within and outside of an institution as if these two forms of medical practice were totally different. In actual fact, according to the terms of the *Act Respecting Health Services and Social Services* (LSSSS, Section 95), private doctors' offices are not considered to be institutions. Nevertheless, the care offered therein constitutes an essential component of the health care system. Most of the medical services offered outside of an institutional setting are covered by the health insurance plan because they are medically required. They are often needed prior or subsequent to the provision of care in institutions that are part of the public network, which makes private offices, and other resources, indispensable partners of the health care system in Québec. Indeed, these resources are increasingly perceived as collaborators with which network institutions should be forging agreements in order to better meet the growing needs of the population.

Private Practice

Over the past few decades, the position of physicians who practice outside of institutions has changed considerably vis-à-vis the health care system. Compared to working in an institutional setting, private practice is always considered to offer more benefits both for patients and physicians, including theoretically greater accessibility, more direct doctor-patient contact and simplified administrative formalities. Doctors in private practice enjoy more professional freedom and manage all aspects of their practice, such as the booking of appointments, keeping of files, work schedule, personnel management, organization of office materials, not to mention assuring the quality of equipment and professional services.

However, we know that private practice also has its disadvantages. First of all, management costs can be relatively substantial. These costs vary depending on the particular discipline, type of activities and place of practice. In order to partially compensate for the inherent costs of private practice, provision has been made for differential remuneration for interventions based on whether they are carried out in institutional or private settings. Within the context of certain organizational models, such as family medicine groups (GMF) and network clinics, additional support is now offered for time-consuming administrative tasks and technical matters. In the case of private practice, this support is usually more limited, particularly for doctors practicing alone, which, in turn, reduces the range of services they can provide.

COLLÈGE DES MÉDECINS DU QUÉBEC. [La chirurgie en milieu extrahospitalier : guide d'exercice](#), Montréal, Collège des médecins du Québec, May 2005 (under revision).

COLLÈGE DES MÉDECINS DU QUÉBEC. [Utilisation de la sédation-analgésie : lignes directrices](#), Montréal, Collège des médecins du Québec, November 2009.

In general, basic services in family medicine include consultations with or without appointment, minor surgery, home visits and, occasionally, specimen collection. For specialties, the variety of services offered varies with the discipline. If the size of the office and its location in a polyclinic allow, laboratory imaging and specialized consultation services may be offered. The location of the practice and the proximity of a medical centre are factors that also have an influence on the types of care 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. Of course, physicians must not collaborate with any individuals practicing medicine illegally (*Code of Ethics of Physicians*, Section 62).

Networks of Primary Care Services

Since the introduction of health insurance, numerous efforts have been made to further integrate private doctors' offices into the public network. The most significant initiative is unquestionably the creation of *Centres locaux de services communautaires* (CLSC). Over the past few years, a number of health and social service agencies have established integrated primary care service networks, with the principal objective being to increase accessibility in given territories. Private offices that voluntarily join these networks must meet specific criteria with respect to the services offered and hours of availability. In certain cases, they are part of an on-call system that operates 24 hours a day, 7 days a week and that is established within their territory to offer home care services to clients in collaboration with *Centres de santé et de services sociaux* (CSSS). Since the fusion of health care institutions in 2005, CSSSs are obliged to assume responsibility for the public within the territory of their local health networks (RLS). Furthermore, in order to meet all of the public's needs, they must establish agreements with medical clinics and GMFs.

For their part, regional departments of general medicine (DRMG) established within agencies are responsible for defining primary care service needs in their territory. They also advise agencies and the Ministry with respect to their respective regions' medical manpower plans (PREM) and ensure that physicians participate in particular medical activities (AMP) they deem to be priorities in their regions. In various areas of Québec, there are CSSS and DRMG committees in place to see that private practice offices work increasingly as part of this network.

As we will see further on, other organizational models, such as specialized medical centres (CMS) and associated medical clinics (CMA), are striving to concretize the desired complementarity.

3.2.3 Practice Outside an Institution and the Health Insurance Plan

For most of their interventions, the vast majority of physicians are remunerated by the Régie de l'assurance maladie du Québec (RAMQ). Although it is always possible for physicians who practice outside of institutions not to participate in the public health insurance plan or to opt out, such doctors are relatively rare in Québec.

Consequently, it is difficult to understand the current situation and its issues without being cognizant of the fundamental aspects of the provincial health insurance plan as it presently operates. In that regard, we consulted the information presented on the [Régie de l'assurance maladie](#) Web site. RAMQ is the organization that administers the province's public health and drug insurance plans. In so doing, it informs the

population, determines the eligibility of individuals, compensates health professionals (doctors, pharmacists, dentists) and assures the secure circulation of information.

Persons Insured Under the Plan

Since November 1, 1970, all residents or visitors to Québec who meet the conditions stipulated in the law are covered by the provincial health insurance plan. To be eligible for insured health care services, individuals must present their valid health insurance card. If the card has expired, they must pay for any services rendered and claim a reimbursement from the Régie. Generally, individuals originating from outside Canada, even if they are Canadian citizens, are eligible for Québec health insurance after a waiting period, of up to three months, subsequent to their registration. This waiting period is also known as the “délai de carence”.

However, certain health care services could be rendered without charge depending on an individual’s particular situation. These could include services for victims of conjugal or family violence or sexual assault, services related to pregnancy, childbirth or abortion, or care provided to people with health problems of an infectious nature that could have repercussions from a public health standpoint. Québec has also signed social security agreements with certain countries exempting citizens of these countries from the usual waiting period.

Natives of another province who settle in Québec are eligible for coverage under the provincial health insurance plan as soon as they are no longer covered by their province of origin’s plan. Coverage under the Québec plan generally begins on the first day of the third month following their arrival in the province. The individual receives the health insurance card within two weeks of the effective date of coverage. While the person remains covered under their province of origin’s health insurance plan, they must present the health insurance card issued to them by that province to the physician when they require health care in Québec. As such, their province of origin’s health insurance plan will assume the costs incurred. However, if the physician refuses the card, the individual must pay the doctor directly and then request a reimbursement from the body administering the plan in their province of origin.

Services Covered in Québec

Insured individuals can take advantage of a number of free services covered under the health insurance plan. In addition to medical services, the plan covers a range of other more specific health care needs, such as dental treatments for children under the age of 10.

With respect to medical services, regardless of where they were rendered, the health insurance plan was initially designed to cover required care provided by a family physician or specialist. These services included examinations, consultations, diagnostics, therapeutic interventions, psychiatric treatments, surgery, radiology and anaesthesiology. Health care systems have since undergone numerous changes, and it is not always easy to determine what is now part of the “basket of services” covered in Québec.

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, in fact, being rendered by physicians. The health insurance card cannot be presented for these services, whatever physician is providing them, and the cost of such care must be assumed by the recipient. Treatments rendered for purely aesthetic purposes are a classic example of these types of services.

Some services are not covered because they are not related to the prevention or treatment of an illness. These include visits to a doctor and, if applicable, tests passed to obtain an insurance policy or its reinstatement, to obtain or retain a job (unless the test is required by Québec legislation other than the *Act Respecting Collective Agreement Decrees*), to obtain a passport or visa, or to be admitted to an academic institution, association, organization, summer camp, fitness centre, athletic club, daycare centre or recreation department.

When an individual sees a doctor and undergoes tests for the sole purpose of obtaining a health certificate, they must also assume the costs. Moreover, although certain exceptions may apply, tests required for legal purposes are also not covered.

Coverage of certain services may vary depending on where they are rendered. For example, some services are only covered if dispensed within an institution. These include most lab tests and some medical imaging, such as ultrasound, computer tomography and magnetic resonance.

Certain services are covered upon special authorization only. As no treatments rendered for aesthetic reasons are covered under the health insurance plan, a physician must determine if the service is requested for such purposes alone, or if it is necessary from a medical standpoint. Services for which a medical consult is required to determine if they are covered by the RAMQ include mammoplasty, abdominal lipectomy, blepharoplasty, electrolysis in the event of hirsutism, treatment of a scar in a location other than the face or neck, and skin grafts required subsequent to a trauma.

Coverage can also be more or less comprehensive. Even if an individual presents their health insurance card for health care services that are covered under the plan, certain costs could be billed to them. In that regard, the term “incidental fees” designates costs billable to patients for some services, even if they are associated with insured services. For example, physicians are entitled to request financial compensation for medications and aesthetic agents used in private practice, for the completion of certain medically related administrative forms, as well as for copies and summaries of files prepared and transmitted upon the request of patients.

Physicians Participating, Opting Out or Not Participating in the Plan

According to the terms of the *Act Respecting Health Insurance*, health care professionals authorized to provide insured services are distinguished based on whether or not they participate in the public health insurance plan. Most Québec physicians participate in the plan. In other words, they accept the health insurance card. Consequently, insured individuals do not generally have to pay for covered services. The Régie pays these participating doctors directly for services rendered in accordance with the agreements negotiated between the government and the medical federations (FMOQ, FMSQ).

Although they are few in number, some physicians who have so-called “opted out” do not accept the card but respect the fee structure as per the agreements. They bill their services to their patients, who can then request a reimbursement from the Régie using the form obtained during their visit. Of course, these physicians must advise their patients of this situation in advance.

Another small percentage of doctors, referred to as “non-participants”, do not adhere to the health insurance plan in any way whatsoever. They bill their services directly to patients, establishing their fees entirely on their own. Barring certain exceptions, the Régie does not reimburse the cost of any services rendered by these physicians, even

in the case of covered services. A non-participating physician who renders an insured service in accordance with the law in an emergency situation may bill the Régie for the amount of fees payable by virtue of the agreement. Non-participating physicians are also obliged to advise people who consult them of their mode of operation before any services are rendered.

Unless otherwise indicated, all physicians participate in the health insurance plan. If they opt out or decide not to participate, they must advise the Régie in accordance with certain terms and conditions prescribed in the agreements. A physician who has opted out or chosen not to take part in the plan can re-adhere to it by filing a formal request. Although it is always possible for physicians to choose not to participate or to opt out of the health insurance plan, a number of the provisions of the *Act Respecting Health Insurance* serve to prevent them from both participating and not participating in the plan (“mixed practice”). The Régie has a list available of [physicians who have opted out or do not participate in the health insurance plan](#). While this list is growing, the number of physicians concerned remains relatively low. Moreover, the government reserves the right to intervene if the Minister deems this number to be too high so that insured services can continue to be rendered in accordance with standardized conditions throughout Québec or within any of its regions (*Act Respecting Health Insurance*, Section 30).

With all the combinations of these three variables being possible (persons insured by the plan, services covered under the plan, and physicians who do or do not participate in the plan), situations can vary considerably outside of institutions. Most of the time, physicians who participate in the plan offer covered services to insured individuals. However, a participating physician may also offer services that are not covered. As well, they could provide covered services, but to individuals who are not insured. At the same time, an insured person could also decide to consult a non-participating doctor to obtain services that would be insured if the physician participated in the plan. And so on, and so forth.....

Despite this great diversity, the fundamental issues remain essentially the same from a doctor’s professional ethics standpoint. When certain costs are billable to the patient, the physician must notify them of such in a very clear and timely fashion. Whether the physician participates in the plan, whether the patient is eligible for coverage under the plan or whether the services are insured, this rule remains unchanged. The cost of certain services, materials or other expenses must clearly be displayed in the physician’s waiting room. Furthermore, if a patient believes that a doctor’s fees are unjust and wishes to contest a bill, they can contact the Collège’s Investigation Department to obtain information and [request an account resolution](#).

3.2.4 Provision of Care Outside Institutions

How medical practice is positioned vis-à-vis the health insurance plan and the health care system, makes it easier to understand that this form of practice complements various organizational models. Moreover, the health care system that prevails in Canada and Québec is often described as a “mixed system”, with the financing of the plan and management of the system being essentially public, while the provision of care is far from being limited to public institutions. Since the beginning, it was established that all health care institutions had to be publicly managed and funded in Canada and Québec. However, the modes of financing and management could always vary for other organizations providing health care.

It is important to properly distinguish between the financing of organizations providing care and the funding of services themselves, which is or is not assumed by the health insurance plan depending on whether or not the patient and service are covered and

whether or not the physician is participating in the plan. Since the creation of the health insurance plan in Québec, the principal sources of financing for organizations other than public institutions have been the professional fees claimed from the RAMQ by physicians, and the management of these organizations has been, more often than not, handled by these doctors. However, the financing may also originate from another government body like the *Commission de la santé et sécurité du travail* (CSST), 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” financing we have just described. A public subsidy can be granted in return for a commitment to offer a defined service. This is the case for GMFs and what is expected for CMAs. Various combinations are thereby possible, even if some of these remain newly emerging phenomena for the time being. Presently, there are only a few specialized medical center projects, but these are already posing new financing and management challenges because they involve considerable private investments out of all proportion to what has been required to date by private doctors’ offices.

3.2.5 Different Organizational Models

There have been several formulas applied, be it to develop medical services offered outside of institutions by physicians practicing alone or in groups, or to promote their integration into the public network. Such endeavours are family medicine groups (GMF), network clinics, specialized medical centers (CMS), associated medical clinics (CMA) and health care cooperatives. These different modes of organization will be summarily described in the sections that follow.

Individual and Group Practice

In the case of independent private practice, the family physician or specialist practices alone in their own office or individually at a private polyclinic. A minority of doctors are now opting for this type of practice. Although a model that is less and less commonplace, it does offer some advantages, including a more personalized doctor-patient relationship.

In group practice, a certain number of doctors join together in an organized and autonomously managed clinic, or they associate with an already established larger group, such as a private polyclinic. In accordance with the regulation governing the keeping of files (see Chapter 2, Section 3.2.1), physicians who practice in a group can maintain one single medical file per patient. This type of practice is increasingly becoming a favoured option among physicians.

Family Physician Groups

In 2000, the Commission examining health and social services in Québec (Clair Commission) recommended the establishment of family medicine groups (GMF). The purpose of creating this new structure for the provision of services was to improve accessibility, dispensation and continuity of care, as well as to entrust clients with greater responsibility. The MSSS estimates that, with 300 average-sized GMFs in place catering to between 15,000 and 24,000 individuals, a total of 75% of the Québec population could be registered with a physician who is a member of a GMF. There are currently both small and large GMFs in place. The first such groups appeared in November 2002, and by 2009, there were close to 200 GMFs operating in the province.

GMFs are comprised of a sufficient number of physicians to assure the equivalent of six to 12 full-time family doctors (ETC) who agree to perform activities specific to GMFs — consultations with or without appointment and home care. These physicians work as a group in an office, CLSC or out of family medicine units (UMF) in close collaboration with nurses and other health professionals. Recognized as a functional body, the GMF defines the services it offers in accordance with those expected of it. In return, it enjoys the benefits of agency and MSSS support. One physician in each GMF takes care of allocating tasks, assigning responsibilities to members of the group, and managing the allotted budget with the personnel who have been designated for that purpose.

Doctors who belong to a GMF sign an agreement among themselves that establishes the decision making procedures within the group, particularly the distribution of tasks and responsibilities. In addition, the group must conclude an agreement with the CLSC in their territory in order to integrate a psychosocial component into its service offerings. As part of a written agreement with the agency, the GMF defines its commitment to the specific services that are to be offered, and in return, the agency agrees to offer specific technical and financial support.

Registration with a physician member of the group is voluntary, free, without territorial limit, and serves as a fundamental element of this organizational model. From an administrative standpoint, the subsidy will be granted based on a progressive scale that takes the weighted number of individuals registered with all members of the GMF into account. The number and type of patients registered with an ETC physician in a GMF normally varies between 1,000 and 2,000. What physicians appreciate most in this model from a clinical standpoint is the important complementary role played by nurses.

Associated Medical Clinics and Specialized Medical Centres

As noted in the previous chapter, a new legal framework was created subsequent to the decision rendered by the Supreme Court in the Chaoulli-Zélotis case in 2005 (Chapter 1, Section 2.2). This framework, outlined in Bill 33 (*Act to Amend the Act Respecting Health Services and Social Services and Other Legislative Provisions*) adopted in December 2006 and clarified in Bill 34 (*Act to Amend Various Legislative Provisions Concerning Specialized Medical Centre and Medical Imaging Laboratories*) adopted in June 2009, is aimed at using resources outside of institutions so as to increase access to certain specialized services without compromising the quality of these services⁴.

Specialized medical centres (CMS) were 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 heretofore provided in institutions. The conditions include obtaining an operating permit issued by the government, appointing a medical director responsible for assuring the quality of the medical services offered, and certification by a recognized organization within three years of obtaining the operating permit. The services specified in the regulation subsequently adopted, and in effect since March 31, 2010, presently consist of surgical interventions that were determined based on the length of stay and the type of anesthesia required, as well as the risks involved⁵. The law recognizes two types of

⁴ See the Appendix containing the currently most pertinent sections of the *Act Respecting Health Services and Social Services*.

⁵ The *Regulation Respecting the Specialized Medical Treatments Provided in a Specialized Medical Centre* can be consulted in the Appendix.

CMS — those where exclusively physicians who participate in Québec's health insurance plan practice, and those with only non-participating physicians.

For their part, associated medical clinics (CMA) — whether or not they are specialized medical clinics or laboratories — were defined as places where physicians who participate in the health insurance plan offer certain services as part of a partnership agreement with an institution operating a hospital centre and with the agency concerned.

Network clinics possess certain characteristics of associated medical clinics. In this model, which is widespread today in the Montréal and Québec City regions, a large number of full-time equivalent (ETC) physicians (generally more than 10) form a group and establish an agreement with a CSSS to offer an extensive range of services with and without appointment (a proportion of approximately 50%). In Montréal, the framework is defined by the agency and the Regional Department of General Medicine. These network clinics operate day and night, on weekends, and on legal holidays. They are mandated to accept so-called orphan clients with no family doctor and those deemed as being vulnerable. In addition to enjoying benefits with respect to remuneration, network clinics have the support of the agency and the use of service corridors to access secondary care medical services. They must have rapid access to basic imaging services and ultrasound, and they are also responsible for helping to find a family doctor using a primary care network they maintain with nearby private practices. It is estimated that a network clinic typically offers services to approximately 50,000 clients.

Health Care Cooperatives

Over the past few years, another health care services organizational model has developed. There are now several health care co-operatives in place for citizens in Québec, generally in locations where there was a scarcity or risk of losing medical resources or health care services. The formula rests on the leadership of people engaged in their milieu, working in collaboration with health care professionals. The members, who must make a contribution, establish structures that support professionals and make the specific services offered by the cooperative accessible.

This model has some unique and interesting characteristics, but it also raises several questions. For example, the physician may enjoy certain benefits from an administrative standpoint, including reduced or even free rent, which, in another context, could be considered to be an unacceptable advantage. At the same time, it must be clear that the fact a patient does not join the cooperative or does not renew their membership cannot in any way whatsoever constitute a hindrance to the accessibility and continuity of care, nor influence the quality of care. It remains to be seen how this formula can respect the ethical obligations of physicians, coexist with a public health care system, and work harmoniously with other organizational models.

3.2.6 Common Professional Issues

The framework for medical practice has been designed for the institutional model on the one hand and private practice on the other. What happens in the case of all these 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 have any easy answers.

Some of these situations probably require a framework that resembles what exists in institutions for the same types of medical interventions and which we have discussed in the previous section (Chapter 1, Section 3.1). Others are more similar to private

practice and should meet its requirements, which we will address in the following chapter (Chapter 2, Section 3.2.1). In fact, the [*Regulation Respecting the Keeping of Records, Physicians' Rooms or Offices and Other Effects*](#) establishes standards for the organization of a private practice. The regulation clearly outlines the rules regarding the keeping of records, doctors' rooms or offices and other effects. It also stipulates the procedure to follow in the event of a cessation or reorientation of the practice.

Fortunately, certain reference points are common to all situations. Regardless of the location or type of practice, whatever the circumstance, physicians remain autonomous professionals responsible for their actions. Whether in an institution, a private setting or elsewhere, the practice of the profession is governed in Québec by the [*Professional Code*](#), the [*Medical Act*](#) and its ensuing regulations, and the [*Code of Ethics of Physicians*](#). The doctor is always bound by the same obligations with respect to competence, providing assistance, respecting professional secrecy or maintaining their professional independence. Moreover, some provisions offer detailed stipulations to better guide physicians faced with situations of greater concern. For example, it has been clearly specified that the physician cannot exhibit "interventionism", which is to say, the doctor must respect the patient's freedom of choice to have prescriptions filled in the location of their choice. Provisions that could apply to the leasing of premises have also been stipulated, and rules governing incorporated practice were updated and are much more explicit with respect to acceptable practices. As well, rules pertaining to physician advertising have been defined.

Furthermore, there are some specifications with regard to the billing of medical interventions. Billing is subject to the agreements concluded with the MSSS, the Québec Federation of General Practitioners (FMOQ), or the Québec Federation of Medical Specialists (FMSQ), as applicable. For reference purposes, the various medical associations also publish fee schedules for the costs charged to patients. The MSSS exercises a certain degree of control via the issuance of permits that 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, as this evolution is giving rise to new challenges on a daily basis.

Maintenance of Competency

The obligation of maintaining competency is inherent to the practice of all professions, and medicine is no exception. Personal needs and practical and organizational contexts vary a great deal from one individual to another, and all physicians are considered to be responsible for their own approach. Several programs exist to support physicians in their individual continuing professional development (DPC) efforts. For instance, the Collège des médecins du Québec's self-management plan offers its members a simple and straightforward approach to carrying out their individual DPC plan. In fact, there are multiple opportunities for professional development. Group practice and exercising the profession within milieus where there is a concentration of health care professionals favour such programs. Clinical contacts also constitute learning opportunities for physicians, and today, the possibilities for discussing cases are multiplying with the use of new information technologies like telemedicine, telecourses and easier access to practice guides, to name but a few.

Respect for Patients and Professional Secrecy

As a professional, it is also important to possess tangible means with which to adequately serve patients. When practicing outside of institutions, physicians have prime responsibility in that regard. Appointment taking and communication systems also merit attention.

There is no doubt that an inadequate appointment system serves to alienate clients, while an efficient system attracts them. There are numerous different formulas in this regard, and each has its advantages and disadvantages. What is important is that the physician adopts and adapts a system so that it best responds to the expectations of patients and to their own requirements and work habits. In the case of group practice, it can be advantageous to select a method common to everyone so as to avoid confusion and error.

Following are some examples of appointment systems:

- **Without appointment** — Although increasingly rare, some physicians receive their patients on a “first come, first served” basis. Except in emergency cases, this method of operating may engender dissatisfaction and frustration among the doctor, office staff and patients alike.
- **Patient flow** — Definitely the most commonplace, this system spaces out appointments into segments of 10, 15, 30, 45 or 60 minutes. In theory, this is the ideal formula, provided the physician and patients are punctual and each visit does not exceed its scheduled time. However, the everyday reality is that this system is far from reliable.
- **Patient concentration** — This method calls for a certain number of patients to arrive at the same time. If the physician plans to see four patients in an hour, they will all arrive at the office at the same time. Inevitably, the concentration of patients at the beginning of the hour leads to frustration among patients who must wait.
- **Open period** — Another way to regulate patient flow is to leave open periods to be able to respond to emergencies or special cases. At the same time, physicians can allow for a few minutes of respite at the end of each hour to make up for lost time if necessary.

It is also possible to schedule appointments several months in advance. The disadvantage of this practice is that appointments must sometimes be cancelled or changed because of an emergency or personal activity like a conference or impromptu vacations.

Appointments must be listed in an appointment register, which needs to be kept for a minimum of 12 months. For group practices comprised of several doctors, it can be advantageous to use a computerized system that can be integrated with a local electronic clinic file. In that case, it is important to always ensure that patient data is protected and used confidentially.

Within the current context, where the demand for medical services far exceeds the supply capacity, particularly when it comes to primary care, the challenge for physicians actually runs in the reverse direction. Doctors must learn to contain the demand within certain acceptable limits. The means being used to do so are more often than not improvised, but the fact is, the results are more or less satisfactory. In order to be able to continue to effectively follow up on their patients, many doctors are simply refusing to accept any new patients. Others are choosing not to conduct follow-ups in favour of dedicating themselves exclusively to the “no appointment” system. In

some cases, coupons are distributed to make waiting times more predictable. In that regard, one basic rule should always apply — provide service that is consistent with what was announced. This rule helps assure respect for patients, even if it is impossible to satisfy all their needs. Certain ethical provisions also allow for the establishment of priorities, such as the obligation to assure emergency care and the required follow-up based on the patient's condition.

Whatever the solution envisaged, communication systems play a pivotal role. The key element here is the direct contact that must be established with patients who use the clinic's services. Two principal factors promote such positive contact and patient loyalty — a satisfactory doctor-patient relationship and a cordial attitude on the part of staff.

Of all the tools available to physicians, the telephone is undoubtedly among the most valuable. In most cases, it is via telephone that initial contacts are made with patients. Because they serve as a reflection of the organization, receptionists should be amiable and courteous individuals capable of exercising sound judgement. In addition, it is important to establish a clear and uniform policy with respect to how telephone calls are directed and managed. In that regard, a rigorous and coherent procedure has a favourable impact on the efficiency of a physician's work. For example, it is advisable that one telephone line be reserved for communication with consultants, pharmacists and laboratories. The criterion for determining how many phone lines are required is simple — the optimal number is that which will reduce waiting to a minimum.

Among the other means of communication available to physicians are computer systems, which can be very useful, particularly when it comes to RAMQ billing and the use of e-mail. A large-scale project to computerize the health care network is currently underway in Québec. This initiative will enable professionals to gain access to certain valuable information for the treatment of patients, including medication lists, laboratory results, medical imaging, data required in emergency situations like susceptibility to allergies, etc.

For its part, e-mail already offers a range of interesting benefits — from quick access to information and reduced paper consumption, to simultaneous communication with several individuals, the transmission of graphic documents, and soon, the transmission of diagnostic examination results as well. However, since the security of information is not always guaranteed, its utilization demands the utmost prudence. Nevertheless, there is no doubt that the evolution of communications is in the process of changing the way medicine is practiced, as confirmed by “telemedicine”, the practice of medicine from a distance⁶. Given a proper framework, telemedicine can significantly contribute to improving access to quality health care.

Finally, there are other indispensable tools available to physicians and their staff to help them serve their patients adequately, such as fax machines, information leaflets and pamphlets, and answering machines or telephone answering services offered by private companies. However, rigorous mechanisms must always be put into place to guarantee the confidentiality of records and communications, whether via telephone, fax or the Internet.

⁶ COLLÈGE DES MÉDECINS DU QUÉBEC. [Telemedicine: Position Paper](#), Montréal, Collège des médecins du Québec, 2000.

Access to Care and Follow-Up

Access to care and follow-up currently pose a number of challenges for physicians, particularly when combined. Doctors are well aware that, if they accept new patients, they will have to monitor their status. In recognition of that fact, many of them believe that the only solution is teamwork. It is important to note, however, that working in groups or teams must not have a negative impact on the care patients receive. On the contrary, regardless of the difficulties this can represent, doctors must always ensure that patients are being adequately taken care of before personally withdrawing from a situation⁷.

Professional Independence and Administrative Aspects

A number of observers believe that the greatest challenges today relate to the professional independence of physicians, with certain business and administrative aspects creating situations of potential conflict of interest. This is certainly a subject that also merits more detailed discussion.

▪ Purchase, Rental and Keeping of Premises

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

Nevertheless, 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 an office that meets the standards outlined in the [Regulation Respecting the Keeping of Records, Physicians' Rooms or Offices and Other Effects](#). As such, the layout of a physician's private office must assure the privacy of clients, as well as the confidentiality of conversations between the doctor, staff and patients. Of course, the organization of space must respect the rules governing sanitation (washrooms readily accessible to clients, sink in the consulting room, etc.), disinfection and sterilization of materials, prevention of infection and safety.

With respect to rental agreements, physicians must ensure that they do not compromise either their professional independence or the right of patients to choose freely. Although the *Québec Code of Ethics of Physicians* already contained several provisions aimed at controlling conflicts of interest and preserving the physician's professional independence, it was amended on March 1, 2008 to establish new rules pertaining to leases. More specifically, it is now stipulated that, in their capacity as physicians or in using their title of physicians, doctors must refrain from accepting any commission, rebate or other material benefit, with the exception of customary tokens of appreciation and gifts of modest value (Section 73.3).

Any agreement entered into by a physician regarding the use of a building or space to exercise their profession must be entirely recorded in writing. Such agreement must also indicate its compliance with the *Code of Ethics of Physicians*, and it must be released to the Collège des médecins du Québec upon request (Section 72). Moreover, the *Code* stipulates that the use of a building or space at no charge or at a reduced rate constitutes a material benefit that is prohibited if granted by a pharmacist or corporation in which the pharmacist is a partner or shareholder, a

⁷ COLLÈGE DES MÉDECINS DU QUÉBEC. [Le suivi médical : il y va de la santé des patients](#), *Le Collège*, Vol. 48, N° 2, Spring 2008, p.15-16.

person whose activities are associated directly or indirectly with a pharmaceutical practice, or any other person within a context that may present a real or apparent conflict of interest (Section 73.1).

To gauge the scope of these amendments and concretely illustrate the behaviour expected of physicians in this regard, it should first be made clear that all agreements or leases must be free of any conditions that could have an effect on a physician's professional independence, in particular, by governing the act of prescribing medication or directing patients after a prescription is written. In addition, the lease entered into by a physician with a professional or an individual or legal entity leading to the sale of goods, products, medications or apparatus prescribed by the physician must call for a just and reasonable rent so as not to be deemed a material benefit prohibited by the *Code*. Just and reasonable signifies that the rent is in line with the area's socio-economic conditions and with the nature and intensity of the services rendered. The rent calculation could be based on an hourly rate or the surface area to be utilized.

There are certain situations in which a physician may enter into a lease under advantageous conditions or even accept free rent. In such cases, these agreements, which are made in keeping with various specific socio-economic conditions, allow physicians to practice their profession in a region where there is a shortage of doctors, while in other cases, they assure the dispensation of medical care and favour interdisciplinarity. One example of such a situation is a doctor who has the benefit of free or discounted rent and the services of a nurse in a private residence for seniors with reduced mobility. Another example could be a physician who makes premises available free of charge a few days per month to a consulting physician in order to offer patients a range of integrated services. Similarly, a physician may agree to practice a few days each month in a remote region within premises made available free of charge by the local municipality. It is important to note in all of these cases that the party with which the physician established an agreement is not linked directly or indirectly to a pharmaceutical practice or the sale of medications, products, apparatus or other goods the physician may prescribe.

In sum, since December 4, 2008, all physicians who have concluded an agreement pertaining to the use of a property or space for the practice of medicine must ensure that this agreement is entirely recorded in writing and that it includes a statement by the parties that the obligations arising from the agreement comply with the *Code of Ethics of Physicians*, as well as a clause authorizing release of the agreement to the Collège des médecins upon request. There are certain rental agreement models available for consultation on the Web sites of the various medical federations.

▪ **Types of Association and Partnership**

A physician working in private practice or within an institutional setting may enter into a partnership contract governed by the *Civil Code of Québec*. Under this contract, which is established within a spirit of cooperation, the physician and his/her associates agree to conduct their activities and contribute to the effective operation of the enterprise in accordance with certain terms and conditions. These could include the pooling of property and knowledge and the sharing of monetary benefits generated by their activities.

— **Partnerships: An Intense Relationship**

When a partnership between individuals is established, it must combine three essential elements — an investment, profit-sharing, and the intention to form the partnership. In this case, all professional fees are pooled and shared. As of recently, physicians can incorporate to form a limited liability partnership or a

joint stock company. The general partnership (GP) offers certain advantages, but it also calls for various conditions to be met, such as the partners having to share a common philosophy, a high level of trust in each other, and similar financial needs. Moreover, unlike a partnership for expenses, the general partnership presumes mutual responsibility in proportion to each individual's share as established in the contract.

Since June 2001, the [Professional Code](#) has allowed professional orders to adopt a regulation enabling their members to conduct their activities within a limited liability partnership (LLP) or a joint stock company (JSC). The Collège des médecins adopted such a regulation, which came into effect on March 22, 2007 and is included in the Appendix⁸.

Unlike associates in a GP, physicians in an LLP or JSC are not held jointly responsible for the professional acts of their partners if they did not participate in those acts. However, professional responsibility toward the patient remains unchanged. In fact, Section 8 of the [Code of Ethics](#) has been modified to make this clear. Physicians practicing their profession within a partnership of this kind must provide and maintain insurance protection on behalf of the partnership to cover its liabilities in the event of fault or negligence on the part of associated physicians.

This regulation allows physicians to practice within these types of partnerships. 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 company's Board of Directors is composed entirely of physicians.

Under the rules adopted by the Collège, the other shareholders or partners may only be:

- other physicians
- the spouse, blood relatives or persons connected to the physician holding shares in the company or partnership
- legal entities, trusts or enterprises where 100% of the voting rights attached to the shares or company are held by physicians or a spouse, blood relative or person connected to the shareholding or partner physician

Physicians must be authorized by the Collège to practice within one of these structures. They should consult with the appropriate professionals to familiarize themselves with the steps to be taken.

— **Partnership for Expenses: A Flexible Formula**

Physicians may associate to form a partnership for expenses as well, also known as a "shell company". The partnership for expenses 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. Oddly enough, there is very little literature available on the legal aspects of this very common type of association and its ensuing responsibilities.

⁸ The regulation and terms and conditions related to practice in a partnership can also be consulted in the [Practicing Within a Partnership](#) section of the Collège's Web site.

The advantages of a partnership for expenses 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 associates, a certain autonomy, greater purchasing power for the acquisition of equipment, easier startup, and respect for everyone's individual working pace. On the other hand, competition is greater with this type of partnership, and team spirit is less developed than in the previous partnerships discussed.

There is a formula known as "mixed division" under which 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 shared expenses like the purchase of books and periodicals, professional dues, attendance at conventions and conferences, as well as automobile expenses. Others set a ceiling on the sharing of expenses so as not to penalize the members who work longer hours.

— **Partnership Contract**

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 best.

The first step in the establishment of a partnership contract is to decide on the terms of the agreement. These must be precise enough to avoid potential interpretation problems, and they must be flexible enough to allow the signatories a sufficient measure of autonomy. The clauses should take individual needs into account and should be reflective of the type of partnership selected.

The number of clauses in a contract can vary. For reference purposes, following is a list of the most important:

- Purpose of the contract and company name
- Duration of the contract
- Investment and conditions of the partnership
- Ownership of the furnishings
- Administration of the partnership
- Professional liability
- Workload
- Division of expenses and fees, if applicable
- Obligation for maintaining competency and policy pertaining to vacations and convention or conference attendance
- Sabbatical leave
- Absence due to illness
- Maternity leave
- Methods of transmitting and keeping records in the event of the dissolution of the group or resignation of a member
- Dissolution of the company

- Departure or death of a partner
- Hiring of a family member
- Fiscal year
- Arbitration

It is strongly recommended that the services of a professional specialized in taxation be retained for the preparation of contracts.

▪ **Rules Concerning Advertising and Public Statements**

Very recently, the *Code of Ethics of Physicians* was modified to create a specific section pertaining to advertising and public statements by physicians⁹. The Collège recognizes the existence of new marketing practices and the emergence of new information technologies within a context where numerous forms of care and service (whether covered by the health insurance plan or not) are being publicly announced. This section echoes the *Professional Code*, which assigns responsibility and certain obligations to professionals with respect to advertising messages promoting their services (Section 60.1).

The cornerstone of the new rules is the honesty of the message. Some practices that were formerly prohibited no longer are, unless they contribute to biasing information. However, physicians must clearly indicate their title of family doctor or specialist (see Chapter 2, Section 3.1.7).

At the same time, the Collège adopted the rule stipulating that physicians post the costs for their services, materials and incidental expenses billable to their patients (*Health Insurance Act*, Section 22.0.0.1; *Code of Ethics of Physicians*, Section 105).

Responsibilities of the Physician-Employer

The *Labour Standards Act* governs all work relations between physician-employers and their personnel. Under the banner of their professional activities, physicians must reconcile restrictions 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 personnel. In fact, efficiency demands delegation of authority and the effective distribution of tasks and responsibilities in accordance with the respective skills of staff members.

Moreover, as principals, physicians are accountable for the actions taken by their personnel. Therefore, it is important for physicians to determine those situations as precisely as possible when their staff must ask them to intervene concerning a patient, such as answering a telephone message or advising them of an incident having occurred. It is also essential that staff members always respect the rules of confidentiality.

Sound personnel management rests on good human relations. It is widely recognized that employees are most productive when they are looked upon as partners and treated with respect.

⁹ It is possible to consult the [new sections of the Code](#) pertaining to advertising on the Collège's Web site, as well as a guide for their application entitled, [Le Médecin, la publicité et les déclarations publiques](#).

Physicians have numerous obligations as employers. They must learn the art of delegating and allow their trusted personnel to take initiative, all the while supervising their work adequately and remaining responsible.

3.2.7 Conclusion

The practice of medicine outside of the health care network's public institutions necessitates a varied range of knowledge and skills on the part of physicians.

The difficulty of integrating private medical practice with primarily public health care systems is not new. It exists everywhere, it persists in Québec, and the current shortage of material and human resources is not helping matters. The fact remains that the autonomy of physicians has its advantages for both doctors and the public, at least with respect to assigning responsibility to physicians. Despite the difficulties, we believe physicians must remain moral agents who are competent and responsible for their actions. Indeed, there are professional norms and standards in place to provide certain points of reference in that regard, and they apply everywhere.

However, these norms were developed based on a fairly classic model characterized by private doctors' offices on the one hand, and entirely public institutions on the other. As such, the transformations currently underway in Québec are creating unprecedented situations and posing new challenges for physicians and all those who seek to preserve the quality of their professional practice. In spite of the complexity of the systems implemented to make health care accessible to all, we cannot lose sight of the ultimate objective of the practice of medicine, which is to assure each and every individual of the care they need and of the best care possible.

3.3 ***Diversification of the Practice of Medicine***

Having obtained a diploma from a faculty of medicine and a permit to practice from the Collège des médecins du Québec, 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.

As was explained earlier, the **medical 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, notably the family medicine group (GMF). The 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. Albeit less known, these are essential, very varied and increasingly recognized.

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

A physician may be a **researcher**, either in a university research centre, a clinical research centre or in the private sector, for a pharmaceutical firm. Without being the principal researcher of a research project, the physician may also participate as a clinician in research projects. More and more physicians practicing outside institutions are also asked to participate in research projects.

A physician may also **teach**, either as a university professor or as a teacher in a facility used for training purposes. He or she may also teach in other settings, notably by giving conferences in the context of scientific activities or by taking part in continuing professional development activities.

As well, some physicians may opt to work in **public health**. These are physicians who are specialists in public health or family physicians who have received additional university training in the public health field and in epidemiology. For the most part, they practice in CLSCs, in regional departments of public health, at the National Institute of Public Health or at the Direction de la santé publique of the MSSS.

Others work in medico-legal assessment, as experts in the context of their medical practice, either for a third party designated as principal or as employees of agencies that call upon the expertise of physicians, such as the Société d'assurance automobile du Québec (SAAQ) or the Commission de la santé et de la sécurité au travail (CSST). Thus they may be called upon to act as expert witnesses in court and to present the conclusions of their expert assessment.

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

A physician may also be a **medical evaluation officer** employed in the health services of a large company or as a consultant for an insurance company. Finally, a

physician may have the medico-legal skills required by the Coroner's office for purposes of investigating the cause 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 certain regulations include sections that specify the obligations of the physician in the practice of certain professional activities, notably those of the research-physician¹⁰, the medico-legal expert¹¹ and the public health physician.

From the very beginning of their training, medical students and medical residents in their clinical training activities are bound by the same framework of rules and regulations applicable to all medical practice.

Medical practice will continue to diversify as knowledge in the field of medicine evolves and as new social needs emerge.

¹⁰ COLLÈGE DES MÉDECINS DU QUÉBEC. [Le médecin et la recherche clinique : guide d'exercice](#), Montreal, Collège des médecins du Québec, July 2007.

¹¹ COLLÈGE DES MÉDECINS DU QUÉBEC, [La médecine d'expertise : guide d'exercice](#). Montreal, Collège des médecins du Québec, September 2006.

4 A Social Achievement Worth Preserving

While physicians' links to the health care system are readily obvious to those working in institutions, all physicians most know the history, characteristics and organization of the system, still considered to be a major social achievement. Whether they work in private practice or 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 ensure the best possible care to 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.

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Chapter 2 Ethical Aspects

1 Introduction

Medical ethics refers to all of the obligations and duties relating to the practice of the medical profession. In other words, physicians have professional obligations that others do not have, and these cannot be ignored.

Physicians have always imposed personal obligations on themselves. But the obligations allowing them to collectively fulfill a social role have changed over time. One way to better understand the nature and scope of these changes is to recall what our profession is. In order to promote health in today's world, all physicians must have medical expertise and utilize it for the service of others. They are allowed to regulate themselves so that their practice is free of all influences that would run counter to this social role.

In order to protect their professional independence, physicians need associations that promote not only expertise but also the development of personal qualities that have helped to make medicine a profession marked by humanism. "Virtues" such as loyalty, integrity, impartiality and respect for the individual traditionally associated with the medical profession are more necessary now than they ever were. Indeed, many prefer to use the term "professionalism" rather than medical ethics. There is now a whole tide in favor of medical professionalism.

Medical ethics unquestionably occupies an important place in Québec. While not attempting to prove this established fact on a theoretical level, this chapter will present the historical reasons which explain it. Since the creation of the College of Physicians and Surgeons of the Province of Québec over 150 years ago, all physicians have been obliged to be members of this corporation. Over the years, the College has put in place many mechanisms whereby it could ensure the competence of its members and oversee the conduct of their professional activities in an ever more effective manner.

The [*Code of Ethics of Physicians of Québec*](#) is not a stranger to the success of these interventions. It has always had the force of law in Québec; indeed, it has even been designed to be used for disciplinary purposes. In fact, physicians have progressively included in the *Code*—so that it could impose penalties—acts that do not meet the public's expectations for all professionals, namely that they be competent, serve others and discipline themselves. This chapter 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.

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 its members and their aptitude to practice; to maintain their competence and oversee their practice; to examine the reasons for dissatisfaction concerning them, and to conduct inquiries and submit complaints to the Disciplinary Council. The government's takeover of the health care system and the profound changes that characterized it did not mean the end of professional independence for Québec physicians. On the contrary, the professional

system is still considered a vital part of the health care system, and the Collège remains the principal body guaranteeing the quality of care delivered by physicians.

The chapter's last section explains why physicians have had to create other associations to defend their interests. Within the Collège, physicians keep an eye on the evolution of obligations allowing them to pursue their social mission, which is to practice quality medicine that not only protects the public but also helps improve the health of Quebecers.

2 Historical and Legal Context in Québec

Medical ethics has always occupied an important place in Québec. The historical reasons for this, as revealed in the recent publication of the history of the Collège des médecins (Goulet, 1997), leads one to think that it will continue to play a vital role. While lawmakers have long recognized the importance of the professional system in our society, the fact remains that it is the medical profession that is pivotal to the system's evolution in the health sector of Québec.

2.1 *Historical Context*

The practice of medicine and surgery was not supervised until 1788, when an ordinance was issued prohibiting any person from practicing medicine in Québec without having first obtained a permit. In 1831, the Legislative Assembly repealed this ordinance following disputes over the low representation of francophone physicians on the board of examiners. It then passed a law authorizing practitioners to elect the members of this board. The quest for a certain professional autonomy for physicians was impeded when disputes erupted over the idea of creating a pan-Canadian organization. In 1847, the Legislative Assembly voted for the incorporation of the College of Physicians and Surgeons of Lower Canada.

The legislator gave this organization the power to regulate its studies, control the admission to practice, oversee the practice of medicine and suppress its illegal practice. Thus, it was implicitly given the two-fold mandate to protect the public and control the practice of medicine. The College then had 190 members. "Still, in 1847, the Grand Charter created a precedent in North America, since no other association of physicians then had the legal status of an autonomous corporation with an exclusive right to practice." (Free translation: Goulet, 1997, p. 30).

In the year of Confederation, the College of Physicians and Surgeons of Lower Canada adopted the name of College of Physicians and Surgeons of the Province of Québec (CPSPQ). While initially threatened in 1867 by the creation of the Canadian Medical Association, which advocated pan-Canadian structures to control the training of physicians, the College saw its role strengthened in 1876 through legislation that gave it more power in the universities and obliged physicians to register on its roll. This set the tone. For more than 100 years, the CPSPQ would be the mainspring with respect to all legal and ethical questions concerning the medical profession (Goulet, 1997, p. 53).

Imbued with a new vitality, the medical profession restructured itself and, in 1878, adopted the code of ethics of the Canadian Medical Association, which was similar to that of the American Medical Association. But this code did not really provide for penalties against deviant members. The creation of a council on discipline by Dr. Emmanuel Persillier-Lachapelle in 1898 marked another important milestone (Goulet, 1997, p. 57). Indeed, it was not so much the adoption of the code in 1878, but rather the quasi-legal power vested in this council that would determine its evolution. The council quickly sensed the need to specify, from among the acts derogatory to the honor of the profession, those that should be penalized. "The creation within the professional corporation of a council on discipline invested with judicial powers established a precedent not only in America, but in most European countries." (Free translation, Goulet, 1997, p. 80) Multiple amendments would reinforce this disciplinary power, so much so that a veritable code was rebuilt around this specification of derogatory acts. The code of ethics used by Québec physicians until 1980 is in fact

section 52 of the *Regulations of the College of Physicians and Surgeons of the Province of Quebec*, which was adopted in 1952 and amended many times since to include acts derogatory to the honor and dignity of the profession.

In the period from 1909 to 1960, medicine advanced, and the medical profession gained more credibility, powers and autonomy. The Collège strengthened its role as protector of the public and consolidated its function as the only legitimate representative of the profession. Legislation passed in 1909 increased its authority in universities and gave its council on discipline the power to compile a list of derogatory acts. Not only did the fight against charlatanism continue, but the Collège became actively involved in the development of the profession. “Professional modernity” was the watchword during this period.

From the 1970s onward, the government would play an expanding role in the field of health, proportionately weakening the medical profession and forcing the Collège to revise its policies and organization. After the institution of hospital insurance in 1960, the Collège’s influence on physicians practicing in the hospital setting also diminished. When the Castonguay-Nepveu Commission proposed the establishment of a complete health insurance system in 1970, physicians took their case to the medical unions to register their opposition to it. The Federation of General Practitioners of Québec (FMOQ) had been formed in 1963, and the Federation of Medical Specialists of Quebec (FMSQ) in 1965. Yet the crisis in the health care sector would be salutary. Despite the government’s intrusion into health care, the *Professional Code* and the *Medical Act*, adopted in 1973, would recognize the independence of physicians and confirm the roles devolved to the Collège since its inception, namely the control of medical practice and the protection of the public.

After this turbulent period, the Collège strives to give itself mechanisms whereby it could more effectively exercise its functions. Control over training and the issuance of permits was implemented with the collaboration of other Canadian bodies, whereas medical ethics in Québec pursued its own developmental path. Thus, the directors of the Collège favored a positive approach based on promoting transparency in processing complaints, relying on preventive as opposed to corrective measures to improve practice, and developing a spirit of openness in all of its activities. The Collège chose to promote quality medicine not only to protect the public, but also to help improve the health of Quebecers.

This line of conduct would pose considerable challenges, given the breathtaking advances in medicine, the constant diversifications in medical practice and the evolution in ways of thinking, not to mention the recent developments in the health care system itself. The problems were such that physicians would have to be part of the solution, but what form this would take had yet to be articulated.

In recent years, the Collège at all levels has ensured that its *Code of Ethics* would continue to provide Québec physicians with the guideposts necessary for good practice. In 2002, the *Code* underwent an in-depth revision, taking into account professional activities and the new realities, such as, clinical research, medico-legal medicine, medical follow-up in a climate of shortages, responsibilities toward communities, conflicts of interest, and transparency in the disclosure of health-care incidents. Many authorized groups also redefined the medical profession’s place within Québec’s professional system. Indeed, the Collège played a part in drawing up various legislative amendments adopted in recent years to promote inter-disciplinarity and to modernize professional organization in the field of health care in Québec. The Collège continues to play a key role in their application.

2.2 *The Legal Context*

The professional practice of physicians is part of a professional system whose legal framework, imposed over 30 years ago, is still evolving.

2.2.1 The Professional Code

Ratified in 1973 and amended several times, the *Professional Code* constitutes the legal framework governing all recognized professions in Québec. It clearly establishes that every order's principal function is to ensure the protection of the public and, to this end, must supervise the professional practice of its members. It also defines the criteria for the constitution of an order:

- the knowledge required to practice;
- the degree of independence required to practice professionally;
- the personal nature of the relationships with persons requesting services;
- the gravity of the prejudice or damage due to incompetence or lack of integrity;
- the confidential nature of the information obtained.

It also determines the organizational structure of professional orders.

The *Professional Code* distinguishes two categories of profession: exclusive professions and professions with reserved titles.

Box II-2.1

Two Categories of Profession

Exclusive Professions

In exclusive professions, members reserve the exclusive right to engage in certain professional activities and to bear the corresponding title, for example, physician, nurse, architect, or chartered accountant.

Professions with Reserved Titles

Professions with reserved titles allow their members the right to use a title, for example, translator or social worker, but the activities of their profession are not exclusively reserved to them.

However, since the adoption of Bill 90 in June 2002 and the coming into force of the *Act to amend the Professional Code and other legislative provisions as regards the health sector* six months later, certain professions with reserved titles have obtained the right to engage in activities considered to entail risk of injury and heretofore restricted to the exclusive professions. In the health care field, they are the professions of registered respiratory therapist, nurse and certified nursing assistant, medical technologist, dietician or nutritionist, speech therapist and audiologist, physiotherapist and occupational therapist.

The *Professional Code* contains provisions common to all orders; these relate to the issuance of permits, recognition of training or the required diplomas. It states “no order may refuse to issue a permit or specialist's certificate or to grant a special authorization for reasons of race, color, sex, religion, national extraction or social origin.” 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 an examination to ascertain whether his or her physical or mental condition is compatible with the practice of the profession. With respect to admission to practice, the legislative provisions henceforth

make it possible to refuse a person who has been the subject of decisions of a criminal or disciplinary nature, and imposes recourse to a disciplinary process for misconduct of a sexual nature. The *Professional Code* also provides immunity for physicians charged with conducting inquiries and for physicians or experts who testify before the Disciplinary Council or the Professions Tribunal.

In order to supervise and coordinate the activities of professional orders, now numbering 45, of which 25 are in the health sector, the *Code* provides for two bodies: the Office des professions and the Inter-professional Council.

Office des professions

Composed of five members, the Office des professions du Québec (OPQ) is an agency whose function is to see that each order ensures the protection of the public. More specifically, the OPQ makes certain that each order,

- adopts a code of ethics;
- has a functional professional inspection committee;
- sets regulations on the management and discarding of records, the keeping of medicines, the use of equipment, the administration of offices, etc.;
- regulates the procedure for elections to the board of directors, to the presidency, etc.;
- sets standards of equivalence for diplomas issued by educational institutions outside of Québec;
- defines the acts that may be performed by other professionals;
- has a disciplinary council.

The OPQ may also make suggestions as to how an order should conduct itself or what measures it should take, if necessary, to protect the public.

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

Interprofessional Council

The Interprofessional Council 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.

2.2.2 The Medical Act

Amended several times, the *Medical Act*:

- defines the practice of medicine;
- establishes qualifications for registration and for obtaining the subsequent permit to practice;
- specifies the organizational structure of the Collège des médecins du Québec.

Box II-2.2

Definition of the Practice of Medicine

According to section 31 of the *Medical Act*, “The practice of medicine consists in assessing and diagnosing any deficiency in the health of human beings and in preventing and treating illness to maintain and restore health.”

With the *Act to amend the Professional Code and other legislative provisions as regards the health sector* (Bill 90), the activities at the very heart of medicine remained intact. The legislator confirmed the exclusive nature of medical practice as it pertains to diagnosing illness and determining treatment plans, among other things.

However, certain activities are **shared** with other professionals. Thus, nurses, occupational therapists and physiotherapists may, under certain conditions, decide to use restraint measures, pharmacists may prescribe emergency oral contraceptives, and nurses may use invasive techniques. These activities have been described in general terms so as to foster professional independence in keeping with the evolution of practices, technology and techniques, but they must be interpreted in keeping with the field of practice of each profession.

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 a common zone of activities restricted to the 11 health professions contemplated in the reform. For example, each professional may, while respecting his or her field of practice, participate in activities involving information, health promotion and the prevention of illness, accidents and social problems.

2.2.3 Permit to Practice

Under the terms of 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 Québec.

The permit to practice is issued to a medical resident who has completed all the required training periods in a manner satisfactory to the faculties of medicine and the Collège and has successfully passed the final examination.

Since 1988, the permit in family medicine has been granted after two years of training and successful completion of the examination in this discipline. For specialists (see Appendix C), the permit is granted to medical residents who successfully pass the

certification examination in their specialty after having completed their training, the duration of which is five or six years. The *Professional Code* forbids any professional from calling himself or herself a specialist, if the professional does not hold a specialist's certificate.

The examinations are harmonized with those of the Royal College of Physicians and Surgeons of Canada, the College of Family Physicians of Canada and the Medical Council of Canada. Furthermore, participation in the training activity on the legal, ethical and organizational aspects of medical practice in Québec (ALDO-Québec) is obligatory for both residents in family medicine and residents in a specialty.

In order to obtain a permit to practice medicine in Québec, a physician with a medical degree from outside Canada and the United States (DHCEU) must first apply for recognition of equivalency of his or her diploma and, if applicable, his or her postgraduate training. This pathway includes a period of postgraduate training¹².

Restrictive Permit

The Board of Directors of the Collège may also, in keeping with established guidelines, issue a restrictive permit to physicians who are not eligible for a regular permit. This permit is issued for one year and may be renewed.

It is granted to physicians recruited as professors in a faculty of medicine, or to medical clinicians recruited to meet needs specified in the medical staffing plans established by the government, or, to medical residents at the end of their training. Indeed, residents who have completed 18 months of postgraduate training in family medicine or four years of postgraduate training in a specialty and who have a valid training card may, under certain conditions, apply for a restrictive permit authorizing them to practice in the discipline relevant to their training¹³.

This type of permit specifies the kind of professional acts that may be performed as well as the institution or institutions where they may be performed. In the case of medical residents, the number of renewals is limited to two.

In other cases, physicians who are holders of a restrictive permit for five years and who have postgraduate training equivalent to one of the recognized medical disciplines in Québec may apply to convert their restrictive permit into a regular permit.

2.2.4 Registration

All students and medical residents enrolled in faculties of medicine in Québec must be registered with the Collège des médecins du Québec. Registration allows them to perform, under medical supervision, and on training sites, medical acts usually restricted to physicians. However, registered residents and students must observe the provisions of the *Code of Ethics of Physicians* and other pertinent regulations. The registration certificate ensures that the training residents and students receive will be recognized as valid for purposes of obtaining a permit to practice.

¹² For more information, see the [website section on International Medical Graduates](#).

¹³ All the conditions are listed in the [website section concerning restrictive permits for medical residents](#).

2.2.5 Training Cards

Residents registered with the Collège des médecins du Québec who are enrolled in a postgraduate training program in a faculty of medicine in Québec must have a training card. This card allows them to perform medical acts under medical supervision and to gradually assume responsibilities in keeping with their level of competence, at training sites authorized by the Collège. The card is also mandatory for clinical fellows who come to Québec for training periods (fellowships). These fellows are subject to the same rules as Québec medical residents. However, the training card does not give the holder unlimited rights. For instance, medical residents may not practice medicine outside of the training sites previously mentioned, may not ask for an honorarium or write a medical certificate other than one to confirm a visit¹⁴.

¹⁴ COLLÈGE DES MÉDECINS DU QUÉBEC. « Les actes professionnels que peuvent poser les résidents. » *Le Collège*, Vol. XLIV, No. 2, Spring-Summer 2004, p. 20.

3 Duties and Obligations of Physicians

3.1 *The Code of Ethics of Physicians*

The [*Code of Ethics of Physicians*](#) is a set of rules, principles and practices that all physicians must observe, the transgression of which may be penalized by the imposition of disciplinary measures. The *Code of Ethics of Physicians* was revised in depth in 2002, and minor amendments were again made to it in 2008 and in 2010 (See Appendix B). This chapter deals with the spirit of the *Code*, its broad themes and certain sections touching on present-day problems.

The *Code of Ethics of Physicians* governs the everyday practice of medicine in both the private and public sectors. It was not conceived to take away the physician's obligation to think independently, but to facilitate the thinking process by specifying the responsibilities and obligations now considered by members of the profession to be essential to the appropriate practice of medicine.

The *Code* takes into account relevant provisions in other pieces of legislation in force in Québec, notably the *Professional Code*, the *Youth Protection Act* and the *Public Health Act*. It also responds to recent debates on bioethics in the medical research field and elsewhere. It defines the general obligations of physicians, namely their obligations toward the patient, the public and the profession. And since the relationship between physician and patient is built on competence and mutual trust, the *Code* recognizes that knowledge-based skills must co-exist with interpersonal skills. It also underlines the rights of individuals who interact with physicians.

The Code of Ethics of Physicians of Québec comprises more than one hundred sections. The first of these establish the universal scope of the document, whereas the others cite the general obligations of physicians as well as their professional obligations, which are listed by topic.

From the very outset, the *Code* addresses itself specifically to “every” member of the Collège (sec. 1), adding that “a physician may not exempt himself, even indirectly, from a duty or obligation contained in this Code.” (sec. 2). The universal nature of these rules is cited so as to avoid any distinction between physicians as to their obligations. Once registered on the roll of the order, all physicians have the same obligations regardless of their professional activities. Every member is subject to the *Code*, whether he or she is a medical resident, a director of professional services in an institution, a member of the staff in a company, faculty of medicine, assistance program for physicians, medical federation or the Collège des médecins, or a member who practices in public health or clinical research.

3.1.1 General Obligations

Of all the obligations physicians must discharge in the performance of their duties, the paramount obligation is to protect the health and well-being of the persons they serve, both individually and collectively. In addition, physicians must:

- behave in an irreproachable manner toward all persons with whom they come into contact in their professional activities;
- promote measures of education and information in the field in which they practice and, in so doing, inform the public of generally accepted medical opinions on the subject;
- maintain the competence acquired during their studies and residency, by attending 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 to know their limitations and respect scientific and ethical standards by maintaining a rigorous diagnostic approach whereby they prescribe only what is medically required. Over the last few years, the Collège has developed a tool to promote the maintenance of competence; it is called “A Self-managed Plan for Continuing Professional Development.” In January 2007, the Collège passed a resolution encouraging every physician to establish a plan to maintain his or her competence¹⁵.

In light of the mission entrusted to them and the privilege of practicing their profession, physicians are personally responsible for their acts. Consequently, they must preserve their professional independence at all times and attend to the interests of patients, by not allowing themselves to be influenced by personal or material considerations or by links to agencies responsible for payment and to business partners. This responsibility also applies to persons and collaborators who work under their authority. It is partially shared in group practice or network practice situations.

In today’s context, physicians must actively participate 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* underlines that physicians must be judicious in using the resources dedicated to health care (sec. 12). This new provision makes it clear that physicians have obligations to the public as well as to the individual (sec. 3).

In compliance with section 13, which cites 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 or her patients or the population. If so, the physician must refrain from taking part in it. This new 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 into account section 41: “A physician must collaborate with his colleagues in maintaining and improving the availability and quality of the medical services to which a clientele or population must have access.” This illustrates that the Code’s sections are not mutually exclusive, but must be read in relation to one another.

¹⁵ On this subject, consult the [Continuing Professional Development](#) section on the website of the Collège. A Self-managed Plan for Continuing Professional Development as well as other articles published in *Le Collège* can be found there.

The practice of medicine is demanding. Physicians must not compromise the quality of their practice or the dignity of the profession through the immoderate use of psychotropic substances or any other substance producing analogous effects, including alcohol, or by practicing in circumstances or conditions incompatible with the practice of medicine (ss. 16 and 43). The fact of being the carrier of a blood-borne infection may oblige a physician to have his or her practice reassessed so as to ensure that it entails no significant risk to patients¹⁶.

3.1.2 Quality of the Professional Relationship

The *Code* emphasizes the importance of respect for human life, the individual and his or her dignity. As the notion of respect touches on all aspects of medical practice, it is mentioned throughout the entire *Code*. One of its most important manifestations is professional secrecy, its protection being fundamental to medical practice. A patient must be able to confide the most intimate aspects of his or her life, and the physician must be able to obtain this kind of information—access to it being indispensable to the quality of care—knowing that nothing from their conversation will be disclosed. It is a secret shared between patient and physician; in case of necessity and with discretion, it is shared with caregivers working with the physician on establishing a diagnosis or treatment, or with other professionals, “[...] when there are compelling and just grounds related to the health and safety of the patient or of others.” (sec. 20). The written consent of a patient must be obtained before communicating confidential information, except in very specific cases. The *Code* describes the manner in which the communication must take place (sec. 21).

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

Physicians must show no discrimination. They “may not refuse to examine or treat a patient solely for reasons related to the nature of the patient’s deficiency or illness, or because of the race, color, sex, pregnancy, civil status, age, religion, ethnic or national origin, or social condition of the patient [...]” (sec. 23). They may, however, refer the patient to another physician (sec. 24).

3.1.3 Freedom of Choice and Consent

The principle of freedom underlies the “liberal” practice of medicine and is the basis of the contract for providing care. This principle applies first to the patient, who is free to choose a physician and to accept or refuse the practitioner’s suggestions (sec. 28). This is called voluntary and informed consent, based on clear and appropriate information. Nonetheless, the patient’s consent does not authorize practitioners to perform acts that are not medically required. The obligation to inform the patient, provided for by law, is one of the obligations always incumbent upon physicians. The law even provides for certain terms and conditions in particular cases. For example, physicians who ask patients to take part in a research project must obtain their voluntary and informed consent in writing (sec. 30).

¹⁶ COLLÈGE DES MÉDECINS DU QUÉBEC. *The Physician and Blood-borne Pathogens*; Position paper, Montreal, Collège des médecins du Québec, April 2004.

3.1.4 Medical Management and Follow-up

The obligation to be available and diligent means that physicians must provide the medical follow-up required by the patient's condition following an intervention, unless they have ensured that a colleague or other professional can do so in their place (ss. 32-41). In walk-in clinics, group practices that call on numerous consultants, and practice settings with medical residents, physicians who cannot provide follow-up for every patient whose investigation or treatment is in progress must ensure that a colleague will do so in their place.

Physicians who cease practicing in a clinic must also compile a list of all patients requiring regular medical follow-up for various health problems, inform their clientele of their departure by advance notice within a reasonable time frame and, finally, see to it that a colleague agrees to ensure follow-up of their patients, excluding those who have chosen another physician.

It is possible in exceptional cases, such as illness, that a physician working in a group practice would have to suddenly stop his or her professional activities in a clinic. Should the physician be unable to ensure the follow-up of his or her clientele, the other physicians in the group must assume this responsibility, at least until another physician takes over the care of this clientele.

3.1.5 Quality of Practice

Taking into account their capacities and the means at their disposal, physicians must practice their profession according to the highest standards and in the interests of their patients. These two obligations imply an ever more transparent physician-patient relationship.

The disclosure “[...] of any incident, accident or complication which is likely to have or which has had a significant impact on his state of health or personal integrity” (sec. 56) addresses this concern for transparency, the patient's right to information, respect for consent and the absolute necessity of mutual trust in the therapeutic relationship. This section is aimed particularly at avoidable medical accidents and advocates an overall improvement in care and services as opposed to disciplinary measures. The obligation to inform falls to the physician responsible, usually the attending physician; it could also fall to a specialist who meets with an unexpected complication while performing a procedure. When uncertainty arises as to who should disclose the situation, the treatment team may discuss it and designate someone. A physician must present information to a patient or legal representative with empathy and without passing judgment. The physician also has an obligation to make himself or herself understood. Disclosure by the physician will help to establish a climate of empathic candor, refocus the relationship on the patient, improve the quality of medical practice and maintain or re-establish public confidence through transparent practice. In institutions, the physician must follow the rules set by the board of directors in this regard (LSSSS, sec. 235.1).

3.1.6 Independence, Impartiality and Integrity

It is vital that the population at large not doubt the integrity of physicians and that patients feel confident in 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, albeit without allowing themselves to become too lenient.

The attending physician must avoid, for example, acting as an expert in a lawsuit concerning his or her patient (sec 66). In fact, the physician's independence could be contested, and his or her role as expert is largely incompatible with the physician-patient relationship. The attending physician may, in this capacity, communicate his or her observations in a factual manner either in a report or as a witness, and give his or her opinion on the patient's condition and progress in terms of health.

A physician should not agree to act as medical expert or assessor if there is any doubt about his or her absolute impartiality. The role of a medical expert or assessor must be focused on seeking the facts, validating the patient's allegations, the quality of the examinations and the interpretation of the results. In fulfilling these functions, the physician must refrain from obtaining any information from the person undergoing the expertise or assessment, or from providing any interpretation or making any comment not relevant to the subject for which he or she was mandated. The opinion of the medical expert or assessor must be factual, objectified and founded on generally accepted scientific principles¹⁷.

Similar precautions must be taken in the organization of continuing professional development activities or participation in research or commercial activities. The professional independence of physicians is increasingly being put to the test, obliging them to be particularly vigilant. Some years ago, the Collège participated in writing a Code of Ethics for parties involved in Continuing Medical Education¹⁸. The various types of conflict physicians are exposed to when participating in research activities have also been specified in a practice guide¹⁹. In light of the questions raised by the incorporation of physicians and certain rental agreements, the Collège has also had to specify the precautions physicians must take in these situations (See Chapter 1, Section 3.2.5).

3.1.7 Advertising and Public Statements

In light of the various questions raised over the past few years concerning advertising and public statements made by physicians, the *Code of Ethics of Physicians* was recently modified to include a specific section to address these subjects²⁰. The cornerstone of these new rules is honesty of the messages. Under the new provisions, certain practices like the use of comparative terms, superlatives and supporting testimonials is no longer prohibited, unless they contribute to biasing the information. However, physicians must clearly indicate their title of family doctor or specialist.

3.1.8 Medical Records and Fees

As regards accessibility and the rectification of records, as addressed in sections 94 to 102 inclusively, the patient is entitled to read documents concerning him or her and to obtain a copy of such, unless, in the professional's opinion, the transmittal of these documents could cause serious harm to the patient or a third party. The patient also

¹⁷ COLLÈGE DES MÉDECINS DU QUÉBEC. [La médecine d'expertise : guide d'exercice](#), Montreal, Collège des médecins du Québec, September 2006.

¹⁸ CONSEIL DE L'ÉDUCATION MÉDICALE CONTINUE DU QUÉBEC AND THE RESEARCH-BASED PHARMACEUTICAL COMPANIES OF CANADA, [Code of Ethics for parties involved in Continuing Medical Education](#), Montreal, Collège des médecins du Québec, June 2003.

¹⁹ COLLÈGE DES MÉDECINS DU QUÉBEC, [Le médecin et la recherche clinique : guide d'exercice](#), Montreal, Collège des médecins du Québec, July 2007.

²⁰ It is possible to consult the [new sections of the Code](#) pertaining to advertising on the Collège's Web site, as well as a guide for their application entitled, [Le Médecin, la publicité et les déclarations publiques](#).

has the right to correct inaccurate, incomplete or ambiguous information in these documents. The patient may also have deleted any information in the record that is outdated or unjustified.

The *Code of Ethics* stipulates that physicians shall claim only fees that are justified by the nature and circumstances of the professional services rendered (sec. 104). In cases where the patient assumes costs, the physician must inform the patient beforehand of the approximate and expected cost of his or her services (sec. 105). The *Code* has adopted a provision of the *Health Insurance Act* stipulating that the fee for services, supplies and accessory costs of a non-insured service, as well as the fee for non-insured medical services or services considered as such, must be posted in public view in offices and specialized medical clinics.

The physician must also provide the necessary explanations so that the patient understands the fees being charged. Physicians who demand payment in advance for services not covered must use the payment solely to cover the cost of these services. In cases of a dispute concerning an account for professional services, these may be submitted to the office of the syndic, pursuant to the *Regulation respecting the procedure for the conciliation and arbitration of accounts of physicians*.

3.1.9 Relations between Professionals and Relations with the College

Confraternity has its requirements in terms of relations with colleagues and other professionals. Disparagement, harassment and the like are unacceptable in any form. An attending physician must provide the consulting physician with all the information at his or her disposal, which is pertinent to the examination, investigation and treatment. As for the medical consultant, he or she must answer promptly and in writing the questions that were asked, reporting on the results of the consultation and the recommendations deemed appropriate. Also, in emergency situations, a physician has an obligation to assist a colleague who asks for his or her help.

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

Protecting the public requires that all physicians in their everyday lives show the utmost respect for the letter and spirit of the *Code of Ethics*. Public confidence and respect for the profession in general depends on this being a constant concern. While certain rules may appear imprecise, difficult to apply or too demanding, particularly the obligations concerning medical management and follow-up, or the obligation to report a colleague to the Collège, it is important to scrupulously observe them, both to ensure protection of the public and the interests of members of the professional order.

3.2 **The Obligations of Physicians under other Regulations**

In addition to the *Code of Ethics of Physicians*, five of the regulations ensuing from the *Medical Act* and the *Professional Code* are considered very important for physicians:

- the [Regulation respecting the keeping of records, physicians' rooms or offices and other effects](#);
- the [Regulation respecting the Professional Inspection Committee of the Collège des médecins du Québec](#);
- the [Regulation respecting professional liability insurance of physicians](#);
- the [Regulation respecting the standards relating to prescriptions made by a physician](#);
- the [Regulation respecting the practice of the medical profession within a partnership or a company](#), which was dealt with in the previous chapter in the section on private practice (Chapter 1, Section 3.2.6).

3.2.1 Regulation respecting the keeping of records, physicians' rooms or offices and other effects

In force since March 24, 2005, the [Regulation respecting the keeping of records, physicians' rooms or offices and other effects](#) updates several standards that physicians must respect in practicing their profession as it pertains to offices or consulting rooms, records and registers, among other things (See Appendix B). Its main provisions stipulate that physicians must create and keep a medical record for each person who consults them, regardless of where, or for a person who takes part in a research project or is the subject of an expert assessment, or for any population or group targeted by a public health intervention.

The Medical Record

The medical record is inseparable from the practice of medicine. It attests first and foremost to the patient's state of health, the progress of the disease and its medical management by the physician. It is an indispensable tool for communication between all members of the care-giving team. It is a supporting document, essential for teaching, research and assessment of the quality of medical acts. It also contributes in a limited way to the progress of medical science.

More specifically, the medical record must rigorously indicate the condition of the patient, all of the care given to the patient, and all events concerning the patient. One cannot overemphasize the necessity on the physician's part of keeping impeccable records, for each of these documents serves many purposes and reveals the physician's professional management of the case. The record also serves as a memory aid for physicians, indispensable to the provision and quality of care.

▪ **A Communication Tool**

As the medical record is an important source of information on the patient, it enables the physician to transmit pertinent information, if necessary;

- to other physicians, such as consultants, replacements or the physician following the patient after discharge;
- to other professionals working with the patient;
- to other health institutions;
- to any other agency or person concerned, for example, an insurance company, an employer, etc.

- **An Assessment Tool**

Record-keeping generally attests to the quality of services physicians provide to their patients and, consequently, to their 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.

- **An Element of Legal Protection**

The medical record provides an element of legal protection for the patient and the physician. The more complete it is, the better it can attest to events that have occurred.

- **A Teaching and Research Tool**

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

Because the medical record is an important communication tool between professionals, physicians must take the necessary means to ensure that entries in the record are legible and that the use of abbreviations is reduced to a minimum. Finally, physicians practicing in groups may create one single medical record.

In record-keeping, the following elements must be included:

- the patient's identity;
- entries in the medical record, which should include the date of the consultation and the signature of its author. In emergency consultation cases, the time must also be written down. Systematic charting of the time may be particularly useful in intensive care, the recovery room, case room, etc. Indicating one's permit number and the name of the medical department or service is also advisable;
- information pertinent to the investigation or treatment of the patient. The medical record should never contain unwarranted comments on the patient's personality, or remarks concerning administrative problems or interpersonal conflicts. Physicians should address their remarks, criticisms or grievances to competent authorities through the appropriate channels.

The Regulation also clearly establishes the information and documents that should usually be contained in the medical record, as well as those that should be filed in the record of any person taking part in a research project. It is important that physicians make the link between information and documents filed as part of a research project and the clinical observations made during the person's examination, in the emergency room for example. In fact, it sometimes happens that a person consults for a problem stemming directly from advice followed or medications taken as a participant in a research project.

If for reasons of convenience, items in the medical record are filed in different places, it is very important to note this on every item in the record and to number each of these, so that the physician can locate all the items he or she needs in the record. For example, in the case of certain psychiatric records, it is essential that the link be made with the medical record, which is perhaps not kept in the same place as the psychiatric record.

- **Corrections to the Medical Record**

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

- **The Computerized Medical Record**

Computer use must respect the usual rules for keeping medical records on paper, namely the authenticity of the record, its content, maintenance and access, and the preservation of confidentiality.

- **The Maintenance of Records**

The standards the physician must apply in the maintenance of medical records are specified in the Regulation. Unless stipulated otherwise in the law, the physician must keep a medical record for at least five years following the date of the last entry or insertion in the record or the date marking the end of a research project. After this period, the record is considered inactive and may be destroyed, except for certain important items such as pathology reports and operative reports on major surgical procedures, which must be kept for ten years. Genetic tests must be kept for an additional ten years, unless these were given to the person concerned or another copy of them exists. In the case of an active record, certain items dating back more than five years may be destroyed, but many important items, as described in the Regulation, must be kept for a longer period.

When a medical record is destroyed, the physician must see to it that safety measures relative to protecting the confidential information are observed.

The Regulation also stipulates what must be done when a physician who has undertaken a patient's clinical follow-up changes his or her place of practice, or when a physician who is part of a group leaves the group, or when a group is disbanded. Various measures serve to ensure that the patient's record remains accessible and under a physician's responsibility.

Other Provisions

According to the Regulation, the physician must create and maintain various registers, namely,

- a register identifying persons who consulted the physician, or whom the physician visited;
- a register identifying patients who underwent a surgical or invasive procedure, including the nature of the procedures or interventions;
- a register identifying all patients who are being assessed, treated or whose treatment the physician is monitoring as part of a research project;
- a register of controlled drugs, narcotics and benzodiazepines for parenteral use, in which is written the kind and quantity of these substances in the physician's possession, the identity of all patients being administered these substances, the kind and quantity of the substances the physician has discarded, including the date and manner in which they were discarded.

The Regulation also contains provisions concerning medications, substances, apparatus and equipment in the physician's possession, as well as the manner in which these are to be safely maintained and disposed of. It also sets standards

concerning sanitary procedures, hygiene and the safety of the consultation room as well as the privacy of patients.

Finally, the Regulation addresses measures to be taken concerning provisional custody or the disposal of medical records in the event of cessation of practice, death, and restriction or suspension of the permit to practice.

To summarize, the *Regulation respecting the keeping of records, physicians' rooms or offices and other effects* is vital to quality medical practice, even as it touches on its technical aspects. Physicians should have easy reference to these as a reminder of the profession's "best practices." The Collège has also produced a guide on its application²¹.

The rules on record-keeping may vary, depending on whether the physician works in private practice or in institutions. The Collège has also produced a guide dealing more specifically with the writing and keeping of records in consulting rooms and CLSCs²², as well as a guide on record-keeping by physicians in a general or specialized hospital centre²³. The Collège also organizes workshops on record-keeping²⁴.

3.2.2 Regulation respecting the Professional Inspection Committee of the Collège des médecins du Québec

Professional inspection is an integral part of the process of evaluating and maintaining the quality of professional practice. In other words, it is a component of quality assurance in professional practice.

In the context of self-regulation, physicians have agreed, like other professionals, to give themselves the means to improve their practice through monitoring activities, such as inspection of medical records, books and registers. In compliance with the *Professional Code*, the [*Regulation respecting the Professional Inspection Committee of the Collège des médecins du Québec*](#) sets guidelines for the creation of a professional inspection record and specifies the conditions relative to professional inspection visits and follow-up visits.

Professional Inspection Committee

The Professional Inspection Committee (CIP) is composed of nine physicians appointed by the Board of Directors of the Collège. The president of the Committee is designated from among the Board of Directors' elected directors who do not sit on the executive committee. Each of the members is appointed for a renewable, two-year term.

²¹ COLLÈGE DES MÉDECINS DU QUÉBEC, [*L'organisation du cabinet et la gestion des dossiers médicaux et autres obligations connexes prévues par le Règlement sur la tenue des dossiers, des cabinets ou bureaux des médecins ainsi que des autres effets : guide d'exercice*](#), Montreal, Collège des médecins du Québec, May 2007.

²² COLLÈGE DES MÉDECINS DU QUÉBEC. [*La rédaction et la tenue des dossiers par le médecin en cabinet de consultation et en CLSC : guide d'exercice*](#), Montreal, Collège des médecins du Québec, September 2006.

²³ COLLÈGE DES MÉDECINS DU QUÉBEC. [*La tenue des dossiers par le médecin en centre hospitalier de soins généraux et spécialisés : guide d'exercice*](#). Montreal, Collège des médecins du Québec, December 2005.

²⁴ On this subject, consult the website of the Collège, under the heading « [Workshops](#). »

Professional Inspection Record

The CIP establishes a record for every physician who has been the subject of an inspection. This record contains the inspection reports, the Committee's recommendations, if applicable, and any other document or information relative to the inspection.

The physician concerned is entitled, under certain conditions, to consult his or her record and obtain a copy of such. Furthermore, "any record established in the course of a professional inspection shall not contain any information which may permit to identify the person who prompted the inspection." (sec. 12).

Professional Inspection

In general, a professional inspection visit to one or several physicians in an institution or private practice is carried out by one or several inspectors. The CIP 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.

The Regulation stipulates the conditions relative to visits, such as sending a written notice prior to the date fixed for the inspection. It also stipulates that the physician who is the subject of the inspection must be present. Furthermore, in compliance with the rules relative to professional secrecy, the physician may choose only one person to assist him or her and to act as an observer. This person, however, may not be present during the review of the medical records.

The committee, one of its members, or an inspector may review the records, hold a structured oral interview, a directed interview, or proceed with direct observation, or subject the physician to questionnaires on practice profile and skill assessment, or to psychometric tests.

Inspection Visit Follow-up

After having studied the report, the Committee must, if appropriate, forward to the physician concerned the comments on the quality of his or her professional practice. It may ask for evidence that the deficiencies identified in the report have been corrected, and it may make a follow-up visit.

Lastly, the Committee may recommend that the Board of Directors oblige a member who was the subject of an inspection to undertake and successfully complete a refresher training period or refresher course, or both at once, and restrict or suspend the physician's right to engage in professional activities until the obligation has been fulfilled. Obviously, this regulatory power is only used in a minority of cases to improve the physician's practice of medicine and to protect the public. This process has absolutely nothing to do with disciplinary measures.

The Collège has prepared a leaflet on professional inspection for physicians²⁵.

²⁵ COLLÈGE DES MÉDECINS DU QUÉBEC. *La visite d'inspection professionnelle*, Montreal, Collège des médecins du Québec, August 2008.

3.2.3 Regulation respecting professional liability insurance of physicians

A fundamental principle tied 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.

The [Regulation respecting professional liability insurance of physicians](#) stipulates that:

“2.01 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 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.

The fact of 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 is to take a big risk and commit an infraction. The Collège therefore insists that its members comply with the Regulation and attest to it once a year, when completing their notice of assessment.

3.2.4 Regulation respecting the standards relating to prescriptions made by a physician

The *Act to amend the Professional Code and other legislative provisions as regards the health sector*, which came into force in 2003, led to a review of the fields of practice of 11 professional orders. It also established a new type of relationship between professionals, by listing the activities to be reserved exclusively or to be shared. To achieve the end-goal of this reform, the health professionals concerned must first establish a climate of mutual confidence and respect. Certain legislative amendments encourage this change in attitude in favor of interdisciplinary work. The notion of delegating medical acts was eliminated, as were certain conditions of practice, such as supervision. However, an individual or collective prescription must still be issued for many of the acts performed.

To provide a framework for implementing this new way of operating, the Collège des médecins du Québec adopted the [Regulation respecting the standards relating to prescriptions made by a physician](#), approved by the government and brought into force on March 24, 2005. In this Regulation, 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. The prescription may be individual or collective.” (*Act to amend the Professional Code and other legislative provisions as regards the health sector, sec. 39.3*).

The *Regulation respecting the standards relating to prescriptions made by a physician* distinguishes as follows:

- 1) the **individual** prescription, given by a physician to an entitled person and meant for a patient;
- 2) the **collective** prescription, which may be given by a physician or group of physicians and meant for a group of patients;
- 3) the **protocol**, which describes the procedures, methods, limits and standards applicable for a specific condition in an institution.

It specifies the standards for each of these prescription forms.

- The **individual prescription** must be written legibly and include:
 - the physician’s name, telephone number, the number of his or her permit to practice, and signature;
 - the patient’s name and date of birth;
 - the date the prescription was written,

The **prescription for medication** must include:

- the name of the medication, the dosage, the method of administration, the duration of the treatment and the amount prescribed;
- the number of renewals authorized;
- the patient’s weight, if applicable;
- the therapeutic intention, if deemed useful;
- the name of any medication the patient must cease taking;
- the prohibition against substituting medications, if applicable.

A **prescription for an examination** must indicate the nature of the examination and the clinical information required to conduct it.

The Regulation also specifies the standards to be applied for treatments and devices, notably ophthalmic lenses. The prescription must also specify the validity period and the reference to a protocol, if applicable. When the patient is admitted to an institution, the physician may omit some of this information.

- The **collective prescription** must be issued in writing. In addition to the information listed above, it must indicate:
 - the persons entitled to carry out the prescription;
 - the group of persons or clinical situation covered;
 - the name, telephone number and signature of all the prescribing physicians, when prescribed outside an institution.

A prescription to begin diagnostic or treatment measures, or drug therapy, must also specify the condition for beginning these, as well as any possible indications or contraindications.

A prescription designed to adjust medical treatments must include the therapeutic intention and any possible indications or contraindications.

According to the Regulation, a reference to a protocol included in a prescription written outside an institution may only refer to a protocol applicable in an institution in the territory where the physician is engaged in professional activities.

In order to appropriately inform physicians and all professionals concerned by prescriptions, the Collège published a practice guide in 2005, called [Les ordonnances faites par un médecin](#). This document deals in detail with new topics, citing specific examples. It also looks at other legislative provisions related to prescriptions written in an institution, namely prescriptions dispensed verbally, by fax or by e-mail, prescriptions for narcotics and controlled drugs, as well as prescriptions for medications used by the prescriber²⁶. Another guide was produced dealing more specifically with the collective prescription for hormonal contraception²⁷; and an update providing clarification on the renewal of prescriptions²⁸.

²⁶ COLLÈGE DES MÉDECINS DU QUÉBEC. [Les ordonnances faites par un médecin : guide d'exercice](#), Montreal, Collège des médecins du Québec, May 2005.

²⁷ COLLECTIF. [Guide to writing a collective prescription for hormonal contraception: practice guide](#) and [Questions-réponses sur le modèle provincial d'ordonnance collective de contraception hormonale](#), Montreal, Collège des médecins du Québec, January 2007.

²⁸ COLLÈGE DES MÉDECINS DU QUÉBEC. [Renouvellement des ordonnances – mise au point : guide d'exercice](#). Montreal, Collège des médecins du Québec, July 2007.

4 The Collège des médecins du Québec and other Associations of Physicians

4.1 *The Collège des médecins du Québec*

The Collège des médecins du Québec is the professional order of physicians in Québec. Its mission is to promote quality medicine so as to protect the public and to help improve the health of Quebecers.

The Collège is one of 45 orders constituting the Québec professional system, 25 of which represent professionals working in the health sector. The system was created in the 1970s to oversee professional practice and to ensure the protection of the public. The *Professional Code* and the *Medical Act* determine the responsibilities of the Collège and specify the mechanisms required to assume these.

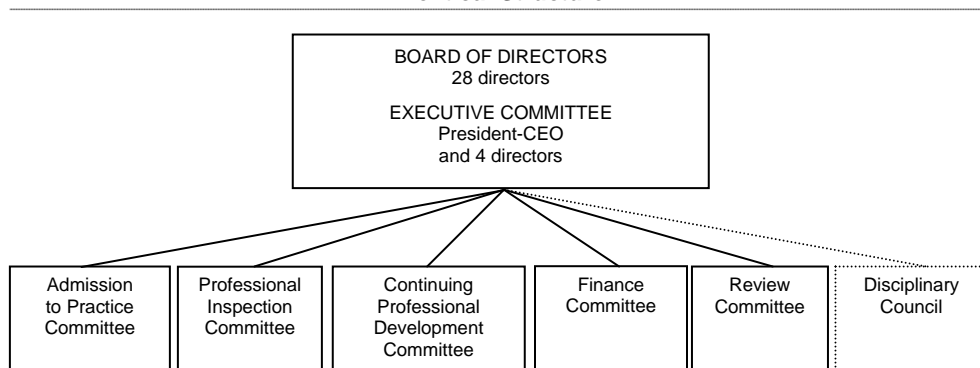
Even before these laws were passed the Collège used many means to fulfill a professional order's mandate, among them, mandatory membership for all physicians, a code of ethics, and a highly effective disciplinary council. It now has elaborate mechanisms, a staff of approximately 100 and a considerable budget coming entirely from membership dues. Its present structures reflect both its collegial nature and the functions it must fulfill as a professional order.

4.1.1 Structures of the Collège

Political Structure

The Collège is first and foremost an association of 18,000 physicians to whom the law confers the power of self-regulation.

Organization Chart II-2.1
Political Structure



MEDICAL EDUCATION AND CERTIFICATION COMMITTEE

MEDICAL DISCIPLINES DEVELOPMENT COMMITTEE

The **Board of Directors** of the Collège is composed of 28 persons, 20 of whom are physicians elected by the members of their region. The directors are elected for a four-year term. Four directors are also physicians appointed by the faculties of medicine in Québec. Four other directors are designated by the Office des professions and are called “representatives of the public” because they are not members of the order on

which they sit. From among themselves, the elected directors in turn elect a president-CEO by secret ballot; the president-CEO's term is for four years.

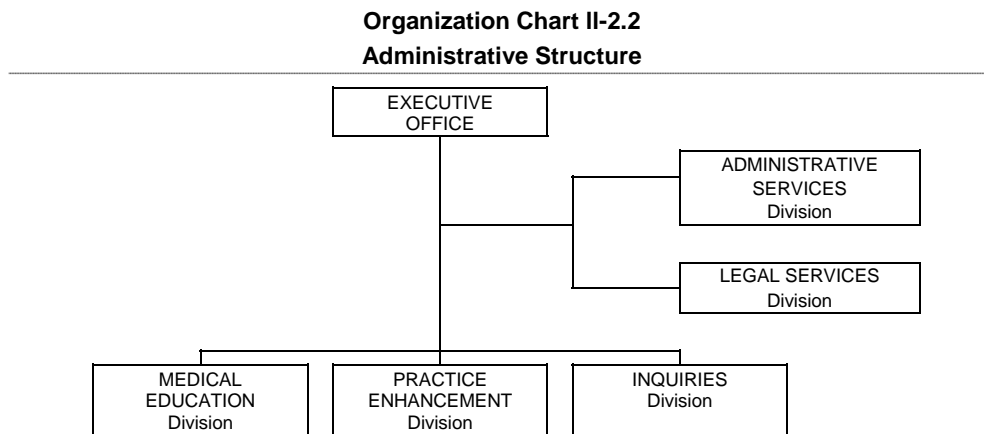
The Collège holds an **annual general meeting** at which a report on activities and a report on the financial statements are presented. The general assembly ratifies the reports, elects the auditors and approves the amount of the annual assessment.

The Board of Directors defines the broad orientations and policies of the Collège. It exercises all the rights, powers and prerogatives of the Collège, except for those appertaining to members of the Collège present at the general meeting. As the body responsible for applying the provisions of the *Professional Code*, the *Medical Act*, and the regulations ensuing from these, the Board of Directors sees to the creation of the **statutory committees** every professional order must set up. These include the Professional Inspection Committee, the Disciplinary Council and the Review Committee. These Committees, as well as the Admission to Practice Committee, the Medical Education and Certification Committee, the Medical Disciplines Development Committee, the Continuing Professional Development Committee and the Finance Committee, all permanent committees created by the Board of Directors, advise the latter on the policies it should adopt in their respective areas.

The Board of Directors also sees to the general administration of the affairs of the Collège. Thus, it designates an executive committee composed of five of its members including the president and CEO and whose mandate is to manage the everyday affairs.

Administrative Structure

In addition to the statutory committees and permanent committees, the Collège has a number of **divisions** which help it fulfill 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 employed physicians and of the necessary support staff. These physicians, like the directors, are subject to ethical rules aimed at preventing all abusive use of their power in relation to their colleagues.

Three divisions see to the implementation of decisions proposed by the committees and adopted by the Board of Directors. These are the Medical Education Division, the

Practice Enhancement Division and the Inquiries Division. They also fulfil the role of the order as provided for in the *Professional Code*.

The Executive Office coordinates the activities of these three divisions as well as the work of divisions needed to support these activities. These are: the Legal Services Division, and the Administrative Services Division, which also coordinates the various communications activities. In the context of the development of draft legislation, it also takes part regularly in parliamentary commissions and tables briefs that reflect the desired policies of the Collège²⁹.

The Executive Office includes a president-CEO, a secretary, and an assistant officer. It is responsible for implementing the decisions taken by the Board of Directors and the Executive Committee; it also looks after external relations. The secretary is also responsible for keeping the membership roll up to date.

4.1.2 Functions of the Collège

Verifies competence of candidates applying for a permit to practice and issues permits to practice

The Admission to Practice Committee, the Medical Education and Certification Committee, the Medical Disciplines Development Committee--and the Medical Education Division have a mandate to ensure that candidates applying to practice medicine have acquired the competence required to practice independently. Thus, they contribute to the setting of standards for professional training in both family medicine and specialty programs, as well as certification criteria for programs and for postdoctoral training sites and continuing medical education. These criteria must be based on excellence and adapted to the real needs of the population. The training given must allow physicians to practice anywhere in Québec and must enable specialists to act as consultants to their colleagues.

- **The Admission to Practice Committee**

This Committee (CAE) analyses individual files with a view to issuing a permit, an attestation in family medicine, or a specialist's certificate. It also analyses files with a view to issuing a restrictive permit, or recognition of equivalence of a medical diploma, postgraduate training, and/or examinations.

- **The Medical Education and Certification Committee (CÉMA)**

The main function of the Medical Education and Certification Committee is to ensure that pre- and post-graduate training adequately prepares candidates for the practice of medicine. To this end, it collaborates in the development and monitoring of certification criteria for programs, training sites and continuing professional development credits.

- **The Medical Disciplines Development Committee (CÉDIM)**

This Committee's mandate is to study all applications for recognition of a new discipline or changes in an already recognized discipline, and to make recommendations to the Board of Directors.

²⁹ Briefs tabled by the Collège are available on the website of the Collège, under the heading "[Publications](#)".

- **Medical Education Division (DEM)**

The Medical Education Division ensures the competence of candidates applying to practice medicine, first, by participating in the establishment of training standards and, second, by seeing to their application before issuance of the permit to practice.

More specifically, this Committee is responsible for:

- developing and updating standards and general and specific policies of the Collège with respect to the training of physicians;
- participating in the accreditation of faculties of medicine in Québec, under the authority of the Liaison Committee on Medical Education (LCME) and the Association of Faculties of Medicine of Canada (AFMC);
- overseeing the application of regulations relative to the certification of these programs and issuance of permits to practice and specialist's certificates and, to this end, studying the submitted files of candidates;
- issuing registration certificates and training cards to students and medical residents;
- ensuring liaison activities with provincial, national and international agencies and participating in research and development activities in the realm of clinical competence evaluation.

Maintaining Competence and Overseeing Practice

The Practice Enhancement Division works in concert with the Professional Inspection Committee and the Continuing Professional Development Committee to ensure maintenance of the competence and aptitudes of physicians and see to their improvement.

- **Professional Inspection Committee (CIP)**

In compliance with the obligation imposed upon it by the *Professional Code*, the Collège has a Professional Inspection Committee (CIP) whose mandate is to oversee the professional practice of its members and examine the professional competence of physicians. The CIP is composed of nine physicians appointed by the Board of Directors, six of whom represent various medical and surgical disciplines. Chaired by a director, this Committee is supported in its functions by the personnel of the Practice Enhancement Division. Some years ago, two subcommittees were formed to support activities related to the supervision of professional practice in specific fields; these are the **subcommittee on perinatality**, and the **subcommittee on transplants**.

In overseeing professional practice, the CIP inspects medical records, registers, medications, products, substances, apparatus and equipment used in practice. At the request of the Board of Directors, or on its own initiative, it may initiate an inspection pertaining to the professional competence of any member of the Collège. Finally, under the terms of the *Medical Act* and the *Act respecting health services and social services*, it also conducts inspections pertaining to the quality of medical care provided in health institutions, by evaluating the medical records and the functions assumed by the institutions' council of physicians, dentists and pharmacists (See Section 3.2.2).

- **Continuing Professional Development Committee (CDPC)**

The Continuing Professional Development Committee is a permanent committee created by the Collège and composed of members of the Board of Directors, among

others. While it is supported by the Practice Enhancement Division, the other Collège divisions are also active on it.

The CDPC has five main functions:

- to make physicians more accountable in matters of continuing medical education;
- to index existing resources;
- to promote concerted action;
- to promote research;
- to devise new strategies for maintaining competence.

As of July 2007, Québec physicians must opt for one of the existing continuing professional development programs, such as the self-managed plan proposed by the Collège³⁰.

This Committee is also responsible for examining complaints in relation to the [Code of Ethics for parties involved in Continuing Medical Education](#).

▪ **Practice Enhancement Division (DAE)**

The mandate of the Practice Enhancement Division (DAE) is clear, and that is to oversee the practice of medicine and to enhance that practice with a view to protecting the public and helping to improve the health of Quebecers.

The DAE performs the following functions:

- supports the Professional Inspection Committee and the Continuing Professional Development Committee;
- evaluates the quality of practice of physicians in private practice and in institutions through monitoring and evaluation at three levels;
- assesses the quality of medical practice in institutions, notably by promoting quality management;
- intervenes with a view to improving the competence of physicians in private practice as well as in institutions;
- participates, at the Collège and elsewhere, in activities affecting 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 interest³¹;
- assumes the duties of secretariat of the Conseil québécois de développement professionnel continu médical du Québec, which is an advisory council grouping together all parties concerned;
- promotes the implementation of its “Self-managed Plan for Continuing Professional Development” within the medical profession in Québec.

▪ **System of Monitoring and Improving Performance**

To fulfill its mandate, the DAE and the CIP have, for a number of years, used an intervention model aimed at improving professional practice rather than identifying deviant physicians. The model focuses on informing physicians, validating

³⁰ See note 10.

³¹ See the various guidelines and guides in the [list of publication on the Collège website](#).

monitoring tools and making a systematic connection between monitoring and activities likely to improve practice.

Box II-2.4

System of Monitoring and Improving Performance

The system of monitoring and improving performance includes three levels of intervention and may be applied to private practice as well as to practice in institutions.

First Level: Monitoring using clinical and administrative indicators

At the first level, the monitoring is done using clinical and administrative indicators. If, for example, the prolonged use of benzodiazepines in the elderly is targeted, all the physicians involved 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.

Second Level: Further evaluation of certain physicians or institutions

The second level of monitoring includes further evaluation of certain physicians or institutions where a specific practice was shown to be problematic during the screening process at the first level. Various tools may then be used, such as the professional inspection visit, which will be followed, if need be, by specific recommendations, such as attending continuing education activities.

Third Level: In-depth evaluation of the needs of certain physicians

At the third level, there is an evaluation of the needs of certain physicians. Other tools such as the structured oral interview or an evaluation period will help to pinpoint these needs and to recommend professional development activities.

All physicians and institutions must cooperate in making professional inspection visits run smoothly, by providing information and the medical records required for individual as well as collective evaluations. When the conclusions drawn from professional inspection visits warrant it, the CIP may transmit suggestions to the physician or institution visited. In some cases, the conclusions are such as to warrant the imposition, by the Board of Directors, of a refresher training period for a member, with possible restriction of the right to practice professionally during the training period.

In its concern to protect the public, the Collège implemented in 1999 an administrative follow-up program for physicians unfit to practice due to illness. Since 2001, this program has been under the responsibility of a physician in the DAE³².

Examining Complaints and Inquiring into the Illegal Practice of Medicine

▪ The Syndic and the Inquiries Division

In order to carry out its mission—to promote quality medicine at the service of the public—the Collège has adopted a number of regulations, among them, a code of ethics. To ensure their implementation, the Collège has one syndic and a number of assistant syndics who intervene and conduct inquiries. In compliance with the *Professional Code*, the syndic is a physician appointed by the Board of Directors of the Collège. The syndic's function is to conduct an inquiry following an explicit request or upon receiving information indicating that a physician has committed an

³² On this subject, the Collège has published the following leaflet: [*Programme de suivi administratif des médecins ayant des problèmes de santé physique ou mentale susceptible de compromettre l'exercice professionnel de la médecine*](#). January 2006.

infraction, violating the provisions of the *Professional Code*, the *Medical Act* or the regulations ensuing from these, in particular, the *Code of Ethics of Physicians*.

Physicians have an obligation to collaborate in inquiries of the syndic and to promptly provide accurate information and the documents requested. The *Professional Code* and *Code of Ethics* impose this obligation, and it takes precedence over respect for professional secrecy. The syndic's inquiries are confidential in nature. The disclosure of information obtained during an inquiry is not authorized except for purposes of applying the disciplinary process. Based on the facts, the circumstances, the seriousness of the presumed infraction, the available evidence and the medical record of the physician concerned, the syndic may or may not lodge a complaint before the Disciplinary Council. Before resorting to a disciplinary process, the Inquiries Division uses a variety of means to help physicians practice their profession in accordance with their obligations.

The Inquiries Division answers questions and examines requests made to the Collège relative to 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. These requests come from patients, family members, physicians, institutions and coroners³³.

Box II-2.5

Non-disciplinary Interventions

A large number of cases are settled by way of interventions such as assistance and information given to complainants. Any question of an ethical or regulatory nature may be submitted to the syndic for discussion with a view to obtaining advice. These questions may touch on respect for confidentiality, the limits of the physician-patient relationship, the physician's leaving a clinic, retirement, advertising, a potential conflict of interest, access to a patient's record or other issues.

In general the problems described in requests accepted for an inquiry are settled through the following measures:

- remarks or recommendations of a preventive nature made to the physician concerned;
- assessment of the physician's practice by the Practice Enhancement Division;
- agreement on the physician's part to undergo an evaluation period or a training period or any other activity to improve his or her professional competence;
- voluntary restriction of professional practice;
- recourse to the *Programme de suivi administratif des médecins ayant des problèmes de santé physique ou mentale susceptible de compromettre l'exercice professionnel de la médecine* (Program providing administrative follow-up of physicians with physical or mental health problems likely to compromise a physician's professional practice) ;
- voluntary registration of the physician's name on the list restricting the prescription of medication managed by Health Canada;
- cessation of practice by the physician.

Many of the requests submitted to the Inquiries Division could be avoided if there was better communication between the physician and the patient or significant others, or if the physician was more conversant with the laws and regulations. Physicians may also call upon the Division's counseling services to obtain the support necessary to prevent a situation from worsening. But when the solutions proposed are insufficient or inappropriate, disciplinary measures must be taken.

³³ The Collège has published a leaflet on the procedure to follow, called "[How to file a request for an inquiry into the professional practice of a physician.](#)" August 2003.

▪ **The Review Committee**

Complainants may call upon the Review Committee to give its opinion when, at the end of an inquiry, the syndic decides against lodging a disciplinary complaint. The number of members on this Committee varies, but it sits in groups of three. Some are public representatives, and their names are listed for this purpose by the Office des professions. Others are part of the Board of Directors or physicians appointed by the Board of Directors. The Review Committee may uphold the syndic's decision not to lodge a complaint before the Disciplinary Council or conclude that it is appropriate to do so. In the latter case, the Review Committee names a person to act as syndic in lodging the complaint. It may also suggest that the syndic or assistant syndic complete the inquiry or submit the case to the CIP.

▪ **Disciplinary Council**

The Disciplinary Council is composed of at least three members: the president of the Council, a lawyer appointed by the government, and two physicians designated by the Board of Directors. This Council is a tribunal independent of the Collège in the performance of its functions. It hears complaints lodged by the syndic or a private complainant concerning physicians who are in breach of the *Professional Code*, the *Medical Act* and of other regulations adopted under these laws, among them, the *Code of Ethics of Physicians* and its provisions.

The hearings and decisions of the Disciplinary Council are public. A physician who testifies before this Council—which functions by the same rules as a court of law—may be accompanied by a lawyer, for he or she is bound to answer all questions, including those that may incriminate him or her.

Box II-2.6

Disciplinary penalties

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

- 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 from the date of the offense;
- a fine that can vary from \$1,000 to \$25,000 for each offence;
- the obligation to remit to any person entitled to it a sum of money the professional is 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 or her permit;
- revocation of his or her specialist's certificate;
- restriction or suspension of the right to engage in professional activities;
- recommendation to the Board of Directors to impose a refresher training period.

Either party may appeal the Disciplinary Council's decision before the Professions Tribunal.

▪ **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 usurping the title of medical doctor or pretending to have the competence to practice the medical profession. In response to complaints from the public, health professionals and other sources, the Inquiries Division may, after investigation, institute legal proceedings for the illegal practice of medicine or wrongful assumption of a title.

4.2 **Other Associations of Physicians**

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

- scientific: maintaining and promoting the quality of professional practice;
- union-based: defending the rights and working conditions of members;
- social: offering services of assistance and support to their members and promoting certain causes.

On the scientific level, various agencies, such as the Royal College of Physicians and Surgeons of Canada (RCPSC) for specialists, and the College of Family Physicians of Canada (CFPC), including its Québec 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, take part in the certification of training programs offered throughout the country. There are also groups in Québec which, in addition to having a scientific purpose, offer support to their members; among these are the Association des médecins de langue française du Canada (AMLFC), the Association of Councils of Physicians, Dentists and Pharmacists of Québec (APDPQ), and the Québec Medical Association (QMA), which is the Québec chapter of the Canadian Medical Association (CMA).

On the union level, general practitioners were the first to create regional associations that would come together and form the Fédération des médecins omnipraticiens du Québec (FMOQ). The FMOQ now has 17 regional associations and two provincial associations—the Association des médecins œuvrant en établissements psychiatriques and the Association des médecins de CLSC.

As for medical specialists, they subsequently formed provincial associations that brought together physicians in the same specialty. These associations together form the Fédération des médecins spécialistes du Québec (FMSQ).

The physicians in training followed suit and created the Fédération des médecins résidents et internes du Québec (FMRIQ), which later became the Fédération des médecins résidents du Québec (FMRQ). As soon as they were formed, the medical student associations in each of the four faculties of medicine in Québec came together to create the Fédération médicale étudiante du Québec (FMEQ).

The federations of physicians play a key role in the organization of medicine in Québec 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 realizing 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 sustained involvement in continuing professional development activities. Québec 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.

On the level of assistance and support for physicians, the medical federations also provide services to their members, such as investment funds and insurance plans. The Canadian Medical Protective Association acts as a mutual professional liability insurance company, covering most physicians in Canada.

The existence of medical associations also made it possible to establish the Programme d'aide aux médecins du Québec (PAMQ, Québec Physicians Health

Program) in 1990. Devised for physicians in difficulty, the program is the result of a joint initiative of the AMLFC, the Collège des médecins, and the medical federations. Its mission is to assist physicians who have personal problems or suffer from a mental illness or from dependence. It does so by assessing each situation and directing the persons concerned to the appropriate resource. A growing number of medical students, medical residents, specialists and family practitioners are benefiting from this program. It is important to distinguish this program, aimed at helping physicians in difficulty, from the administrative monitoring program operated by the Practice Enhancement Division of the Collège, whose aim is first and foremost to protect the public by way of risk management as it pertains to fitness to practice medicine.

5 Obligations of Physicians: Guideposts

In Québec, professional ethics, the *Code of Ethics* and the Collège des médecins are indispensable guideposts. Nonetheless, one should point out that “ethics”, or that which helps a person decide what he or she should do in a specific situation, cannot be reduced to a set of obligations, much less professional obligations, for two reasons.

First, there are many other obligations not particular to physicians but which physicians must fulfill like all other citizens. This is true of laws, for example. Indeed for many, laws are considered to be the mandatory rules that come closest to “ethics” and, for this reason, are the best insurance of a humanistic approach on the part of physicians. Secondly, the real moral challenge is not so much to submit to all of these obligations, but to deal with them on a personal level, in a lucid manner, and on a daily basis.

The fact remains that the professional obligations of physicians can serve as guideposts, provided they keep a watchful eye on their evolution. They are also guideposts on which the public can rely and on which physicians can build their own personal ethic.

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Chapter 3 Legal Aspects

1 Introduction

Physicians are practicing their profession within societies increasingly defined as legal entities.

In Québec, medical practice is subject to various legal provisions, because the latter either concern the health sector, or provide a framework for professional relations, or apply to all citizens. This chapter first presents an overview of the laws that may affect the practice of medicine; it then focuses on medical civil liability and concludes with a presentation of the laws imposing very specific obligations on physicians.

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

2 The Law and Medical Practice in Québec

2.1 *The World of Law*

Law establishes the rules that facilitate life in society. In our pluralist societies the law is particularly important, since laws are the rules that all members of society, despite their differences, must observe.

Determining who has the legitimacy necessary to enact these rules has not been an easy task. The advent of democracy, where every citizen has the right to choose by free vote and elect those who will hold legislative and executive power for a given period is a relatively recent phenomenon. In a democracy, the laws represent the social choices that all citizens must respect since they have participated in their making.

In Canada, the laws include constitutional laws and all other laws adopted by parliaments in accordance with constitutional laws. The regulations also have the force of law, as their purpose is to apply the legislative measures.

A law enacted by a legislator can sometimes be interpreted in different ways. Also, the power to interpret laws in litigation cases has been entrusted to persons designated to do so. Courts—independent of the executive powers—hear the proposed interpretations of opposing persons or their lawyers and then render a decision. The parties concerned also have recourse and may then appeal the judge’s decision. The appeal ensures that the trial judge has properly applied the rule of law.

In exercising its functions, the court must take into account previous decisions and devote particular attention to the judgments that make up the “jurisprudence”. The jurisprudence is all of the judgments rendered by the courts on a given subject. Eminent jurists sometimes summarize the decisions rendered on a given subject, discuss the state of law and express an informed opinion on its evolution. Their numerous essays and research works constitute what is known as “doctrine”.

Thus, the three principal sources of law are the laws and regulations, jurisprudence, and doctrine.

2.2 *The Legal System in Canada and in Québec*

Modern societies have inherited one or the other of two great legal traditions: civil law and common law.

Civil law and its roots date back into antiquity, when the principle of a “code” was already being applied to summarize traditions, rules and customs and to formalize these rules in one text. By consulting the code, one could usually come up with a clear answer or, at least, articulate a general principle whereby a dispute could be settled.

Common law is all of the rules of an ordered society that are derived from judgments rendered by courts for centuries. In this system of law, the judge must examine the previous decisions of courts, notably those of superior courts, with a view to finding precedents that have acquired the force of law.

Several European, Asian and African countries have adopted civil law. This is true of France, Germany, Italy, Russia, China and Japan. On the other hand, countries with a British heritage apply common law. Aside from the Great Britain itself, these include the United States, Australia, India and Canada, with the exception of Québec. For historical reasons, Scotland and Louisiana have also retained the civil law system.

Whereas the other provinces have always applied common law, Québec has remained an essentially “civilist” society. Indeed, its first civil code, adopted in 1866, was largely inspired by the French Napoleonic Code. It also contained a number of British rules, namely those applicable to commercial law.

The British North America Act of 1867, promulgated in London by the British Parliament, created the modern Canada and established the powers of the provinces and federal government by granting them the right to govern and enact laws in their respective areas of jurisdiction. The Act also gave the French language official status in the federal parliament and in the National Assembly of Québec. It recognized or created superior courts, among them the Supreme Court of Canada and a superior court in each province. The provinces were also empowered to create their own courts: the Court of Québec (Civil Division, Criminal and Penal Division, Youth Division), the municipal courts and the administrative courts such as the Administrative Tribunal of Québec and the government agencies. The latter are subject to the supervisory authority of the Superior Court. The federal government appoints the judges of the Supreme Court and the courts of appeal and superior courts in each province. The Québec government appoints the judges of the Court of Québec.

In 1982, Ottawa repatriated the British North America Act from London. As well, the Canadian Charter of Rights and Freedoms was made law and enshrined in the Constitution. Indeed, Québec has had its own Charter of Human Rights and Freedoms since 1975. These laws solemnly establish the values of our society by recognizing the fundamental rights of the individual, notably in his or her relations with the government. The charters also describe the limits of other legislative texts and allow the courts to invalidate a provision incompatible with the charters and to grant remedy to those whose fundamental rights have been violated.

In 1994, the new *Civil Code of Québec* came into force. It takes into account over 100 years of evolution in jurisprudence and bears witness to the modernization of Québec society. The Code’s preliminary provision elucidates its overall scope and reads as follows:

“The Civil Code of Québec, in harmony with the Charter of human rights and freedoms and the general principles of law, governs persons, relations between persons, and property.”

“The Civil Code comprises a body of rules which, in all matters within the letter, spirit and object of its provisions, lays down the *jus commune*, expressly or by implication. In these matters, the Code is the foundation of all other laws, although other laws may complement the Code or make exceptions to it.”

2.3 Law in the Field of Health

Many provisions in the *Civil Code* impact on the field of health, especially those intended to protect the integrity and inviolability of the person and to establish the right to life. These touch on many subjects concerning health: care; the 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; a person’s right to have access to records concerning him or her; as well as transplants, research projects and ethics committees.

The rules on civil liability, now called contractual liability and extra-contractual liability, are also prescribed in it. Insofar as the relationship between the patient and the physician constitutes a contract, certain articles in the *Civil Code* influence medical practice. In fact, the *Civil Code* governs all contracts established between two persons and fixes their conditions, so that each party is responsible for complying with his or her obligations and for damages resulting from noncompliance.

Because hospitals and professions come under provincial jurisdiction, Québec enacts the laws concerning health. In 1971, the National Assembly adopted framework legislation concerning the organization of the health care system in Québec, namely the *Act respecting health services and social services* (LSSSS). Given its purpose to improve the health and well-being of individuals and populations, the law establishes the principles and guidelines for the organization of health services and social services in Québec.

Amended many times since, the LSSSS still determines the mandates and methods of organization of public institutions, community groups and coordinating agencies, such as the ministère de la Santé et des Services sociaux and the regional 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 “user’s rights”, among them, the right to choose one’s physician, the right of access to one’s medical record and to adequate care, given the resources available. The processing of users’ complaints has been the subject of important amendments, among them, creating the position of local service quality commissioner.

The *Professional Code* enacted in 1973 is also a legal framework, in this case for the professional system in Québec. This *Code* defines the criteria for recognition of a profession, determines the powers of a professional order and stipulates the mechanisms an order may use to supervise the professional practice of its members in order to protect the public. Thus, a professional order must establish its own professional inspection committee and its own code of ethics, put in place a syndic with powers to conduct inquiries, and a disciplinary council with the competence to examine complaints when a member is in breach of a provision of its code of ethics. The *Medical Act* defines the practice of medicine and establishes the requirements for a permit to practice.

One legal source of particular importance is the *Code of Ethics of Physicians of Québec*. This regulation, adopted under the *Professional Code*, is the fundamental guide to good medical practice.

Among the other laws touching on the field of health, are 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*.

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

The federal government has the power to enact laws in areas devolved to it by the Constitution, namely criminal law, foods and drugs, as well as medications and patents. The federal government has also participated actively and financially in the setting up of provincial health insurance plans. It then passed the *Canada Health Act* in 1984, which was intended to ensure uniformity among the provincial plans and to establish national standards. This legislation allows the federal government to reduce its financial payment to a province that chooses to disregard it or call into question the

principles of accessibility, universality, comprehensiveness and transferability, or of publicly administered health care systems.

2.4 **Medical Practice and the Law**

This overview of the various laws touching on the area of health shows how a medical act can have legal consequences.

- A medical act can go against the public order or a standard deemed essential to life in society, such as a *Criminal Code* provision. One example might be a physician who is the subject of criminal proceedings for having refused to assume care for a tramp in the emergency room; the man had died without having received 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. More recently, in a Canadian province, a medical specialist was accused of having put an end to the life of a suffering, moribund patient, because euthanasia or assisted suicide is still prohibited under the *Criminal Code*. If a physician is found guilty of a criminal act, the court must, within the guidelines fixed by law, impose a penalty 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 all reasonable doubt”, and the accused is not compellable, or not bound to testify.
- A medical act may also be subject to one or another of numerous federal or provincial laws that determine a physician’s conduct in a specific instance. This applies notably to the physician’s “statutory” obligation to report to the director of youth protection situations in which a child could be in danger because of negligence or the incapacity of his or her parents. In case of violation, these laws have penalties attached to them, usually in the form of a fine.
- A medical act 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. Physicians are not exempt from a penalty against ethical standards simply because their breach did not have 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, restriction of the right to practice, or temporary or permanent striking off the roll. The disciplinary council may also recommend that the professional order impose a refresher training period or course on the physician. Finally, the physician is compellable. Preponderance of evidence is the degree of proof required.
- When a wrongful act has caused injury to a patient or his or her family, the *Civil Code* provides for compensation regimes: the professional or civil liability regime. The *Civil Code* requires that the victim of a medical error establish that a fault was committed, that an injury was sustained and that there is a causal link between the fault and the injury. The physician is compellable. The burden of proof rests with the claimant, except in particular circumstances, and the degree of proof is preponderance of evidence.
- If, in addition to having committed a fault and caused harm, the physician has illicitly and intentionally violated a fundamental right as contemplated in the Québec Charter of Rights and Freedoms, such as the right to personal integrity, the court may impose exemplary damages.
- A medical act may also be the subject of a complaint, under the system for examining complaints provided for in the *Act respecting health services and social services* (LSSSS).

These forms of recourse, on the civil as well as disciplinary and administrative levels, may be used by all patients or their legal representatives, either simultaneously or alternately.

3 Medical Civil Liability

3.1 Introduction

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 or her case before the courts.

The *Civil Code* sets the rules for civil liability:

“Every person has a duty to abide by the rules of conduct which lie upon 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 responsible for any injury he causes to the person and is liable to reparation for the injury, whether it is bodily, moral or material in nature [...]” (Art. 1457).

This article establishes the three elements essential to a lawsuit in civil liability:

- a fault that can be defined as a failure to fulfill a pre-existing duty;
- injury, for the law in civil liability seeks to repair the damage. If there is no damage to repair, there is no basis for legal action, at least not in civil liability;
- a causal relationship between the fault and the damage.

There are also compensation plans that do not consider fault, where a person is compensated for the injury sustained without having had to prove the presence of fault on the part of the person responsible. In the compensation plan for work accidents, for example, a person merely has to demonstrate that the accident “arises out of or in the course of” his work in order to obtain the compensation provided for. Similarly, in 1978, Québec adopted a no-fault compensation plan for victims of automobile accidents so as to eliminate the problem of insolvent automobile drivers and to avoid interminable civil liability court cases. Many have proposed a similar system to compensate victims of medical errors. The debate is ongoing.

One noteworthy example is the particular situation of the person who acts as a “good Samaritan”. Article 1471 of the *Civil Code* reads as follows:

“Where a person comes to the assistance of another person or, for an unselfish motive, disposes, free of charge, of property for the benefit of another person, he is exempt from all liability for injury that may result from it, unless the injury is due to his intentional or gross fault.”

3.2 The Evolving Concept of Medical Fault

No law or regulation clearly defines the notion of medical fault. Thus, we must look to jurisprudence and doctrine for its definition.

Until the middle of the 20th century, the concept of medical liability was almost nonexistent in jurisprudence. In 1930, the Supreme Court stated the following: “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.”¹

Yet with time, changes occurred gradually. The rules of civil liability were applied to medical practice in cases of “serious, gross and inexcusable” negligence. In 1948, the Supreme Court established, while referring to physicians as “men of art”, that, “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.”²

In 1957, the principle of medical civil liability was established by the Court of Appeal, stating, “The general rule is therefore that professional negligence is a fault like any other.”³ In the same decision it also established that the physician’s liability was contractual in nature: “As soon as the patient enters into the physician’s office, a contract of professional care arises between the physician and the patient by and of itself.”

The “medical contract” was therefore recognized as potentially introducing rights and obligations of a contractual nature into the professional physician-patient relationship, since the patient is obliged to cooperate in the investigation and treatment, and the physician is obliged to provide quality care in return for remuneration. It should be emphasized that “extracontractual” civil liability imposes the same obligation to provide quality care, even without a contract. This is the case in the emergency room, for example, where the unconscious patient cannot sign a contract with the emergency specialist who assumes responsibility for his or her care.

In 1965, the Court of Appeal defined the four obligations inherent in the contract of professional care⁴, and these can be summarized as follows:

- the obligation to inform the patient and obtain his or her consent;
- the obligation to provide attentive, prudent and diligent care in accordance with scientific data, save under exceptional circumstances;
- the obligation not to abandon the patient;
- the obligation to respect confidentiality.

Therefore, each time a patient takes legal action against a physician for professional liability, he or she must prove the existence of fault, that is, a breach of one or the other of these four obligations. A breach is defined essentially as the fact of not having met the standards of the profession.

As a result, it must be determined whether the physician behaved as a normally prudent, competent and diligent physician would have in similar circumstances. Using objectivity as the criterion, a family physician is compared to another family physician, or a medical specialist is compared to a physician practicing in the same specialty. Jurisprudence shows that, in assessing the situation, one must think back to the moment when the events occurred and take into account elements that were known then or that should have been known then, and not elements that made themselves known subsequently⁵. The physician should not be judged using the “retrospectroscope”, 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 competence—who will then express 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 the decision after having heard the lay witnesses and expert witnesses of both parties, and after having examined all the relevant documentation, all the medical or hospital records and articles in medical journals submitted as evidence. He or she then determines if there was fault and injury, and if there is a causal link between the two. The judge must also evaluate the injury sustained and quantify it in dollars. If the judge concludes the existence of a fault, an injury and a causal link, he or she will order the defendant to pay the claimant the sum of money

required for full compensation. Either party may appeal this decision in order to contest the liability, the amount granted, or both.

3.3 Scope of Obligations Inherent in Medical Contract

3.3.1 Obligation to inform the patient and obtain consent

In Québec, the principle of the patient's voluntary and informed consent to receive care is well recognized in jurisprudence and in the *Charter of Human Rights and Freedoms*, the *Civil Code* and the *Code of Ethics of Physicians*. Obviously, the consent will be voluntary and informed in as much as the patient receives sufficient, appropriate information on his or her condition, possible treatments and their respective risks. The *Code of Ethics* is particularly clear in this regard:

“A physician must, except in an emergency, obtain voluntary and informed consent from the patient or his legal representative before undertaking an examination, investigation, treatment or research.” (sec. 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.” (sec. 29).

Jurisprudence also recognizes the principle whereby good medical practice implies communicating the necessary information, not only at the start of the relationship but throughout the follow-up period. The *Code of Ethics* reinforces this requirement for transparency by obliging physicians to inform their patients of any incident that could have a significant effect on their state of health:

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

The *Code of Ethics* reiterates this obligation, already recognized in jurisprudence, as is illustrated by a judgment of the Superior Court rendered in 1992. A surgeon had performed a mastectomy on the strength of a report stating the presence of an infiltrative canalicular epithelioma. After the operation, it proved to be a granulomatous mastitis. The surgeon was judged liable, not for the error in diagnosis and treatment, but for having left the patient in ignorance of the second diagnosis and in fear of a recurrence of her cancer for over five years⁶.

This example shows the distinction to be made between error and fault. In this case, it was a diagnostic error: the first examinations strongly suggested a diagnosis of cancer, whereas subsequent examinations ruled it out. But this error does not necessarily constitute a fault. The fault lies in that the physician did not respect the standard whereby the patient should have been informed of the new diagnosis. Patients, like the law, can accept that the physician can make a mistake, but they certainly will not accept being deceived.

3.3.2 Obligation to provide attentive, prudent and diligent care

It is acknowledged straightaway that the physician's obligation should 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 fault. Rather, the physician's obligation is said to be one of means; in his or her profession, the physician is required to use methods as appropriate as those that would be used by a physician of equivalent training in similar circumstances.

The physician may also be held liable for care provided by persons who were directly under his or her authority, such as a student or a nurse acting under the physician's direct control in an operating room, for example. The physician may be sued as "principal" for the fault of his or her "attendant", somewhat like an employer being sued for a fault committed by an employee. The attendant may also be sued personally. However, if a hospital staff member is not under a physician's immediate control, as a nurse providing professional care in a care unit, the liability of the physician would not be incurred for any fault on the nurse's part. The nurse is professionally liable, as is the hospital as the employer.

Can a patient hold a hospital responsible for a fault committed by a physician enjoying hospital privileges? For a long time, hospital services provided by physicians not chosen by patients, such as the physician on call in an emergency room, the radiologist or pathologist, were considered to be included in the "hospital contract". Thus, the hospital could be held responsible for the nonperformance of an obligation or the commission of a fault by one of these physicians. Other physicians were not judged to be employees of the hospital centre; as a result their activities could not incur the institution's liability.

Others thought that the hospital contract, linking the patient to the institution, extended to all medical care including that provided by physicians enjoying hospital privileges. From this perspective, the patient could claim reparation from the institution, even if the fault was strictly medical. It was then up to the hospital to sue the physician responsible. Recently a judgment of the Court of Appeal cast into doubt the very existence of a hospital contract, for the *Act respecting health services and social services* determines the hospital's obligations and the services to which a patient is entitled, medical services included. One of the judges stated the following: "*I am of the opinion that the hospital institution could not answer for a medical act over which it can exercise no control, and which the law entrusts exclusively to the physician to provide.*" (Free translation).⁷

Since the coming into force of the *Act to amend the Professional Code and other legislative provisions as regards the health sector* in 2003, the field of practice of many health professionals, notably nurses, has been amended and expanded. However, all the rules concerning professional liability remain the same. Every professional incurs his or her own professional liability and, in the absence of any "master and servant link", the professional is not held responsible for the fault of a third party.

There have also been cases where several physicians have been sued jointly. Article 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 sharing applies to them only and does not deprive the claimant of the right to execute the entire judgment against one or another of the defendants.

Since the coming into force of the regulation respecting the practice of the medical professional within a company, physicians in Québec may practice their profession within a limited liability partnership (LLP) or joint-stock company (JSC) constituted for this purpose. Physicians who practice within an LLP or a JSC are not held jointly or severally liable for the obligations of the company or another professional as they pertain to fault or negligence committed by the latter, or of their attendants or representatives in the practice of their professional activities within the company, if they have not participated in the acts contemplated. However, the physician's professional responsibility toward the patient remains unchanged. Furthermore, physicians practicing their profession within a company of this kind must provide and maintain, for this company, professional liability insurance coverage that satisfies the

requirements of the Collège. Physicians are therefore well advised to consult a professional so as to inform themselves of the other legal requirements involved. (See Chapter 1, Section 3.2.5).

3.3.3 Obligation to not abandon one's patient

Failure to respect the obligation to not abandon one's patient is sometimes described by jurists as a fault by omission. Jurisprudence and doctrine establish that physicians must remain reasonably available to their clientele, taking into account each patient's condition.

The obligation to provide follow-up is indeed specified in the *Code of Ethics*:

"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 a colleague or other competent professional can do so in his place." (sec. 32).

"A physician who wishes to refer a patient to another physician must assume responsibility for the patient until the new physician takes responsibility for the latter." (sec. 33).

"A physician who treats a patient requiring emergency care must ensure the medical management required by the patient's condition until the transfer is accepted by another physician." (sec. 43).

Physicians must fulfill this obligation wherever they practice. They must be particularly vigilant in activity sectors where there is risk involved, as in walk-in clinics or emergency rooms, or when they discontinue certain activities.

A new provision of the *Code of Ethics* prohibits physicians from taking part in a strike action of a nature that would endanger the health or safety of a clientele or population (sec. 13). It will be interesting to see how jurisprudence deals with the relevance of this provision in cases of civil liability.

3.3.4 Obligation to ensure confidentiality

The right to professional secrecy is recognized under the *Charter of Human Rights and Freedoms*, as well as the *Civil Code*, the *Professional Code* and the *Medical Act*. The *Code of Ethics* also reaffirms this right but provides for certain exceptions:

"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 or the law authorizes him to do so, or when there are compelling and just grounds related to the health and safety of the patient or of others". (sec. 30, p. 5).

Indeed, certain laws authorize or oblige the physician to divulge to the director of youth protection or public health division information considered essential to the protection of the health and 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 a person or an identifiable group of persons is in imminent danger of death or serious injury. It stipulates, however, that the information may be communicated only to those persons who are likely to come to their rescue, and only the information necessary for the express purpose of the disclosure may be communicated.

Section 21 of the *Code of Ethics* specifies the items that must be filed in the medical record to document and justify such a breach in confidentiality. To the extent that physicians satisfy these requirements, they cannot be accused of anything in terms of ethics or professional liability. However, medical liability could be incurred if an

unfortunate event resulted from a failure to alert the persons in danger or the police authorities.

A physician may also be freed from the obligation to ensure confidentiality when the patient explicitly, or even implicitly, relinquishes professional secrecy when instituting legal proceedings against his or her physician. In as much as the confidential information is relevant, the physician may use it for his or her own defense.

3.4 Rules Concerning Proof

3.4.1 Proof of the standard of care

The burden of proof rests 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. The patient must demonstrate that the physician being sued did not give the same quality of care one might expect from another physician with the same training in the same circumstances. The physician being sued may also produce his or her own expert witnesses.

Unlike criminal law, where “proof beyond all reasonable doubt” is required, “preponderance of evidence” is the degree of proof required in professional civil liability. Note that this standard is not of the same order as that of expert scientific evidence.

3.4.2 Presumption of fact

Certain circumstances may warrant a burden of proof reversal in matters of fault as well as causal link. Articles 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 classical example is forgetting 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 or she did not commit a fault.

3.5 Period of Time for Prescription

If legal proceedings are not instituted within a certain time period, the claim is “prescribed”. Actions in medical civil liability are subjected to a legal prescription of three years. If the victim, his or her representative or family members do not respect this time period, the right to claim is abolished.

The law stipulates that the time period for prescription may be “suspended”, if it can be demonstrated that it was “impossible for the victim to act”. Therefore, when the victim is unaware of the physician’s faulty act, the period of time for prescription is suspended, especially if the physician has kept the lack of awareness alive by remaining silent on the incident. As a general rule, the time period for prescription begins to run on the date the fault was committed or on the date of the first manifestation of the injury.

3.6 Compensation

In medical liability, it is clearly established that the amount granted to a victim must compensate for the loss he or she has sustained and the profit of which he or she has been deprived. Compensation takes the form of capital payable in cash to the victim, unless “otherwise agreed by the parties”.

The damages are paid to compensate for pecuniary losses and non-pecuniary losses.

- **Non-pecuniary losses** include moral injury sustained, pain, suffering and difficulties experienced, as well as the loss of moral support experienced by a family member when the victim dies or is seriously injured. This particular category of damages is one approach adopted by the courts for complete reparation of the injury caused. It is often very difficult to quantify these losses. Also, in the late 1970s, the Supreme Court of Canada rendered decisions on three leading cases in which it concluded that, barring exceptional circumstances, the maximum that could be granted in this situation should never exceed \$100,000. Given the rate of inflation in the last 25 years, the maximum today would be roughly \$300,000.
- **Pecuniary losses** include the cost of past and future care, the cost of home adjustments, if applicable, and above all, the loss of the victim's earning capacity or 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 a family member would have received from the victim. It is up to the first judge who decides on liability to determine the amount, and this is based on expert actuarial analysis presented as evidence by the parties.

Finally, since January 1, 1994, when the judge deems that, at the moment of the ruling, there is not enough information on the progress of the victim's physical condition, he or she may grant the victim the right to go to court again for a reassessment of his or her condition and to claim additional damages.

3.7 **Civil Courts**

3.7.1 Trial

Claims of less than \$7,000 are addressed to the Small Claims Court. Claims between \$7,000 and \$70,000 are addressed to the Civil Division of the Court of Québec, and those over \$70,000 to the Superior Court.

3.7.2 Appeal

The Court of Appeal hears, by right, the appeal from a judgment of the Court of Québec or the Superior Court if the sums involved exceed \$50,000. If not, the appeal may only be heard with permission.

The Supreme Court will agree to hear, with permission only, an appeal from a Court of Appeal judgment that would be in the national interest or constitute a new and eminently important case. Decisions of the Supreme Court are final.

3.8 **Professional Liability Insurance**

Under the terms of the *Regulation respecting professional liability insurance [of physicians]* ensuing from the provisions of the *Professional Code*, a physician must hold and keep in force an insurance contract for this purpose or provide proof that his or her 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.

Two formulas are offered to physicians:

- **Protection offered by the CMPA** – This protection is guaranteed on the basis of events. The Association will defend the physician who is a member when the event occurs.
- **Protection offered by an insurance company** – The company will insure the physician's defence on the basis of the claim, if it is the physician's insurer on the date the action is taken.

In both cases, the insurer pays the costs of the defence as well as the amount of the settlement or judgment, if applicable, within the limits provided for in the insurance contract, if there are such limits.

However, if a physician was a member of the CMPA in 1995 and is the subject of legal action in 1996 for an act performed in 1994, the CMPA will not defend the physician, because he or she was not a member when the event occurred. Furthermore, the insurer with whom the physician was insured in 1993, but not in 1996, will not defend him or her either, because he was no longer the physician's insurer on the date of the claim.

Therefore it is essential that members of the CMPA, if indicated, provide for additional coverage for acts performed before they became members.

3.9 *Record-keeping*

One cannot overemphasize the importance of creating good medical records in private practice and of entering all of 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 cases of litigation. In a very recent judgment of the Court of Appeal, one reads:

"I am in agreement with the solicitor for the appellant when he pleads that we must rely primarily on the notes in the medical record and, excepting clear and plausible explanations, we must consider that what was not noted, was not in principle done."⁸ (Free translation).

It should also be specified that, in cases of lawsuit, a physician must immediately seek help from the insurer. In fact, it is the insurer's responsibility to defend the physician and to compensate the victim, if it is demonstrated that the physician committed a professional fault. The physician should never try to settle the dispute himself or herself and run the risk of adversely affecting the case and subsequently being refused coverage.

4 The Physician's 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 personal right to integrity and inviolability, to a private life, and to professional secrecy. Physicians are sometimes permitted, however, to overstep these rights in order to care for and protect the individual or the population.

This overview of the principal pieces of legislation notes the exceptions with respect to fundamental rights that impose specific obligations on physicians.

The *Civil Code of Québec* defines certain offences against the right to personal integrity and inviolability in the context of care. The provisions of the *Act respecting the protection of persons whose mental state presents a danger to themselves or to others* specify its general rules. Many legal provisions provide for exceptions with respect to professional secrecy. The *Code of Ethics of Physicians* stipulates that a physician “may not divulge facts or confidences which have come to his personal attention, except when the patient or the law authorizes him to do so, or when there are compelling and just grounds related to the health or safety of the patient or of others.” (sec. 20, p. 5). Also, the *Youth Protection Act*, the *Public Health Act*, the *Highway Safety Code*, and the *Act respecting the determination of the causes and circumstances of death*, permit physicians, indeed in some cases oblige them, to report their patient's situation to an administrative authority responsible for the security and protection of certain persons.

Lastly, we will touch on laws that grant rights and recourse to citizens and impose obligations on physicians to ensure the exercise of these rights, such as the *Automobile Insurance Act*, the *Act respecting occupational health and safety*, and the *Act respecting industrial accidents and occupational diseases*.

The most relevant sections of the legislation cited here, as well as the names of certain forms physicians must complete in discharging their obligations, are listed in the Appendix B.

4.1 *Civil Code of Québec*

Article 10 of the *Civil Code of Québec* establishes the right to personal integrity and inviolability. The growing importance given to personal rights over the last 30 years is in keeping with the movement to defend individual rights. Many factors have favored this evolution, among them, the spectacular advances in biotechnology and the rejection of medical paternalism.

Surgical procedures, medical procedures, experiments and confinement in an institution all violate the integrity of the person. When they are necessary for the person's well-being, the legislator controls these violations and subjects them to strict conditions. Justified violations are permitted if the person consents to them or if the law provides for them.

One complete section of the *Civil Code*, that is, Articles 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, sample-taking, treatment or procedure of a medical, psychological or social nature, required or not required for the physical or mental health of the person.

The consent to care must not only be obtained, but it must be voluntary and informed, meaning that the person gives it without undue coercion or pressure after having received sufficient information. The person consents on his or her own behalf. Exceptionally, a third party may authorize a violation of the integrity of a person under his or her charge or protection. This is called a substituted consent to care, notably for a minor under the age of 14, a minor 14 years or older according to the nature of the care and the circumstances, or an incapable person of full age. Note that a legally incapable person's right to give consent or to refuse it is not necessarily ruled out. In fact, the incapacity may often be limited to the administration of property. In other cases, the incapable person may understand the scope of the care and its effects and give consent voluntarily or refuse care. In emergency situations, consent to care is not required when a person's life is in danger or his integrity so threatened that a consent cannot be obtained in due time.

Consent is usually expressed verbally. Article 24 of the *Code* requires a written consent when 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, a revocation may always be made verbally.

Confinement in an institution and mandatory psychiatric examination are exceptional care measures. They deprive the person of physical freedom and impose an examination that violates his or her right to personal integrity and inviolability. The legislator thus deemed it pertinent to dedicate one entire section to it. Articles 26 to 31 of the *Code* rigorously define these procedures and establish the ordinary rules on this matter, which is also dealt with in other laws, such as the *Act respecting the protection of persons whose mental state presents a danger to themselves or to others*.

"No person may be confined in a health or social services establishment with a view to his undergoing a psychiatric examination or in consequence of a psychiatric examination report without his consent or without authorization by law or the court." (Art. 26). Dangerousness is the standard used in the legislation for this type of protective supervision. A number of factors are analyzed in assessing the danger a person presents. The law therefore requires that a psychiatric expert assessment be used 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.

4.2 *An Act respecting the protection of persons whose mental state presents a danger to themselves or to others*

The protective measures cited in [this Act](#) complement the more general provisions of the *Civil Code*.

Section 7 of the Act reiterates the concept defined in the *Civil Code* with respect to preventive confinement when the danger is serious and immediate. 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 the confinement extended so that the person may undergo further psychiatric examination. The Act also stipulates that a law enforcement officer may be called upon to bring the patient, against his or her will, to the establishment (sec. 8).

When the court has set a duration of confinement exceeding 21 days, the person under confinement must be examined periodically to ascertain whether continued confinement is necessary.

4.3 **Youth Protection Act**

Under the terms of the *Youth Protection Act*, all professionals, including physicians, must notify the director of youth protection if, in practicing their profession, they have reasonable grounds to believe that the security and development of a child is or may be in danger. Professional secrecy is not an impediment to discharging this obligation (sec. 39).

Section 38 lists the situations in which the security and development of a child are considered to be endangered; these include abandonment, neglect, psychological mistreatment, physical or sexual abuse, and serious behavior problems. Physicians who do not comply with this obligation expose themselves to penalties (sec. 134).

The *Code of Ethics of Physicians of Québec* is clear in this regard. It states that physicians may divulge confidential information when the law authorizes it (sec. 20). It specifies that physicians must report to the director of youth protection all situations in which there are reasonable grounds to believe that the safety and development of a child is or may be in danger and must furnish all the information they deem pertinent to the protection of that child (sec. 39).

4.4 **Public Health Act**

The purpose of this law is to protect the health of the public and to establish conditions conducive to maintaining and improving the health and well-being of the population at large. The intent of certain 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 included in the list of diseases that must be reported (MADO). Also, a physician who suspects the presence of a threat to the health of the population, other than MADO, must notify the public health director in the region. One should emphasize that this reporting is mandatory, and physicians who neglect to do so commit an offence and are liable to a fine.

The reporting methods and MADO list are regularly updated. Certain illnesses such as scarlet fever have been left off the list, whereas others have been added, notably infections caused by the West Nile virus (WNV), severe acute respiratory syndrome (SARS), and outbreaks of methicillin-resistant staphylococcus aureus (MRSA) and vancomycin-resistant enterococcus (VRE). Only tuberculosis remains a disease requiring mandatory treatment. And there is only one reporting form, the AS-770, which was also changed (A sample form is available in the Appendix.). In addition to the usual information, one must now write the medical insurance number, the name of the laboratory to which the sample was sent, and the date of the sample-taking, if applicable, and for blood-borne diseases, information on the giving or receiving of blood, blood products, tissues or organs. This form is also used for nominal reporting of sexually transmitted infections. However, to promote detection of sexually transmitted and blood-borne diseases, there are integrated services providing screening on an anonymous basis to vulnerable populations.

Physicians must forward their reports to the public health division in their territory in the 48 hours following the consultation. In cases of high alert diseases, these 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.

In Québec, AIDS and human immunodeficiency virus (HIV) are diseases that must be reported only when they involve the giving or receiving of blood, blood products,

tissues or organs. In these cases, physicians must complete an AS-770 form. However, the collection of epidemiological information for monitoring purposes is mandatory for all positive anti-HIV tests. A worker in the public health division collects the information by telephone from the physician who prescribed the screening test. To promote screening in vulnerable populations, there are integrated services providing screening for sexually transmitted and blood-borne infections on an anonymous basis. The physician who has made a diagnosis of an illness indicative of AIDS, must complete the SP-100 form used for collecting epidemiological information, a sample copy of which is found in the Appendix.

4.5 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) the state of health of a patient he or she deems unfit to drive a road vehicle. In this situation, it is advisable that the physician speaks to the patient and give an opinion on his or her state of health and the risk it represents when driving. But if the physician has reason to believe that the patient will not obey the interdiction to drive and presents a serious risk to public safety when driving a vehicle, he or she may inform the SAAQ of such.

Note that this type of reporting constitutes a legally authorized departure from the rules for professional secrecy; as a result, the physician need not obtain the patient's permission. What is more, the law protects against legal action for damages for having reported the situation.

The *Regulation respecting medical and optometrical standards for driving a road vehicle and respecting conditions attached to a license* establishes the medical and optometrical standards used in Québec to determine a driver's fitness to drive and the restrictions necessary given the driver's state of health. When there is doubt about a patient's ability to drive a road vehicle, the physician may recommend that the patient undergo a thorough assessment of his or her ability.

The SAAQ publishes a Guide to Drivers' Medical and Optometric Assessment in Québec, which may be downloaded (PDF format) from its website. The Collège has also produced a guide in this regard, entitled [*L'Évaluation médicale de l'aptitude à conduire un véhicule automobile: guide d'exercice*](#). (March 2007).

4.6 An Act respecting the determination of the causes and circumstances of death

This Act stipulates that a physician, who certifies a death for which he or she is unable to establish the probable causes or which appears to have occurred in obscure or violent circumstances, must immediately notify a coroner or peace officer. It also establishes that the coroner must be notified of deaths that occurred in a nursing home, rehabilitation centre, sheltered workshop, detention centre, penitentiary, security unit within the meaning of the *Youth Protection Act*, or police station.

The same applies to the death of a person placed in confinement in a health institution, a child in the custody of the holder of a permit from the ministère de la Famille et de l'Enfance, and a person in a foster home or taken in charge by a family-type resource. In all cases, the Act stipulates that the director of the place contemplated or the person in authority there must notify the coroner. The physician should nonetheless remain vigilant and make certain that these cases of death are reported to the coroner.

4.7 Automobile Insurance Act
An Act respecting occupational health and safety
An Act respecting industrial accidents and occupational diseases

The purpose of these laws is, notably, to give rights and recourse to persons who are victims of injuries of a physical or psychological nature caused by an automobile 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 automobile accident must, within the prescribed time period and in keeping with the patient’s condition, produce the required reports and certificates. These reports from the attending physician are necessary, for they enable patients to assert their rights and to obtain compensation as a result.

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 employment disease or injury, work accident or automobile accident and then collect all the information necessary to complete the forms to be sent to administrative agencies responsible for the application of these laws.

5 Conclusion

Québec has inherited a complex legal system. On the one hand, the constitutional laws have established the areas of competence of the federal and provincial governments. As a result, the practice of medicine in Québec is subject to federal legislation, notably the Criminal Code, and to the various Québec laws, among them, the *Professional Code*, the *Medical Act* and the *Civil Code*. On the other hand, while public law in Québec is British in tradition, private law comes from French law, with a British influence. Civil liability comes under the provisions of the *Civil Code of Québec*, whereas the other provinces apply common law in cases of civil liability. Still, we have to admit that in both instances the decisions reached are often the same. Finally, Québec 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 enacted several other laws that have a more or less direct effect on the practice of medicine.

Finding one's way through this juridical and legislative maze is not an easy process for physicians. Indeed, one same medical act can bring into play the application of,

- a provision of the charter that protects, for example, the integrity of the person, the violation of which may result in a conviction with damages, and when the fundamental rights violation is "illicit and intentional" a conviction with exemplary damages;
- the *Criminal Code*, which prohibits "active" euthanasia in particular and provides for penalties intended to reflect societal disapproval and to ensure the protection of the public;
- 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 first purpose of which is to protect the public;
- a penalty in the form of a fine imposed by the tribunal, if, in the practice of his or her art, the physician disregarded a provision of a particular law or regulation.

While they are different, these mechanisms are part of the body of legislative measures ensuring the population of quality care. While civil liability is primarily intended to compensate patients who have sustained an injury, it is also linked to professional obligations and medical ethics in the same way as medical ethics is linked to laws that have an impact on the practice of medicine.

To the extent that these laws and regulations are also perceived as beacons, whose purpose is not to hinder but to guide, they should in practice facilitate decision-making for physicians and patients alike. And these decisions should take into account social choices, the professional obligations of physicians, the rights and expectations of patients as well as the interests and convictions of each and everyone.

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PART II

CLINICAL INTEGRATION OF LEGAL, ETHICAL AND ORGANIZATIONAL ASPECTS

THEMATIC APPROACH

INTRODUCTION

Medical practice requires that physicians know how to apply their scientific knowledge in a manner that meets the health needs of their patients, while respecting the ethical rules of the profession and legal framework in effect in their field of activity.

To illustrate how legal, ethical and organizational aspects can be incorporated into medical practice, Part II considers four themes, accompanied by clinical examples. These are:

- Consent
- Professional secrecy
- End-of-life issues
- Personal convictions.

In our society, there is broad consensus on the subject of consent and professional secrecy, and this is expressed through legal and ethical guidelines that are quite clear. However, their application in particular cases calls for discernment and vigilance on the physician's part.

On the other hand, issues emerging from end-of-life situations can be particularly difficult, for they oblige the physician to test his or her convictions against those of the patient, as well as reconcile them with professional obligations and legal constraints.

As for conscientious objection, it represents the extreme situation where personal convictions are irreconcilable. In this case, the moral challenge is to come to an arrangement that respects all parties involved.

Thus, the objective in Part II is to illustrate, by way of specific clinical situations, how moral, ethical and legal principles can be applied and integrated into medical practice.

The examples presented merely serve to explain, and the analyses given may not be applicable to other cases. Specific cases always require in-depth personal reflection. In some situations, it may be necessary to consult legal texts, to seek legal advice, to solicit the opinion of the Collège des médecins, or to submit the question to an ethics committee, where and if there is one. Many health care institutions in Québec have a clinical ethics committee (CEC), which must be distinguished from a research ethics committee (REC). These advisory and multidisciplinary committees play a role in promoting awareness of ethics in the context of the care and support of caregivers grappling with sensitive situations.

A CONSENT³⁴

Clinical Case

Ms. Lise T., forty-six years old, has been suffering from abdominal pain for three days. When she is brought to you, she is in septic shock and her abdomen is distended. Blood volume treatment and antibiotic therapy are begun, and an emergency laparotomy is contemplated. You must explain the situation to the patient and ask for her consent.

What do you do?

1 What is Free and Informed Consent?

Consent is “an explicit or tacit manifestation of will by which a person approves an act to be undertaken by another”¹. In recognizing the patient’s right to consent, we necessarily and implicitly recognize the patient’s right to refuse.

The need for consent is clearly spelled out in Article 11 of the *Civil Code of Québec*:

“No person 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.

If the person concerned is incapable of giving or refusing his consent to care, a person authorized by law or by mandate given in anticipation of his incapacity may do so in his place.”

The patient’s right to consent and the health professional’s consequent obligation to obtain this consent before undertaking any investigation or treatment is in keeping with the right to inviolability of the person protected by the Canadian and Québec charters of rights and freedoms and the *Civil Code of Québec*. Without the consent of the person, or his legal representative, a professional may not treat or undertake an investigation of that person, except in situations that are exceptional. This concern is also reflected in the *Code of Ethics of Physicians of Québec* (ss. 28-31) and in the *Act respecting health services and social services* (sec. 9).

To be valid, the **consent** to investigation and/or treatment, as well as the refusal, must be **free (voluntary) and informed**.

For a **consent** to be **free (voluntary)**, it must be obtained without pressure, threat, duress or promise of any kind on the part of the physician, the family or significant others. It must also be obtained without threat of reprisal, for example, without threatening to suspend support or assistance should the patient not consent to the proposed treatment or investigation. To give such a consent, the person or his legal representative must be **capable of giving consent** and be in full possession of his faculties; consequently, the person’s mental faculties must not be weakened by, among other things, alcohol, sedatives or any other drug.

The **consent** must also be **informed**. Legal texts make the distinction between “free” and “informed”, even if, in everyday language, the two notions are inseparable. One cannot be considered “free” to decide without being adequately informed. Freedom to decide, therefore, goes hand in hand with being informed.

³⁴ COLLÈGE DES MÉDECINS DU QUÉBEC, « [Le consentement aux soins, une question de respect et d’humanité](#). » *Le Collège*, Vol. XLVI, No. 3, Autumn 2006.

Before obtaining the patient's free and informed consent, the following information must be given to the patient:

- the diagnosis;
- the nature of the treatment;
- the procedures to be performed;
- the benefits and risks associated with the procedures;
- the consequences of refusal or not intervening;
- other treatment options.

While the **benefits** sought after by the patient and the physician may be mentioned first and be given special attention with the view to obtaining consent, they are not the only items of information required.

Indeed, the **risks** must also be disclosed and must take into account the patient's particular situation. Serious and infrequent risks (for example, paralysis) must be disclosed, but only in terms related to the patient's precise situation. Frequent risks must also be mentioned, even those considered minor, inasmuch as they may have a particular impact on the patient. For example, a surgical procedure on a finger will not have the same impact on a security guard as it will on a professional pianist. Presenting the benefits and risks of the procedure will allow the patient to judge the situation, based upon the most accurate information, and make the best possible decision in the circumstances.

Other treatment options are also part of the information given to the patient. The physician must therefore present all options to the patient, including what would happen if the patient refused the investigation or treatment.

But it is not enough to explain all the possible benefits and risks. The physician must also ensure that the patient has understood what was said and grasped the extent of its impact on his life. For this reason, the physician must present the information in terms that are simple and comprehensible to the patient. The patient in turn must be given an opportunity to ask questions and to obtain satisfactory answers before giving his consent.

The physician's obligation to inform the patient is therefore not uniform; indeed, it varies with the circumstances. The extent of the obligation changes notably according to the care, defined in three broad categories: **emergency care, medically required care and care not medically required**. When a patient's life is threatened if treatment is not given immediately, and consent cannot be obtained in due time, the physician is relieved of this obligation. As for medically required care, the extent of the obligation increases with the prevalence and gravity of the complications; on the other hand, care not medically required entails a much greater obligation (Civil Code, Art. 13-25).

The *Civil Code of Québec* in fact requires that written consent be obtained for care not medically required, experimentation, and organ donation (Art. 24). Care not medically required includes cosmetic surgical and medical treatments, among others. In this field, it is essential that the physician present to the patient not only the probable risks of the treatment, but also the possible risks, even if they are rare³⁵. The *Civil Code of Québec* goes as far as to prohibit all experimentation involving a serious risk to minor or incapable patients (Art. 21). The Organization and Management of Establishments Regulation (ROAE) provides for a written consent to the anesthesia and the surgery

³⁵ COLLÈGE DES MÉDECINS DU QUÉBEC, « L'information médicale avant la prise de décision. » *Le Collège*, Vol. XL, No. 1, May-June 2000.

(ROAE, sec. 52.1). It also stipulates that the user's record must contain a document attesting that consent was obtained for the care and services provided, as well as for the taking of photographs, the making of films or other documents, if applicable (ss. 53-57).

Generally, a **written consent** is considered necessary for the following procedures:

- anesthesia;
- surgical procedure;
- care given in an institution;
- the taking of photos, the making of films or video documents;
- organ donation;
- experimentation;
- non-therapeutic care.

But let us be clear: a free and informed consent is much more than a simple signature on an authorization form. And while it is often required, the signed form does not necessarily mean that consent has been freely given after having received all of the relevant information.

In practice, the consent may be implicit or explicit. In both cases, the decision to accept or refuse the proposed care is up to the patient. Furthermore, the physician must be able to demonstrate that the patient has been adequately informed, by entering the appropriate note in the patient's medical record. This note must reflect the exact nature of the information given, the questions asked by the patient and the discussion on the other treatment options. In case of litigation, a well-kept medical record is the best means of clarifying the facts.

But how long is the consent, even the written one, valid? There are no provisions in the *Civil Code of Québec* or in the *Act respecting health services and social services* (LSSSS) with respect to the duration of the validity of the consent. This explains the validity, albeit limited, of "living wills." It is reasonable to believe that the consent to a procedure of short duration is valid for the entire duration of the procedure. However, for long-term treatments (chemotherapy, radiation therapy, use of immunization schedule), it is reasonable to believe that the consent given at the start of treatment may be withdrawn, even verbally, at any time. Consent is an evolving process. Therefore, a patient may always change his decision, based on new information or new developments.

Consent to care given in training facilities or in a research context requires special attention. Patients must be informed if medical residents are part of the treatment team. And the consent to treatment given as part of a research protocol must meet very specific requirements³⁶.

³⁶ COLLÈGE DES MÉDECINS DU QUÉBEC, [Le médecin et la recherche clinique : guide d'exercice](#), Montreal, Collège des médecins du Québec, July 2007.

Clinical Case

Ms. Lise T. refuses the proposed procedure. Yet the procedure is urgently required. You check whether Ms. T. knows the consequences of her refusal. Ms. T. clearly states that she would prefer to die rather than have surgery. Checking with her spouse reveals that the decision dates back to a period before her illness. Furthermore, you do not perceive any particular coercion or outside influence compelling her to refuse.

What do you do?

2 Capacity to Give Consent

For the consent or refusal to be valid, the patient must be fit to give her consent. Québec law does not define the criteria for concluding the aptitude of a person to consent to medical care; it is therefore left to the physician to determine the person's inaptitude. The five following questions may help the physician determine the patient's aptitude to give consent:

- Does the person understand the condition for which the treatment is proposed?
- Does the person understand the nature and the purpose of the treatment?
- Does the person understand the risks involved in undergoing the treatment?
- Does the person understand the injury he or she may incur in refusing the treatment?
- Is the person's ability to consent affected by her illness?

The physician must not neglect to assess a patient's capacity to give consent simply because the latter consents to the proposed care. Medical interventions intruding upon the patient's life have a particular meaning for her, and the physician must try and understand this. Knowing the patient's history, the usual choices made and their meaning, as well as her values, will help the physician reasonably assess the validity and coherence of the consent—or refusal of these interventions. Sometimes, however, the help of a psychiatrist may be needed.

Assessing a patient's aptitude to give consent, calls for discernment on the physician's part. Physicians who practice in long-term care centers have developed an expertise in this regard that deserves to be better known³⁷.

3 Substituted Consent

If a person of full age is judged incapable of giving consent, even temporarily, a third party must be called upon to give consent in his place. This is called **substituted consent**. In Québec's legislative framework, the rules concerning substituted consent vary with the care required and not with the state of health of the incapable person.

If the care is not required, (care provided in the context of research, organ donation), consent may only be given by a legal representative, tutor or curator of the person recognized as incapable, or by a duly identified mandatary; this is a person to whom the patient, before becoming incapable of giving consent, entrusted the right to make

³⁷ COLLÈGE DES MÉDECINS DU QUÉBEC, [La pratique médicale en soins de longue durée : guide d'exercice](#), Montreal, Collège des médecins du Québec, May 2007, p. 18-20.

decisions on his behalf, if and when the situation arose⁴. But this mandate is only valid when approved by the court. For a mandate to be approved by the court,

- the incapacity to consent must be diagnosed by a physician;
- there must be a similar opinion from another health professional, often a social worker.

On the basis of these two expertises combined, the court will certify the mandate. The authorization of the court is also necessary if the care presents a serious risk to health or could cause grave and permanent effects (Art. 18).

If the care is required, consent may be given by the legal representative or a close relative. In cases where there is no mandatory appointed beforehand by the patient, no tutor, or no curator, the spouse is approached first. If there is no spouse, a **close relative** (parent, child, brother or sister, etc.) **who is a significant other** to the patient may express his wishes to the best of his knowledge and speak on the patient's behalf. Usually the relative or significant other who has been involved in the care of the patient is the one designated.

Furthermore, the patient must be presumed capable of giving consent until there is evidence to the contrary. He cannot be considered incapable simply because his choice differs from that of the physician. In all cases, the physician must ensure that conditions are favorable to giving consent, and

- avoid family discord at the incapable patient's bedside;
- avoid any coercion of the patient, who is vulnerable owing to his disease;
- prevent the patient's vulnerability from becoming a real obstacle to free and informed decision-making, particularly for fear of abandonment or reprisal;
- see to it that the consent is the outcome of a dialogue between the patient (or his close relatives or legal representative in case of incapacity) and the physician on the meaning of the procedure, and that it leads to a consensus, if possible.

Thus, in addition to the requirements for a **free and informed consent** already mentioned, the substituted consent must be given in the **best interests of the person replaced**. Article 12 of the *Civil Code of Québec* stipulates that the substituted consent must meet the following requirements:

- respect the best interests of the person, taking into account, as far as possible, any wishes the latter may have expressed;
- ensure that the care is beneficial notwithstanding the gravity and permanence of certain of its effects;
- ensure that it is advisable in the circumstances;
- ensure that the risks incurred are not disproportionate to the anticipated benefit.

A substituted consent does not exempt the physician from taking into account the **refusal** of the person incapable of giving consent. In the case of an incapable person of full age, for example, Article 16 of the *Civil Code of Québec* stipulates certain situations in which only the court may legally authorize care, thus ensuring a prudent second look. When the incapable patient **categorically refuses**, despite the consent of the third party, when the third party is prevented from consenting or opposes a refusal that seems unjustified or when the care is not medically required and presents serious risks (Art. 18), the physician must ask the court for the authority to proceed. However, in cases of emergency or hygienic care, immediacy takes precedence.

4 Who May Give Consent?

According to the *Civil Code of Québec*, the following persons may give consent to care:

- the capable person of full age;
- the minor 14 years of age or over may consent alone to care, whether the care is required by his state of health or not. However, parental authority is necessary for care which, while not required by his state of health, entails serious risks and may cause him serious and permanent effects (Art. 14 and 17). Certain measures also provide for the minor 14 years of age or over having to submit to the care required for his state of health and which he refuses (Art. 16);
- the person having parental authority, in the case of a minor under 14 years of age (Art. 14). Even if the law specifies that the father and mother together exercise parental authority (Art. 600), the consent of both parents is not necessary, since each has parental authority and “where the father or the mother performs alone any act of authority concerning their child, he or she is, with regard to third persons in good faith, presumed to be acting with the consent of the other parent.” (Art. 603). In a case where the professional is informed that the parents have differing opinions, it is up to the court to decide (Art. 604). Finally, if the child is accompanied by a person other than one of his parents, the latter’s authority to give a valid consent must be verified.
- the mandatary of an incapable person of full age and designated by the latter when he was capable, or the latter’s tutor or curator, if the care is not required.

If there is no mandatary, no tutor or no curator, and the care is required, “consent is given by the legally married or common-law spouse, or if there is no spouse or if his spouse is prevented from giving consent, it is given by a close relative or a person who shows a special interest in the person of full age.” (Art. 15).

Upon verification, you conclude that Ms. Lise T. understands the nature of her illness and the nature of the proposed surgical treatment goal; furthermore, she knows that surgery is her only chance of survival and that her refusal of the surgery will quickly lead to an inexorable prognosis. Her categorical refusal of the surgery is long-standing, dating back to well before the illness began. The psychiatric consultation you urgently requested concludes that Ms. T. shows no sign of incapacity to consent.

In the hours that follow, the patient’s health deteriorates. At one point, her state of consciousness wavers and, for an instant, she allegedly gives a sign that could be interpreted as consent to surgery. When the psychiatric consultant returns to reassess Ms. T., she, albeit weak, reiterates her refusal of the surgery.

Ms. Lise T. dies in the evening on the day of her admission.

4.1 **Minors 14 years of age or over**

Clinical Case

Jeremy, a 16-year-old adolescent, comes to the emergency room with acute abdominal pain. The examination reveals an acute appendicitis. Jeremy is alone.

What do you do?

In Québec, a minor 14 years or over may **consent** alone to care, unless it is care not required by his state of health and entails major risks. Thus, at age 16, Jeremy may consent to his appendectomy. The physician may then proceed as he would for an adult, evaluating his ability to give consent. The five questions suggested previously to evaluate the capacity to give consent are therefore relevant in his case.

But if Jeremy refuses the care required by his state of health, court authorization becomes necessary in order to take action, except in an emergency situation. When the life (or integrity of a limb) of a minor 14 years of age or over is threatened, the consent of the person having parental authority is sufficient in order to act, even if the minor explicitly refuses (Art. 16).

When a minor 14 years of age or over consents to the **care required by his state of health** and must be kept in an institution for over 12 hours for this care, the physician must **nonetheless notify** the parents that he is in hospital. In this case, it is not a question of obtaining their consent to the care of their child. Nor is it a question of giving the reasons for admission, unless the child 14 years of age or over relieves the physician of his or her obligation to confidentiality.

The law stipulates, therefore, that the minor 14 years of age or over may consent to the care required by his state of health, but he may not necessarily refuse it.

But why this distinction between consent and refusal for minors 14 years of age or over? It stems from legislators wanting to give adolescents access to screening and treatment for sexually transmitted diseases (STD). This measure also allows adolescents to have access to contraceptive measures without needing parental authorization. The law also permits access to induced abortion (IA). As this procedure does not usually require a hospital stay of more than 12 hours, the parents need not be informed of it.

Application of this law is not confined to circumstances of contraception and reproduction. Thus, patients in this age category may consent alone to all care, required or not. However, if the care not required entails major risks, the law insists upon the need to obtain parental authorization. If, however, the minor 14 years of age or over refuses the care required by his state of health, the authorization of the court is then needed to give the care nonetheless, unless it is an emergency situation, in which case parental authorization will suffice.

4.2 Minors under 14 years of age

Clinical Case

Audrey, who is only eight years old, is alone in the emergency room, and you cannot reach her parents. She also presents with a clinical profile of acute appendicitis.

What do you do?

If it is an emergency, that is, if the life or integrity of a limb of the minor is threatened, the emergency justifies intervention, regardless of the minor's age. On the other hand, if the child is a minor under 14 whose condition is not really urgent, one must wait for the consent of the person having parental authority.

If the person having parental authority refuses and the physician judges the refusal to be unjustified, he or she may ask the court to intervene and override the unjustified refusal.

Even if children under 14 are not legally recognized as capable of giving consent, they are still human persons and have the right to be informed about what awaits them. Certain decisions may indeed greatly affect their quality of life. One should always seek the best interests of the patient, even if they do not coincide with the interests expressed by the person having parental authority. Certain studies have demonstrated that parents are not without bias when assessing the impact of treatment on the quality of life of their child. Physicians must keep an eye out for factors influencing the decisions of those in parental authority. They must be discerning and remain vigilant.

5 Exceptions to Obtaining Consent

In practicing their profession, physicians may encounter situations that constitute exceptions to obtaining consent. Among these are:

- emergency treatment;
- confinement in an institution;
- diseases for which treatment is mandatory (MATO);
- blood alcohol tests (under certain conditions).

5.1 *Emergency Treatment*

An emergency is defined as a situation in which the life (or integrity of a limb) of a person is in **immediate danger**. It is a condition where obtaining consent is excepted and not simply foregone. Indeed, whenever the patient's consent is possible, even in an emergency, it is required. On the other hand, if there is an emergency, and the consent cannot be obtained in due time, the physician must act in the best interests of the patient.

Furthermore, the *Civil Code of Québec* stipulates in Article 13 that, even in an emergency, consent must be obtained (from the person or his representative) "where the care is unusual or has become useless or where its consequences could be intolerable for the person." This explains the necessity of obtaining a specific consent in the context of a research protocol, even if the investigation methods are used to treat an emergency. As legislators have not identified these terms, it is up to the physician to use his or her good judgment.

For a physician to declare that the state of emergency was such that consent (direct or substituted) could not be obtained in due time, he or she must demonstrate the **immediacy** of the threat to the patient's life or health. Note that it cannot be a question of convenience; the necessity to proceed **at the precise point in time the professional act was performed** must leave no room for doubt.

Furthermore, in an emergency situation, only the treatments immediately required by the emergency may be carried out. As soon as the patient can once again make decisions that concern him, the physician must obtain from him a free and informed consent before continuing or changing the treatment. It is up to the physician to record as soon as possible the circumstances that forced him or her to act without a valid consent. In other words, it is up to the physician to define the emergency.

5.2 **Confinement in an Institution**

Clinical Case

Mr. Louis P., forty years old, is brought in by the police because he broke everything in his apartment. He is very aggressive, suffers from paranoid schizophrenia and stopped taking his medication a few weeks ago. He claims he is Jesus and categorically refuses to remain in hospital. He does not understand why the police brought him in, and he threatens to hit you.

What do you do?

The *Act respecting the protection of persons whose mental state presents a danger to themselves or to others* (R.S.Q. c. P. 38.001) complements the provisions of the *Civil Code of Québec* (Articles 26 and 27). All of these legal provisions are intended to protect persons, notably by allowing confinement in an institution against their will, while respecting their rights as much as possible. To this effect, the legislation provides for three types of confinement: preventive confinement, temporary confinement and authorized confinement.

Preventive confinement may be ordered by a physician practicing in an institution, despite a lack of consent from the person concerned, without a court order and without any psychiatric examination, if the physician judges that the person presents **a grave and immediate danger** to himself or to others.

This preventive confinement may last no longer than 72 hours, unless the court orders that the confinement be extended so that the person concerned may undergo psychiatric assessment. However, if this period ends on a Saturday or on a non-judicial day so that no judge having jurisdiction in the matter is able to act, and if termination of confinement presents a danger, the confinement may be extended until expiry of the next judicial day.

Temporary confinement is a confinement ordered by the court so as to submit the person to a psychiatric assessment. This temporary confinement should not normally exceed seven days, taking into account the time required to perform a psychiatric assessment and submit a report to the court.

Authorized confinement is ordered by the court, if two psychiatric assessment reports conclude that it is necessary. The duration of the confinement is also fixed by the court. In a case where the confinement is longer than 21 days, a report must be submitted to the court 21 days after the court order authorizing the confinement, and every three months thereafter.

Mr. Louis P. is dangerous, at least to you, because he is threatening you; he may be a danger to himself as well. You may admit Mr. Louis P. to preventive confinement. For immediate emergency reasons, you are also authorized to administer medication to him. However, once the agitation is controlled by the emergency treatment and the immediate danger eliminated, the patient may not be kept and treated against his will.

Box II-1.1

**An Act respecting persons whose mental state presents
a danger to themselves or to others**

PERSON WHOSE MENTAL STATE
PRESENTS AN IMMEDIATE DANGER
TO HIMSELF OR TO OTHERS



ADMISSION TO PREVENTIVE
CONFINEMENT IN AN INSTITUTION
for a period not usually exceeding
72 hours

REQUEST TO THE COURT FOR TEMPORARY
CONFINEMENT FOR PSYCHIATRIC
EXAMINATION IN CASE PATIENT REFUSES



TWO PSYCHIATRIC EXAMINATIONS
The first within 24 hours
The second within 48 hours of the first



Submission to the court of
two psychiatric examination reports



Judgment ordering confinement



COURT ORDER AUTHORIZING
CONFINEMENT IN AN INSTITUTION

Note: There is an obligation to inform the patient of his right to contest the confinement in an institution.

5.3 Diseases that Must be Treated

Clinical Case

You make a diagnosis of pulmonary tuberculosis in a 40-year-old male patient from South America. The patient fears the side effects of the treatment and refuses it.

What do you do?

The *Public Health Act* (R.S.Q., c. S-2.2) deals with the organization of public health, national and regional programs in public health, the responsibilities of the Minister and directors of public health in matters of promotion, prevention and protection of public health, as well as the obligations and powers to investigate and intervene which are entrusted to them.

Diseases requiring compulsory treatment (ss. 83-88) and prophylactic measures (ss. 89-91) are dealt with in Chapter IX of the *Act*. It stipulates that the “Minister may, by regulation, draw up a list of the contagious diseases and infections for which any person affected is obligated to submit to the medical treatments required to prevent contagion.” (sec. 83). Pursuant to this list, any physician who observes that a person is likely suffering from an infection included on the list must take the required measures to ensure that the patient receives the care required by his condition. If the person refuses or neglects to be treated, the physician must notify as soon as possible the appropriate public health authority in the territory (ss. 84-86). The latter must then make an inquiry. If the person refuses to be examined or treated, “he may apply to the Court for an order enjoining the person to submit to such examination or treatment.” (ss. 87-88).

The Minister’s Regulation under the *Public Health Act* specifies the list of diseases that must be reported (maladies à déclaration obligatoire—MADO) (Chapter I) and the diseases for which treatment is mandatory (maladies à traitement obligatoire—MATO) (Chapter II). At present, tuberculosis is the only disease for which treatment is mandatory. The *Public Health Protection Act*, repealed in 2002, considered gonorrhea and syphilis as diseases for which treatment was mandatory, but this is no longer the case. On the other hand, it is now possible to make treatment obligatory for any disease, simply by adding it to the list of diseases for which treatment is mandatory.

In fact, the new provisions give more powers to the director of public health. First, they give him investigative powers (sec. 100), allowing him to obtain information or even clinical samples, as needed, by court order; they then give him the power to intervene (sec. 106) if he judges that the health of the population is threatened. The director of public health may notably order a person to be placed in isolation for a maximum of 72 hours or “order any other measure he considers necessary to prevent a threat to the health of the population from worsening or to decrease the effects of or eliminate such a threat.”

These sweeping powers partly explain why the list of diseases for which treatment is mandatory is so short. However, they give the public health director more flexibility, allowing him to individualize and confine these exceptional interventions to situations that really require them.

5.4 Blood Alcohol Test (under certain conditions)

Clinical Case

Mr. James S., 52 years old, was the driver of an automobile involved in an accident in which several people were injured. The police bring him in and ask if he is fit to consent to blood alcohol testing.

What do you say?

The physician may not take intravenous blood samples for purposes of blood alcohol testing **without the consent** of the person, unless the police have a court order issued pursuant to section 256 of the *Criminal Code*. This court order is given when there are reasonable grounds to believe that the person drove with his faculties impaired by alcohol or by drugs and “was involved in an accident resulting in the death of another person or in bodily harm to himself or herself or to any other person.”

As for the physician, he or she must believe that “by reason of any physical or mental condition of the person that resulted from the consumption of alcohol or a drug, the accident or any other occurrence related to or resulting from the accident, the person is unable to consent to the taking of samples of his or her blood.” He must also be of the opinion that taking the blood sample does not present a risk to the life or health of that person.

When all of these conditions combined are met, the patient may not take legal action against a physician who took a blood sample, or against a person authorized to do so, inasmuch as the sample-taking was done according to professional standards. In practice, the physician must go as far as to verify that the patient understands that his refusal to undergo blood alcohol testing (requested by the police) could be used against him in the event of legal proceedings. For the patient can always refuse blood alcohol testing even if the police have obtained a court order enjoining him to undergo the test.

Conclusion

Systematic use of the following questionnaire may facilitate the process of obtaining a free and informed consent:

1. Is the person **fit to give his consent**?
2. Has the person **received all the information** relative to the proposed investigation and treatment (benefits, risks, other treatment options)?
 1. Has the person **understood** the information relative to the proposed investigation and treatment?
 2. Does the person have **questions to ask**?
 3. Did the person **receive satisfactory answers** to these questions?
 4. Does the person **now agree to undergo** the proposed investigation and treatment?

The principle of autonomy and the inviolability of the person, protected by the Canadian and Québec charters of human rights and freedoms, are at the heart of this process. Every medical act may be interpreted as an infringement on the integrity of the person and may not be performed without the person's consent, even if the act seeks the well-being of that person.

However, when an emergency puts a patient's life in danger, the integrity of the patient is threatened by the emergency itself; thus, the presumption of beneficence must prevail, compelling the physician to take action.

Sometimes the patient himself may become a threat. Suicide comes to mind as well as agitation and all the conditions where a patient puts himself and others in danger. In these situations, seeking the patient's consent no longer has the same pertinence. But even in these situations, the physician must act within strict guidelines aimed at minimal restraint of the patient while ensuring his safety and that of others. The use of restraints for agitated persons follows the same logic and must be a measure used exceptionally.

When the patient becomes a danger to others due to mental illness or the risk of contagion, the public must be protected. To deal with these situations, the legislative framework provides for precise mechanisms allowing one to bypass free and informed consent as well as professional secrecy, a topic that will be addressed in the next section.

Thus, the circumstances when the fundamental rights of a patient may be restricted are well defined. But how do these alter the ethical obligations of physicians? In such cases, physicians must give precedence to the security of others in the patient's environment; this precedence represents a choice expressed in legislation granting privileges and assigning obligations to designated persons. The medical profession is therefore party to a special social contract. Its roots go back to a time when people were looking for ways to control epidemics. In order to protect communities against the threat of contagion from plague and cholera, for example, persons or groups of persons were quarantined. These age-old methods to protect the public were also applied, albeit on another scale, against present-day infections such as acquired immunodeficiency syndrome (AIDS) and severe acute respiratory syndrome (SARS).

To summarize, consent, the conditions it calls for and the particulars for its substitution, have gradually imposed themselves on the physician-patient relationship, which has long been characterized as beneficent. In today's context, the exceptions to obtaining consent also impose themselves, since the physician-patient relationship does not operate in isolation, but within the spectrum of other social relationships.

B PROFESSIONAL SECRECY

See or hear what I may in [...] the practice of my profession, I will keep silent about what need never be divulged, seeing discretion as an obligation in this case.

– Hippocrates

I will respect the patient's right to confidentiality and not divulge information which I have learned during the practice of my profession, except upon the patient's request or when obliged by law.

– Oath of Office of Physicians

(excerpt)

Collège des médecins du Québec

1 What is Professional Secrecy?

Western medicine situates the historical origins of its professional secrecy in the Hippocratic Oath. Respect for private life, particularly in the context of the professional relationship, still has meaning in our day. The protection of confidential information is ensured by the Canadian and Québec charters; it is also confirmed in the *Civil Code of Québec*. Both the *Act respecting access to documents held by public bodies and the protection of personal information* and the *Act respecting health services and social services* contain several provisions to ensure the confidentiality of health information within health establishments, including CLSCs. As for private practices, they are subject to the provisions on the matter as stipulated in the *Act respecting the protection of personal information in the private sector*. Whatever the place of practice, the *Professional Code* and the *Code of Ethics of Physicians of Québec* apply. They place particular emphasis on professional secrecy, while providing for certain exceptions. Indeed, the physician must often reconcile respect for professional secrecy with other equally important concerns, notably the safety of others.

As for consent, the primary concern of professional secrecy is to safeguard the independence and private life of the person. Add to this the desire to maintain the patient's confidence in the medical profession. Here in Québec, observing professional secrecy is not an absolute. Thus, barring rare exceptions, patients may have access to their medical record. And while the information must first be disclosed to the patient, there are instances when a patient will ask the physician to transmit certain information concerning him to a third party. When there is a just and compelling reason concerning the health and safety of the patient or a third party, the physician may communicate certain items of information even without having obtained authorization from the patient. Indeed, in certain specific situations, the law provides for certain departures from professional secrecy, particularly for the purpose of protecting others.

2 Professional Secrecy's Regulatory Framework

Section 20 of the *Code of Ethics of Physicians* cites the physician's obligations with respect to professional secrecy.

"A physician, in order to maintain professional secrecy,

1° must keep confidential the information obtained in the practice of his profession;

- 2° must refrain from holding and participating in indiscreet conversations concerning a patient or the services rendered him or from revealing that a person has called upon his services;
- 3° must take reasonable means with respect to the persons with whom he works to maintain professional secrecy;
- 4° must not use information of a confidential nature to the prejudice of a patient;
- 5° may not divulge facts or confidences which have come to his personal attention, except when the patient or the law authorizes him to do so, or when there are compelling and just grounds related to the health or safety of the patient or of others;
- 6° may not reveal a serious or fatal prognosis to a patient's family if the patient forbids him from so doing."

In concrete terms, this means that:

- waiting rooms and examination rooms must provide a discreet, welcoming and calm atmosphere that preserves the private nature of conversations between physician and patient;
- the more sensitive the content of the conversation, the greater is the obligation to observe discretion;
- protecting conversations of a private nature between physician and patient is also a concern for the administrators of health institutions, who must create practice settings conducive to confidentiality. Physician-administrators, like all other physicians, are subject to the *Code of Ethics of Physicians of Québec*;
- the physician must avoid sources of distraction, for example, pagers or telephone calls during interviews, particularly when the situation requires attention and tact;
- persons who collaborate with the physician (office employees and professionals) must respect the letter and spirit of professional secrecy;
- the same reserve and discretion applies to the discussion of cases with colleagues or other professionals. In these circumstances, it is advisable to pay special attention to the place and manner in which the care of patients is discussed; this applies as well to teaching activities with students-in-training.

Finally, the obligations as regards professional secrecy also apply to the clinical research field. Even if the findings of all research projects must be disseminated, this must be done in a manner that preserves the anonymity of the subjects. Research ethics committees in institutions (including research centres in university hospital centres) must rigorously abide by these rules. Like medical clinicians, medical researchers must take the necessary measures to ensure that their collaborators respect professional secrecy³⁸. Indeed, professional ethics concern all physicians and all activity sectors.

3 The Medical Record

Clinical Case
Ms. Chantal P. wants to see her own medical record and that of her 12-year-old daughter.
What do you do?

³⁸ COLLÈGE DES MÉDECINS DU QUÉBEC, [Le médecin et la recherche clinique : guide d'exercice](#), Montreal, Collège des médecins du Québec, July 2007.

If one accepts the premise that a person's state of health is an integral part of her private life, then the medical record must be considered a confidential document. Section 19 of the *Act respecting health services and social services* (LSSSS) is clear in this regard:

"The record of a user is confidential and no person may have access to it except with the consent of the user or the person qualified to give consent on his behalf, on the order of a court or a coroner . . ."

The *Regulation respecting the keeping of records, physicians' rooms or offices and other effects* (sec. 11), adopted by the Collège des médecins du Québec pursuant to the *Professional Code* (R.S.Q., c. C-26, sec. 91) and the *Medical Act* also specifies that:

"The physician shall ensure the confidentiality of medical records and restrict access to authorized individuals only."

Indeed, this Regulation specifies, for all physicians, the conditions for creating, keeping, holding, maintaining, preserving, using, managing, administering, transferring or handing over medical records.

The rules on the writing and keeping of records vary, depending on whether the physician practices in a consulting room and a CLSC, or in a hospital centre. However, only information relevant to the purpose of the medical record must be part of it. On occasion, it may contain information concerning third parties. This is why certain rules have been established to maintain the confidentiality of the information.

3.1 **Access to the Medical Record**³⁹

Even if the medical record is a confidential document, according to all laws, the patient in Québec has the right to read the content of her file and obtain a copy of it. However, the physician must always make sure that the original is kept; indeed, the physician is the medical record's custodian. Pursuant to the provision in the *Professional Code* prescribing that all professionals respect this right (sec. 60.5) the *Code of Ethics of Physicians* (sec. 94) stipulates that,

"A physician must promptly, and within no more than 30 days of its receipt, respond to any request made by his patient to examine or obtain a copy of documents concerning him in any record established in his respect."

The rules on the age at which one may have access to one's medical record differ slightly from those concerning consent to treatment. Barring exceptions, it is therefore the person with parental authority, notably the father or mother, who has the right to access the medical record of a minor under 14 years of age. Persons 14 years of age or over may have independent access to their medical record. In an institution, the person with parental authority may also have access to the record of a minor 14 years of age or over, under certain conditions. In fact, the LSSSS stipulates that an institution must refuse this access if the patient herself does not consent to it and if the institution determines that the communication of the information in the record could cause harm to the patient's health, even if the harm is not serious (sec. 21). There is no specific provision in this regard concerning medical records held outside an institution. The office of the syndic at the Collège is of the opinion, however, that the person with parental authority, the parents or the tutor of a child 14 years of age or over, may not request

³⁹ COLLÈGE DES MÉDECINS DU QUÉBEC, [*L'accès aux renseignements personnels contenus dans le dossier médical constitué par le médecin exerçant en cabinet; guide d'exercice.*](#) Montreal, Collège des médecins du Québec, May 2007.

access to the record of the minor and obtain a copy of such record, unless the minor authorizes it. The minor may also restrict access to some of the items in the record or even refuse all access to it.

Ms. Chantal P. is therefore entitled to have access to her record, which does not include information about a third party. If such information were contained in the record, it would have to be removed before answering her request.

Ms. Chantal P., the person with parental authority, may also have access to the record of her minor daughter, who is under 14 years of age, provided there are no other restrictions.

What do you do?

3.2 Restrictions to the Patient's Right of Access to His or Her Medical Record

The only exceptions to this rule concern cases where the disclosure or information contained in the record is likely to cause serious harm to the patient or to others (*Professional Code*, sec. 60.5). In these cases, the physician must justify his or her refusal (*Code of Ethics*, sec. 96):

“A physician who refuses a patient access to information contained in a record established in his respect must, at the written request of the patient, inform him in writing of the reasons for his refusal and enter such reasons in the record.”

Both the *Act respecting health services and social services* and the *Act respecting the protection of personal information in the private sector* allow the authorities of an institution and a physician to refuse a patient access to her medical record, if they judge that the disclosure of the record's content, in whole or in part, would cause **harm** to her health. This exception is not “permanent” since the institution must determine the point in time at which the content of the record to which access has been refused may be transmitted to the patient, and the latter must be informed of such. It is also up to the physician to prove that the disclosure would cause serious harm to the patient's health.

Only serious harm to the patient may be invoked in refusing access to the patient's medical record. Most frequently, these are situations related to mental health. The physician must therefore judge which is more dangerous to the patient—the refusal or access to the record. In this context, the term “physician” may include more than one physician who may intervene at various times in one same care episode. The obligations set out in sections 94 and 96 of the *Code of Ethics* are not limited to one single attending physician. All physicians must respect the patient's right to read her records and only restrict that right in cases where harm could be done.

From this viewpoint, the provisions of the LSSSS limiting access to the record of a minor patient (sec. 21) are better understood. As mentioned earlier, the law specifies that the person having parental authority has the right of access to the record of her minor child. However, this access may be limited in two situations where there is a risk of harm:

1° when the minor child under 14 years of age is the subject of an intervention by the youth protection director (DYP) and it is determined that consultation of the child's record by a person with parental authority could cause harm to the child's health;

2° when a minor 14 years of age or over explicitly refuses to give her parents access to her record and it is determined that their having access to it could cause harm to the minor's health.

Certain restrictions have also been imposed to ensure the confidentiality of information which, while contained in the patient's record, concerns third parties or was obtained by third parties who would be identified when the record was consulted. The LSSSS formally prohibits the communication of information to a patient concerning him furnished by an identifiable third person, unless that third person has agreed in writing to the disclosure (sec. 18)⁹. The patient retains the right of access to her file, but only after this information has been removed. Section 88 of the *Act respecting access to documents held by public bodies and the protection of personal information* prescribes the same sort of restrictions for information concerning third parties. The *Act respecting the protection of personal information in the private sector* stipulates that information concerning third parties must remain confidential when it could prejudice these third parties (sec. 40).

We should point out that the medical expert who receives a request from a patient to have access to a medico-legal assessment report concerning him or her must forward the request to the person or agency that requested the medico-legal assessment. In case of refusal, the patient may go to the *Commission d'accès à l'information*.

4 Disclosing Information to Third Persons: the Patient's Family

Clinical Case

Mr. Paul G., 59 years old, who has just returned from a trip, is brought in by his brother and sister because of impaired cognitive function. The investigation leads to a diagnosis of AIDS and syphilis. The brother and sister ask for information and want to know what he has. Mr. Paul G. is a celibate priest and pastor of a parish. The patient expressly asks you to keep his illnesses a secret.

What do you do?

The obligation to professional secrecy is established in favor of the patient. The patient may therefore authorize the physician to reveal confidential information concerning him. In these cases, the physician must provide the information in his possession which is pertinent to the request.

The *Code of Ethics of Physicians* (sec. 20) outlines the framework for establishing, not only ways to preserve professional secrecy, but the conditions to be respected in communicating information protected by it:

“A physician, in order to maintain professional secrecy [...],

5° may not divulge facts or confidences which have come to his personal attention, **except when the patient** or the law **authorizes** him to do so, or when there are compelling and just grounds related to the health or safety of the patient or of others [...].”

Sections 97 and 98 of the *Code of Ethics* also specify that,

“A physician must provide a patient who requests it, or such a person designated by the latter, with all information allowing him to obtain a benefit to which he may be entitled.” (sec. 97)

“A physician must, at the patient's written request and within no more than 30 days of its receipt, hand over to the physician, employer, establishment, insurer or any other persons designated by the patient, pertinent information from the patient's medical record which is in his possession or safekeeping.” (sec. 98)

However, in everyday medical practice, the authorization to disclose information on diagnoses and treatments is not always clearly expressed. Often, persons who have helped the patient in the past, induced him to consult a physician, and who are likely to take care of the patient in the future, are progressively given information useful to the care and follow-up of the patient. For example, a patient may ask the physician to repeat to his daughter what has already been said to him. In this situation, there is an implicit and practical authorization to share information of a confidential nature with a third party. These “supportive” persons or “natural helpers” rub shoulders with the medical team at various times during the care episode. In these circumstances, the physician must, in the interests of the patient's well-being, consider himself or herself implicitly authorized to share information with loved ones and to enlist their cooperation in executing the treatment plan.

But the physician must be discerning and have a good understanding of the purpose of professional secrecy, which is to respect the integrity of the person, including his reputation. The physician must also respect the patient's autonomy, for it is the patient

who is most capable of judging the danger to his reputation vis-à-vis those who inquire about his condition. Each situation will present its own opportunity for physician and patient to assess the arguments for and against disclosure of the information to loved ones.

Professional support, spread out over several days, gave M. Paul G. time to examine the reasons why he was opposed to informing his relatives of his condition. Little by little, he came to understand that he greatly needed the help of his brother and sister to accept his prognosis. Touched by the physician's unfailing commitment to respect his confidentiality, he himself disclosed the nature of his illness to his loved ones.

5 Disclosing Information to Third Persons: Medical Certificates

Clinical Case

Ms. Louise L., a young lawyer, works in a prestigious law firm in Montreal. In less than 21 months, she has accumulated an impressive number of work hours, refusing holidays and vacations, so great is the pressure to win a permanent position. You quickly recognize that she is suffering from burnout. Since she fears being fired, Ms. Louise L. asks you to say nothing about the burnout diagnosis and gives you a form to complete so that the insurer will agree to pay salary compensation.

What do you do?

While the physician must respect professional secrecy, in the interests of the patient, the physician must also respect his or her own integrity, in keeping with sections 84 and 85 of the *Code of Ethics of Physicians*:

“A physician must refrain from entering, producing or using data that he knows to be erroneous in any document, particularly in any report, medical record, or research record.” (sec. 84).

“A physician must refrain from issuing to any person or for any reason whatsoever a false certificate or any information, either verbal or written, which he knows to be erroneous.” (sec. 85).

While the general principle that a patient’s state of health is an integral part of her private life still holds, a patient who requests a medical certificate attesting to her state of health implicitly consents to the disclosure of pertinent confidential information concerning her. She may not invoke her right to confidentiality so as to oblige the physician to conceal, for example, the reason for a work leave, or its duration, from those who employ her and with whom she has taken a job.

On the other hand, the employer who asks for a medical certificate (attesting to absence) must be able to demonstrate that the information is necessary to execute the work contract. More precisely, he must demonstrate that the legitimate interests of the enterprise take precedence over the rights granted to persons by the Quebec Charter of Human Rights and Freedoms, in cases of frequent absenteeism or for a long-term absence, for instance. But when the employer acts as insurer, he has a right to demand all the pertinent information he needs to determine whether or not to compensate his employee for her absence. In fact, if the employee’s work stoppage follows a work accident, the employer will receive a copy of the medical certificates related to the accident, in accordance with the laws and regulations governing the Commission de la santé et de la sécurité du travail (CSST).

A medical certificate must therefore attest to the state of health of the patient and contain pertinent information only. It must indicate the date on which the disability began and, if possible, the date on which it will end, as well as the nature of the disability. The diagnosis justifying the inability to work must be included, provided the disclosure of the information is authorized by the patient and is necessary for the employer’s execution of the work contract or pertinent to the insurer.

Whether the information is disclosed to family members or in the context of a medical certificate, one must keep in mind that “active listening” and dialogue will help the

physician and patient maintain a professional relationship that considers their respective points of view. The physician must avoid the “compliant certificate” pitfall. Rather, it is up to the patient to use the means at her disposal in this process. If necessary, the physician can testify as the attending physician (not as an expert).

You reassure Ms. Louise L. and clarify with her the request to the insurer. You agree to complete the form, but in a discreet, albeit frank, way. The patient accepts this option.

Thanks to your treatments, Ms. Louise L. recovers her health and gradually returns to work. The first weeks of reintegration go well, allowing Ms. Louise L. to quickly return to full-time work. She receives a favorable appraisal confirming that she has recovered all of her capacities. You think she has made a good recovery.

6 Exceptions to Professional Secrecy

While the general rules are intended to protect confidentiality and professional secrecy, the law provides for certain exceptions, notably when the health and security of the patient or of others is endangered. The *Code of Ethics of physicians* (sec. 20) in fact specifies that,

“A physician, in order to maintain professional secrecy, [...]

5° may not divulge facts or confidences which have come to his personal attention, **except when the patient or the law authorizes him to do so, or when there are compelling and just grounds related to the health or safety of the patient or of others.** [...]”

6.1 *Compelling and Just Grounds*

The different exceptions provided for in the *Code of Ethics of Physicians* as well as in other specific laws consider the responsibilities of the physician—not only toward his or her patient, but also toward those who have a relationship with the patient and whose health and safety may be in danger. In the *Code of Ethics*, the lawmakers did not deem it useful to further specify the notion of “compelling and just grounds related to the health and safety of the patient or of others,” thus entrusting the latter to the physician’s good judgment.

However, certain laws are more explicit; they authorize or even order the disclosure of certain items of information in situations where health and safety are at issue. For example, many legislative provisions have recently been amended in Québec so that certain essential items of information could be communicated to persons concerned or implicated in acts of this kind, when there is a risk of acts of violence, among them, suicide. As a result, the *Code of Ethics* was amended so as to specify the terms and conditions to be respected in similar cases:

“A physician who communicates information protected by professional secrecy must, for each communication, indicate in the patient’s record the following items:

- 1° the date and time of the communication;
- 2° the identity of the person exposed to danger or of the group of persons exposed to danger;
- 3° the identity of the person to whom the communication was made, specifying, according to the case, whether it was the person or persons exposed to danger, their representative or the persons likely to come to their assistance;
- 4° the act of violence he aimed to prevent;
- 5° the danger he had identified;
- 6° the imminence of the danger he had identified;
- 7° the information communicated.” (sec. 21)

6.2 *Youth Protection*

Clinical Case

Ms. Chantal P. wishes to see the record of her minor daughter. But you know that the record contains details concerning physical abuse committed by Ms. Chantal P.’s new spouse, and that the daughter has concealed everything from her mother.

What do you do?

The person having parental authority may be refused access to her child's record once the child is the subject of an intervention by the director of youth protection (DYP), yet the physician is obliged to disclose to the authorities concerned information leading him or her to think that the security or development of a minor is in danger. In fact, the law, in order to safeguard the inviolability of the vulnerable minor, obliges every citizen to alert the authorities. The *Youth Protection Act* stipulates that the obligation applies to physicians regardless of their obligations to professional secrecy.

In institutions, the law allows the DYP to have access to the medical record of the child involved without any further authorization. However, the DYP must obtain a court order to have access to the medical record of a third party (parent or tutor). Only information necessary to the assessment of the situation of the child may be disclosed, in keeping with the principle of minimal infringement on professional secrecy.

In private practice, the law has nothing to say on the powers of the DYP. It is up to the physician to decide to divulge the secret, subject to protecting her privacy, on the one hand, and protecting the child from serious harm, on the other. In case of doubt, the physician may request information by telephone from the Collège des médecins du Québec or solicit the opinion of a legal advisor with his or her professional liability insurer.

Clinical Case

Given that Ms. Chantal P.'s daughter had confided to you that her mother's new spouse had sexually abused her and that she had concealed everything from her mother, there was reasonable cause, not only to refuse access to the record, but to believe that the security of the child was in danger. You should therefore have alerted the DYP the moment this information was confided in you. While waiting for the DYP to intervene, you should have done your utmost to protect the daughter, drawing up with her a list of the dangers to her security and development. This action is part and parcel of your commitment to provide follow-up care for your patients.

Clinical Case

Jonathan, a four-year-old boy, is brought in by his mother because he told her a story about sexual abuse at the day care centre.

What do you do?

Even if the investigation with respect to youth protection is not the physician's responsibility, this does not exempt him or her from checking to see whether there is just cause to launch an alert. Doubt is enough to legitimize calling the DYP. The physician's obligation to report situations of abuse against children is mentioned in the *Youth Protection Act* and confirmed in the *Code of Ethics of Physicians* (sec. 39):

"A physician must report to the director of youth protection any situation where there is reasonable cause to believe that the security or development of a child is or may be considered to be in danger; he must then transmit to the director any information he deems pertinent to protecting the child.

The physician himself may also report to the police authorities the situation of a child whose physical integrity or life appears to him to be in danger."

The seriousness of situations of this kind should be enough to discourage irrational or groundless denunciations motivated by nothing but vengeance. It does happen, however, that quarrels over shared custody result in scenarios of this kind.

6.3 **Public Health Protection and the Diseases that must be Reported**

Clinical Case
You meet Mr. Simon L., who asks you for a screening test for HIV because he fears having been contaminated by a transfusion. But he hesitates to undergo the testing because he doesn't trust the results to remain confidential.
What do you do?

The *Public Health Act* provides for means to better identify and control threats to public health. Thus, it recognizes the obligation of physicians and laboratories to report to the director of public health in their territory the infections, diseases and intoxications for which surveillance is required, in accordance with the Minister's Regulation. It also establishes, as necessary, the interventions required to protect the public, in this case, the diseases for which reporting is mandatory (*maladies à déclaration obligatoire—MADO*).

The legislation does not violate professional secrecy; indeed it takes it into account and reinforces it, in as much as the public health director to whom the diseases and intoxications are reported must be a physician, who is bound by the same obligations as are all physicians in the performance of their functions.

Every physician has a responsibility with respect to public health, if he or she judges that a patient's illness is likely to threaten those who come into contact with that patient. This responsibility is spelled out in the *Code of Ethics of Physicians* (sec. 40):

“A physician who has reason to believe that the health of the population or of a group of individuals is threatened must notify the appropriate public health authorities.”

The public health authority referred to in this section falls to the public health director in the region.

The Minister's Regulation respecting the application of the *Public Health Act* lists the diseases that must be reported (MADO) and the ways and means of reporting them. This list, which is regularly updated, is presented in the Appendix; it distinguishes three groups:

- **High-alert diseases that must be reported** (anthrax, botulism, cholera, plague, smallpox, viral hemorrhagic fever, yellow fever). These must be reported immediately, by telephone or by fax, simultaneously to the national public health director and to the public health director in the territory and confirmed in writing within 48 hours.
- **Diseases of infectious origin.** These must be reported in writing to the public health director in the territory by means of a form used expressly for this purpose (AS-770) (Appendix B) and available from the director of public health in the territory. This list includes some 50 infections.
- **Diseases of non-infectious origin** (intoxications). These must be reported in a manner similar to that of diseases of infectious origin.

Once the disease is reported, the director of public health may use the powers provided for in the legislation to investigate and intervene so as to protect the health of the population.

But the physician's obligation to report is not limited to the diseases listed in the Regulation. In fact, sections 93 and 95 of the *Act* include provisions aimed at extending the responsibility to report, with a view to adding any new, heretofore unknown, syndrome, as was the case when AIDS was identified in 1982 or SARS in 2003. Thus sections 93 and 95 cite the following:

"Any physician who suspects a threat to the health of the population must notify the appropriate public health director." (sec.93)

"Reporting a situation under this chapter does not authorize the person making the report to disclose personal or confidential information unless, after evaluating the situation, the public health authority concerned requires such information in the exercise of the powers provided for in Chapter XI." (sec. 95)

The "public health authority" mentioned in section 95 is the director of public health, and the "powers provided for in Chapter XI" are the powers of investigation entrusted to him. These are similar to the powers of a commissioner in a commission of inquiry.

The physician-director of public health must exercise his or her powers and mandate, while respecting the ethical obligations of all physicians, among them, professional secrecy, and legal obligations, notably all legislative provisions protecting privacy and personal information. Thus, the physician's disclosure of information to a colleague who is a physician-director of public health amounts to the sharing of a professional secret, similar to the sharing of patient information between an attending physician and the medical colleagues he or she consults.

In the spirit of the *Public Health Act*, responsibility for vigilance in the face of threats to public health is to be shared by all physicians.

As for this case in particular, it should be kept in mind that the human immunodeficiency virus (AIDS) is a disease that must be reported when blood, blood products, tissues or organs are donated or received. In this case, the physician must complete the AS-770 form. Note also that, to encourage screening for sexually transmitted and blood-borne diseases in vulnerable populations, there are integrated services providing screening on an anonymous basis.

You explain to Mr. Simon L. that you must transmit to the public health authorities information that will identify him if the test is positive. You urge him to have the test nonetheless, since the public health authorities are obliged to protect the confidentiality of the information.

6.4 **Attestation of Death**

Clinical Case

The nurse from a summer camp in your region, whose campers come from abroad and locally, brings in a 12-year-old girl named Sylvia A., who has died following a lightning-quick development of what you think is meningitis.

What do you do?

The physician is responsible for drawing up a certificate (DEC-101) attesting to a person's death for the Directeur de l'état civil. The physician must also indicate the causes and circumstances of death in the Return of Death form (SP-3) meant for public health authorities and the Institut de la statistique du Québec. This document includes the name of the institution and cites the principle diagnosis and associated diagnoses relevant to the cause of death as well as the identity of the person who died. Thus, a very specific portion of the medical record is divulged here.

Québec law also stipulates the particular circumstances in which the physician must notify the coroner. The rules in these instances are set out in the *Act respecting the determination of the causes and circumstances of death* (R.S.Q., c. R-0.2). A fast-reference list (see box) summarizes these rules, but in no way does it replace reading the texts in the *Act* and the regulations pursuant to it.

Box II-1.2

Act respecting the determination of the causes and circumstances of death

Fast-reference List

The coroner must be notified in the following circumstances:

- The physician finds it difficult to establish in a satisfactory way the probable causes of death (if the death occurs in an institution, the director of professional services must first be notified).
- The circumstances of death are obscure or violent (sudden death, accident, homicide, suicide, fire, disaster, etc.).
- The identity of the person is unknown.
- The death occurs in one of the following places:
 - rehabilitation centre
 - sheltered workshop
 - close treatment centre
 - detention centre
 - day care centre
 - penitentiary
 - security unit
 - police station
 - family-type resource.
- The body is transported outside of Québec.
- The body comes from outside of Québec and the probable causes of death have not been established or the circumstances are obscure or violent.

In Sylvie A.'s case, a combination of many factors justify your writing a death certificate and seeing to it that the coroner is notified.

6.5 Highway Safety⁴⁰

Clinical Case

Mr. Bertrand B. is under your care for an epileptic condition that has been well controlled for many years. He asks you to complete an SAAQ form attesting to slight injuries sustained in an automobile accident. During the examination, you come to the conclusion that Mr. B.'s accident was probably associated with a mild epileptic seizure.

What do you do?

The *Highway Safety Code* stipulates that a physician **may** notify the Société de l'assurance automobile du Québec when he or she judges that a patient is unfit to drive. However, jurisprudence tends to make an obligation of the physician's discretionary power. Despite appearances, this is not a contradiction. Indeed, the courts take into consideration the right to professional secrecy and the private life of patients suffering from a condition that may render them unfit to drive, on the one hand, and the right to health and security for others, who risk being injured by an unfit driver, on the other. The physician is asked to show judgment in balancing these two concerns.

Furthermore, the *Automobile Insurance Act* rules that a physician consulted by a patient claiming indemnities following a road accident must send a report to the SAAQ. This report should include all of the physician's findings, treatments and recommendations and should be sent within a prescribed **six-day time limit** (*Highway Safety Code*, sec. 83.15). Under the same law, the physician must also provide the SAAQ with any other medical or hospital document it may request relative to the patient.

Before completing the form, you must inform the patient of the association you've made between the accident and his disease and discuss with him the risks involved in continuing to drive without having had this condition reassessed. You recommend that he notify the SAAQ of such, telling him that you will do so if he does not.

⁴⁰ COLLÈGE DES MÉDECINS DU QUÉBEC, [L'évaluation médicale de l'aptitude à conduire un véhicule automobile : guide d'exercice](#). Montreal, Collège des médecins du Québec, March 2007.

Conclusion

Public confidence in the profession and the patient's confidence in his physician rely on the certainty that professional secrecy will be respected. The legislative framework ensures the protection of this right and sets out guidelines for overriding this right when the health and security of the patient or others is threatened.

The physician-patient relationship is part and parcel of a whole set of rules governing our social relations. For these rules to coexist in a coherent way, the physician must show good judgment and discernment.

C END-OF-LIFE ISSUES

The principles underlying consent and respect for professional secrecy apply in a particular way to end-of-life situations. The prospect of imminent death or incurable illness unleashes predictable reactions that are well described in the medical literature: denial, escape, compassion, mourning and reconciliation. In this stage of life, the dilemmas physicians and patients face are increased.

This section addresses many end-of-life issues on which there is little unanimity; these will be illustrated by clinical cases:

- Cessation of treatment
- Euthanasia or assisted suicide
- Futility and aggressive therapy
- “Do-not-resuscitate” order

As these problems frequently occur in facilities dedicated to long-term care, it may be useful to consult the guide produced by the Collège on medical practice in long-term care centers⁴¹.

1 Cessation of Treatment

Clinical Case

Nancy B. is 23 years old when admitted to hospital. Two years later, she remains totally dependant on the respirator due to Guillain-Barré syndrome. She asks to be taken off the respirator.

What do you do?

The example of Nancy B. is a case that was submitted to the courts in Québec City in 1992. Recourse to the courts was precipitated by the ambiguity experienced on a clinical level. Indeed, the *Criminal Code*, of federal jurisdiction, continues to convey ambiguities and lack of clarity on the legal implications of the cessation of treatment. This recourse to the courts confirmed that the physician who disconnects a respirator in response to the free and informed request of a patient does not commit an unreasonable act or an act of criminal negligence. This act cannot be considered to be homicide. In reading the judgment, it is clear that this is a case of refusal of treatment and that respect for the autonomy and **free and informed consent** of the patient takes precedence in these cases. In fact, the cessation of treatment poses a problem when the person cannot interrupt the treatment herself and the interruption necessitates the participation of a third party. In this case, the physician had to agree to terminate the treatment at Nancy B.'s request. The situation is different when an autonomous patient refuses to continue treatment; in this case, the patient simply stops coming for treatment, stops taking her medication or signs a refusal of treatment.

Usually, the question of cessation of treatment arises when the patient's physical autonomy is compromised. This question gives rise to another, which touches on proportionate treatment as opposed to disproportionate treatment. These notions help us better evaluate the reasonable options, given the diagnosis on the one hand, and

⁴¹ COLLÈGE DES MÉDECINS DU QUÉBEC, [La pratique médicale en soins de longue durée : guide d'exercice](#). Montreal, Collège des médecins du Québec, May 2007.

the intensity of the treatment sought after on the other. Care is said to be proportionate or disproportionate according to the desired goal: does one envisage a cure, maintenance or relief for the patient? If a cure or remission is impossible, maintenance and supportive care may be the only relevant or desirable option.

It is important that the maintenance and supportive care not conflict with the obligation to provide relief, from which no physician is exempt. On this matter, section 58 of the *Code of Ethics of Physicians* stipulates the following:

“A physician must, when the death of a patient appears to him to be inevitable, act so that the death occurs with dignity. He must also ensure that the patient obtains the appropriate support and relief.”

Analgesia in order to provide comfort, for example, is an approach widely used in palliative care.

The story of Nancy B. brought to light the conflict between the principle of self-determination and the sacredness of life, which, for many, can still exist. In fact, from this legal debate emerged the questions of assisted suicide and euthanasia.

2 Euthanasia and Assisted Suicide

There are many definitions of euthanasia. But for purposes of this document, we will adopt the definition proposed by the Law Reform Commission of Canada in 1982 in which euthanasia is defined as a “positive act causing the death of a person for humanitarian reasons. Unlike death caused by the illness itself or by the cessation of treatment of a given disease, euthanasia, as matters stand now, is a voluntary and deliberate act causing death in the context of providing relief to a person suffering from an incurable terminal illness or experiencing unmanageable suffering. It is generally performed by administering a lethal dose of a medication. We speak of **euthanasia** when the medication is administered by a health professional, and of **assisted suicide** when the patient himself administers the medication prepared beforehand for this purpose by a professional.

In legal terms in Canada, both are considered to be criminal acts of first- or second-degree murder (*Criminal Code*, sec. 229). The legislation takes into account the intent to kill and not the motive that inspired the intent. The law does not recognize the merits of the “murder by compassion” concept.

Within the present legal framework, be it for euthanasia or assisted suicide, the consent of the victim has no influence on the criminal liability of the author. The *Criminal Code* stipulates the following:

“No person is entitled to consent to have death inflicted on him.” (sec. 14)

“Everyone who a) counsels a person to commit suicide or b) aids or abets a person to commit suicide, whether the suicide ensues or not, is guilty of an indictable offence and liable to imprisonment for a term not exceeding fourteen years.” (sec. 241)

The medical clinician must appropriately interpret a patient’s request expressing the wish to die. According to some, a request of this kind conceals distress and solitude, or again, reflects depression, from which people in the terminal phase of life are not immune. For others, these requests express the reasonable and conscious wish of a person who does not wish to unduly prolong his life, who wishes to control his situation, or who no longer wishes to be a burden and who is asking to be relieved of

the pain and the agony. Whatever the motive, the point of view of the patient should always be at the heart of the debate, even if, at the moment, society does not always choose to respect it.

3 Futility and Aggressive Treatment

There are many definitions of futility and aggressive treatment. For purposes of this document, a treatment is generally considered “medically futile” or not beneficial if it offers the patient no reasonable hope of cure or improvement or any benefit.

Three questions should be asked in assessing the futility of treatment:

- Is the proposed procedure in keeping with the patient’s expectations?
- Does the proposed procedure have adverse effects that must be evaluated in relation to the expected beneficial ones?
- Will the proposed procedure benefit the patient as a whole?

The futile or aggressive aspect of medical treatment cannot be evaluated without taking into account the point of view of the patient himself and of his family. Nevertheless, the physician must make every effort to come to an objective judgment in keeping with his or her ethical obligations. In this regard, sections 50 and 58 of the *Code of Ethics of Physicians* cite the following:

“A physician must only provide care or issue a prescription when these are medically necessary.” (sec. 50)

“A physician must, when the death of a patient appears to him to be inevitable, act so that the death occurs with dignity. He must also ensure that the patient obtains the appropriate support and relief.” (sec. 58)

Even if no legislative provisions anywhere explicitly stipulate so, it is generally agreed that the physician is not obliged to offer care not required by the state of a patient’s health. At the end of life, more specifically, the physician must determine, with the necessary competence and according to the rules of professional ethics, the treatments compatible with a serene and dignified death; he or she must also refuse the imposition of ill-considered treatments by the patient or his family.

In determining end-of-life treatments and their intensity, the physician must use the approach used in seeking a free and informed consent—information, active listening and dialogue. The physician and the patient must come to grips with death in order to discuss it and reach an understanding as to the medically required supportive care the patient wishes to receive.

4 “Do Not Resuscitate” Order

In health establishments, there is generally a presumption in favor of life, so that when cardio-pulmonary arrest occurs, cardio-pulmonary resuscitation is performed, unless there are explicit orders to the contrary in the record. The presumption in favor of life seems to seek the patient’s best interests. But in fact, the requirement to write the order “do not resuscitate” in the patient’s record presupposes that the patient would consent to resuscitation. Also, if the patient clearly expresses his refusal to be resuscitated, the record must indicate it just as clearly.

An order not to resuscitate may also be suggested by the physician if the procedure is judged futile within the meaning given it by the American Heart Association, which sets out guidelines for justifying a physician's unilateral decision not to resuscitate:

- a) Resuscitation manoeuvres were tried but did not restore the circulation.
- b) No physiological benefit may be expected from advanced resuscitation manoeuvres, considering that the patient's vital functions are deteriorating despite the treatment.
- c) No survivor has been reported in the studies in similar clinical situations.

The first two criteria indicate when resuscitation in progress should be stopped, whereas the third indicates when it should not begin.

Between these two extremes, (one where the patient refuses CPR beforehand, and the other where the physician does not want to begin it), there is a whole range of situations where communication is possible, allowing the patient and/or his family to explicitly discuss end-of-life issues with the physician. This is the course to choose, for, in addition to removing ambiguity, it enables one to give the patient the support and solace he wishes and requires.

Clinical Case

A 78-year-old man, Mr. Pierre T., is suffering from generalized arteriosclerotic vascular disease and arrives with pain in the right foot felt while at rest. The investigation reveals that his vascular condition is more than precarious. The patient suffers from end-stage renal disease and gangrene of the right foot. Metatarsal amputation and chronic hemodialysis follow.

Mr. Pierre T. returns seven months later. The gangrene has reached the other foot, giving him severe pain while at rest. Mr. Pierre T. lets his wife speak for him, withdrawing when it becomes time to discuss treatment. His wife keeps repeating the same request: "The pain has to stop."

What do you do?

Patients and their families do not always express themselves explicitly. This is especially true when death is at issue and highly charged emotions make discussion difficult for the patient, the family and the physician. Thus, it is up to the physician to be vigilant and perceptive in this regard. In Mr. Pierre T.'s case, one might perceive his wife to be hinting at wanting to discuss the possibility of discontinuing the technical procedures and facing the inevitable.

In the context of advanced cancer, a certain institutional culture of palliative care has been developed. Yet there are many other clinical conditions for which the patient's prognosis is equally poor, but for which no culture of palliative care has been developed. When we think of patients with terminal respiratory failure, or of patients like Mr. Pierre T. suffering from almost generalized arteriosclerotic cardiovascular disease, we realize that discussions on end-of-life issues should not be confined exclusively to oncologists. The physician should not lose sight of the clinical deterioration, even if it is marked by a succession of remissions and exacerbations. The hopes raised by minimal, short-lived improvements should not unduly delay discussions about end-of-life issues and imminent death.

The example of Mr. Pierre T. is real. He had clearly adopted an attitude of withdrawal, entrusting his wife with the task of speaking on his behalf. Yet he showed no sign of incapacity to consent.

The question was raised with the treatment team: "What does Mr. Pierre T.'s wife mean when she asks that his pain stop?" The surgeon then returned to the bedside and calmly broached the subject with Mr. Pierre T. and his wife, offering to stop all surgical procedures but to provide relief and support to Mr. Pierre T. The latter then spoke. His choice was to stop treatment even before the hemodialysis began. With an amputated limb and an artificial kidney, he was a prisoner and no longer had any quality of life. Mr. Pierre T.'s wife then explained that, as his second wife, she feared the reaction of the children from his first marriage, if the palliative approach was chosen.

The order not to resuscitate is one of many end-of-life issues. It may give rise to discussion on other issues, thereby improving the special professional relationship between physician and patient at this stage.

In all cases, it is never advisable for the physician to decide for the patient, based on what he or she thinks is best for him. In this sense, the criteria for non-resuscitation are merely tools to help in decision-making; but the decision cannot be made without the free and informed consent of the patient, his representative, or his close relatives. Even if the living will has no real legal value, it can be highly useful in this regard. However, the physician is not obliged to provide care he or she deems inappropriate. In the view of the Collège, the physician might more specifically indicate his or her refusal to take part in resuscitation he or she judges to be completely inappropriate, provided he or she makes certain that this difference of opinion will not interfere with the quality of follow-up care⁴². Like any other treatment, resuscitation may be considered futile (that is, meaningless), if there is no hope of achieving the objectives expressed by the well-informed patient to his physician. These situations are not simple. Hence the importance of the physician reflecting on these questions beforehand.

⁴² COLLÈGE DES MÉDECINS DU QUÉBEC, [La pratique médicale en soins de longue durée : guide d'exercice](#), Montreal, Collège des médecins du Québec, May 2007, p. 14.

Conclusion

Be they cessation of treatment or an order not to resuscitate, end-of-life issues are all too often a taboo subject in the physician-patient relationship. Indeed, death is still a **culturally** taboo subject in our society. And for the physician it is doubly so. On the one hand, society tends to avoid the subject of death to the point of altering the language and rites attached to it. On the other hand, it increasingly entrusts the care of the dying to hospital institutions, when they themselves are caught up in the dynamics of an all-out fight for life and an “efficiency” rationale. Should physicians not re-learn how to provide support and solace in the same measure as they seek to heal?

Without wanting to single-handedly change the culture of the society in which they live, physicians can, through their professional commitment, play a decisive role in the approach to the care of the dying. Just as they do at other times in the lives of their patients, they must provide supportive care and information to the patient and his family at the end of life and, in so doing, help patient and family go through the final stage of life with dignity. As a group, physicians must also participate in the increasingly frequent public discussions on these questions.

D PERSONAL CONVICTIONS OF PHYSICIAN AND PATIENT

While physicians have legal constraints to respect and professional obligations to fulfill, they also have personal convictions, as do their patients for that matter.

In this section, four situations will serve to illustrate how these aspects (professional, personal and legal) can create conflict. They are as follows:

- refusal of a blood transfusion on the part of a Jehovah's Witness;
- request for female genital mutilation;
- refusal to treat on the physician's part;
- a physician's beliefs or convictions likely to influence the care he or she gives to patients.

1 Refusal of Treatment for Religious Reasons

Clinical case

Marie, age 16, is brought in by ambulance following a road accident; she is conscious but in shock from active hemorrhaging. She refuses to be transfused because she is a Jehovah's Witness. Her family confirms her religious allegiance and her expressed refusal.

What do you do?

Regardless of the reason invoked and in spite of the physician's opinion, a free and informed refusal from a person capable of giving consent must be respected, in accordance with the rights recognized in the Canadian and Québec charters of rights and freedoms, and the principles of autonomy and inviolability of the person. A conviction, notably a religious one, may be one of the reasons for which a person may refuse treatment. For example, refusal to submit to a blood transfusion is in keeping with the precepts recognized by Jehovah's Witnesses.

Among the rights recognized by the Canadian and Québec charters is the right to religious freedom. However, even in this case, physicians must ensure that all of the conditions for free and informed refusal have been respected when adapting their assessment to a religious conviction. In particular, they must verify and document the strength of the religious conviction as well as the patient's ability to refuse. The general principles for free and informed consent or refusal have only one application in this case, a particularly difficult one.

1.1 *Person of full age*

As stipulated in the *Civil Code of Québec*, refusal of a blood transfusion expressed by a capable person must be respected, even in emergency situations (Art. 13, par. 2), if there is no doubt about the refusal expressed. If there is **reasonable doubt** about the refusal, the transfusion may not be administered unless it is **an emergency situation AND there is hope of saving the person's life**.

1.2 *A Minor Person*

Here, the situation varies slightly with the person's age.

Minor under 14 years of age — The minor person may not consent alone to care or refuse care. If it is an emergency, and it is not possible to reach the persons having

parental authority, the transfusion may then be administered. But if the parents can be reached and refuse the transfusion for their child, the latter cannot be administered, unless the parents' refusal is deemed to be unjustified, which an authorization by the court could be able to confirm.

Minor 14 years of age or over — The minor 14 years of age or over may consent alone to the care required by his state of health, but he may not always refuse it. If he refuses it, the court may intervene to overrule his refusal and make it possible to take action. In emergency situations, the law stipulates that the consent of the person having parental authority is sufficient to take action. However, the law does not necessarily provide for cases where the person having parental authority decides to respect the decision of the minor and refuses care likely to save his life. Opinions differ as to what the physician must do in these difficult situations. Should he respect this refusal from both sides or not take them into account if he feels the refusals are unjustified? If the physicians opt for the second solution, he or she should address the situation to the court as soon as possible.

1.3 ***Validating the Refusal***

According to Ontario jurisprudence, namely the *Malette v. Schulman* decision, and to the *Civil Code of Québec*, religious conviction is clearly a valid and accepted reason for refusing treatment. The principles invoked are self-determination and respect for the autonomy and inviolability of the person. The emergency situation does not always permit an exception. To transfuse a patient who has clearly and freely expressed her refusal exposes the physician to prosecution for assault, even if the life of the person in danger was saved by the transfusion.

Refusal of treatment for reasons of religious belief poses an additional problem, given the hold coreligionists may have over the patient's will, consequently making it difficult for the patient to choose freely, which is a frequent phenomenon among followers of sects. On the other hand, the right to freedom of conscience and belief presumes that one may choose freely to adhere to a faith and make its precepts one's own. When there is an emergency, and the patient is a minor, the situation is not easy to judge.

In this case and for any other refusal of treatment, the physician must "validate" the refusal. In case of reasonable doubt, the presumption must seek the good of the patient. But the physician must demonstrate that the refusal was doubtful. Similarly, if the refusal is based on religious allegiance, it is up to the physician to demonstrate that it is reasonable to doubt that religious allegiance. In such case, the physician would have to cite arguments to explain why, in the circumstances, it was reasonable not to take the refusal into account.

2 **Request for Female Genital Mutilation**

While it is recognized in Québec and in Canada that a patient may refuse a treatment based on religious beliefs, the request for female genital mutilation for religious or cultural reasons is an entirely different story.

In 1997, legislation criminalizing FGM was passed in Canada. The College of Physicians and Surgeons of Ontario had already adopted a policy in 1992, forbidding female genital mutilation (FGM) and stating that physicians who performed this practice would be prosecuted for professional misconduct. The same is true for infibulation in Ontario. The *Code of Ethics of Physicians of Québec* is not as precise.

But it specifies (sec. 60) that the physician must refuse to collaborate in medical acts that may harm the health of his or her patient:

“A physician must refuse to collaborate or participate in any medical act not in the patient's interest as it pertains to his health.”

Thus, when a patient asks a physician to perform an act that may be harmful to her health, the physician is bound not to perform the act, particularly FGM. For the physician, it is a question of preserving his or her professional independence and making the distinction between the professional realm and the realm of personal convictions. Respecting the personal convictions of patients does not mean that patients can dictate how physicians should behave. Physicians must, however, be vigilant and see to it that their personal convictions do not interfere with their professional obligations.

Masculine circumcision could become the subject of a similar reflection process, but it is still permitted in Canada.

3 Discrimination

Clinical case
A patient comes to your clinic. Upon reading her medical record you realize that she has AIDS. Can you refuse to treat her?

In Québec, section 10 of the *Charter of Human Rights and Freedoms* forbids any discrimination based on race, color, sex, pregnancy, sexual orientation, civil status, age (except to the extent provided by law), religion, political convictions, language, ethnic or national origin, social condition, handicap or the use of a means to palliate it.

For physicians, section 23 of the *Code of Ethics* stipulates the following:

“A physician may not refuse to examine or treat a patient solely for reasons related to the nature of the patient's deficiency or illness, 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; he may, however, refer the patient to another physician if he deems it to be in the patient's medical interest.”

In other words, physicians may not refuse to treat a patient because she is infected by the AIDS virus.

In a more general sense, physicians are bound to provide only the care that is medically necessary, as specified in section 50 of the *Code of Ethics*:

“A physician must only provide or issue a prescription when these are medically necessary.”

However, physicians may refuse to provide a patient with the medically required care for reasons of lack of competence, conflict of personality with the patient, lack of cooperation on the part of the patient, or a request for care that is foolhardy or not in keeping with medical science.

Physicians may never shy away from their obligation to provide assistance, particularly to a person in a state of emergency requiring immediate attention, regardless of the circumstances. This is an obligation for any citizen, all the more so when that citizen is a physician.

4 Conscientious Objection

While physicians must honor their obligation to come to the rescue and assistance of all patients who consult them, they are nonetheless citizens themselves with rights, notably the right to their own beliefs. When their convictions could influence the nature or quality of care provided to a patient, physicians must make sure that they fulfill their ethical obligations. In this regard, section 24 of the *Code of Ethics* is clear:

“A physician must, where his personal convictions 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.

The physician must then offer to help the patient find another physician.”

For example, a physician who is opposed to abortion or contraception is free to limit these interventions in a manner that takes into account his or her religious or moral convictions. However, the physician must inform patients of such when they consult for these kinds of professional services and assist them in finding the services requested.

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*ALDO-Québec***Acronyms and Abbreviations**

AETMIS	Agence d'évaluation des technologies et des modes d'intervention en santé
AFMC	Association of Faculties of Medicine of Canada
AIDS	Acquired immunodeficiency syndrome
AMLFC	Association des médecins de langue française du Canada
AMP	special medical activities
APDPQ	Association of Councils of Physicians, Dentists and Pharmacists of Québec
CAE	Admission to Practice Committee
CCF	Cooperative Commonwealth Federation
CCP	Conseil consultatif de pharmacologie
CDPC	Continuing Professional Development Committee
CEDIM	Medical Disciplines Development Committee
CEMA	Medical Education and Certification Committee
CH	hospital centre
CFPC	College of Family Physicians of Canada
CHSLD	residential and extended care centres
CHU	university hospital centre
CIP	Professional Inspection Committee
CLSC	local community service centres
CMA	Canadian Medical Association
CMA	associated medical clinic
CMPA	Canadian Medical Protective Association
CMQ	Collège des médecins du Québec
CMR	regional medical commission
CMS	specialized medical centre
CN	council of nurses
CPDP	council of physicians, dentists and pharmacists
CPEJ	child and youth protection centres
CPSPQ	College of Physicians and Surgeons of the Province of Québec (former name)
CQMF	Collège québécois des médecins de famille
CR	rehabilitation centre
CSSS	health and social services centre
CSST	Commission de la santé et de la sécurité au travail
DAE	Practice Enhancement Division
DE	Inquiries Division

DEM	Medical Education Division
DH	department head
DPS	director of professional services
DRMG	regional departments of general medicine
DYP	director of youth protection
ED	executive director/CEO
ETC	full-time family physicians
FMEQ	Fédération médicale étudiante du Québec
FMOQ	Fédération des médecins omnipraticiens du Québec
FMRQ	Fédération des médecins résidents du Québec
FMSQ	Fédération des médecins spécialistes du Québec
GMF	family medicine group
HIV	human immunodeficiency virus
IA	induced abortion
INSPQ	Institut national de santé publique du Québec
JSC	joint-stock company
LCME	Liaison Committee on Medical Education
LLP	limited liability partnership
LSSSS	Act respecting health services and social services
MADO	disease that must be reported
MATO	disease for which treatment is mandatory
MC	multidisciplinary council
MED	Medical Education Division
MRSA	Methicillin-resistant staphylococcus aureus
MSSS	Ministère de la Santé et des Services sociaux
NDP	New Democratic Party
OPQ	Office des professions du Québec
PAMQ	Programme d'aide aux médecins du Québec
PED	Practice Enhancement Division
PIC	Professional Inspection Committee
PREM	regional medical manpower plans
QMA	Québec Medical Association
RAMQ	Régie de l'assurance maladie du Québec
RC	rehabilitation centres
RCPSC	Royal College of Physicians and Surgeons of Canada
RLS	local services network
ROAE	<i>Organization and Management of Establishments Regulation (Règlement sur l'organisation et l'administration des établissements)</i>
RUIS	integrated university services network
SAAQ	Société d'assurance automobile du Québec

SARS	severe acute respiratory syndrome
SOI	structured oral interview
STD	sexually transmitted disease
WNV	West Nile virus
VRE	vancomycin-resistant enterococcus

CODE OF ETHICS OF PHYSICIANS

Medical Act

(R.S.Q., c. M-9, s. 3)

Professional Code

(R.S.Q., c. C-26, s. 87)

CHAPTER I

GENERAL PROVISIONS

1. This Code determines, pursuant to section 87 of the Professional Code (R.S.Q., c. C-26), the duties and obligations to be discharged by every member of the Collège des médecins du Québec.

O.C. 1213-2002, s. 1.

CHAPTER II

GENERAL OBLIGATIONS OF THE PHYSICIAN

2. A physician may not exempt himself, even indirectly, from a duty or obligation contained in this Code.

O.C. 1213-2002, s. 2.

3. A physician's paramount duty is to protect and promote the health and well-being of the persons he attends to, both individually and collectively.

O.C. 1213-2002, s. 3.

4. A physician must practise his profession in a manner which respects the life, dignity and liberty of the individual.

O.C. 1213-2002, s. 4.

5. A physician must discharge his professional obligations with competence, integrity and loyalty.

O.C. 1213-2002, s. 5.

6. A physician must practise his profession in accordance with scientific principles.

O.C. 1213-2002, s. 6.

7. A physician must disregard any interference which does not respect his professional independence.

O.C. 1213-2002, s. 7.

8. A physician's duties and obligations under the Medical Act (R.S.Q., c. M-9), the Professional Code (R.S.Q., c. C-26) and their regulations are in no way changed or reduced by the fact that he practises the profession within a partnership or joint-stock company.

CODE OF ETHICS OF PHYSICIANS

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 those regulations.

O.C. 1213-2002, s. 8; O.C. 39-2008, s. 1.

9. A physician must not allow other persons to perform, in his name, acts which, if performed by himself, would place him in contravention of this Code, the Medical Act (R.S.Q., c. M-9), the Professional Code (R.S.Q., c. C-26) and the regulations ensuing therefrom.

O.C. 1213-2002, s. 9.

10. A physician, in the practice of his profession, must not consult a charlatan, nor collaborate in any way whatsoever with him.

O.C. 1213-2002, s. 10.

11. A physician must, in the practice of his profession, assume full civil liability at all times. He may not elude or attempt to elude liability, nor request that a patient or person renounce any recourse taken in a case of professional negligence on his part.

O.C. 1213-2002, s. 11.

12. A physician must be judicious in his use of the resources dedicated to health care.

O.C. 1213-2002, s. 12.

13. 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.

O.C. 1213-2002, s. 13.

14. A physician must promote measures of education and information in the field in which he practises.

O.C. 1213-2002, s. 14.

15. A physician must, as far as he is able, contribute to the development of the profession by sharing his knowledge and experience, notably with his colleagues, with residents and medical students, and by his participation in activities, courses, and periods of continuing training and evaluation.

O.C. 1213-2002, s. 15.

16. A physician must refrain from the immoderate use of psychotropic substances or any other substance, including alcohol, producing analogous effects.

O.C. 1213-2002, s. 16.

CHAPTER III

THE PHYSICIAN'S DUTIES AND OBLIGATIONS TOWARD THE PATIENT, THE PUBLIC AND THE PROFESSION

DIVISION I

QUALITY OF THE PROFESSIONAL RELATIONSHIP

17. A physician's physical, mental and emotional behaviour toward all persons with whom he comes into contact in the practice of his profession, particularly toward all patients, must be beyond reproach.

O.C. 1213-2002, s. 17.

18. A physician must seek to establish and maintain with his patient a relationship of mutual trust and refrain from practising his profession in an impersonal manner.

O.C. 1213-2002, s. 18.

19. A physician may put an end to a therapeutic relationship when there is reasonable and just cause to do so, particularly when the normal conditions required to establish and maintain mutual trust are absent, or if such trust no longer exists.

Inducement on the part of the patient to perform illegal, unjust or fraudulent acts constitutes a reasonable and just cause.

O.C. 1213-2002, s. 19.

20. A physician, in order to maintain professional secrecy,

- (1) must keep confidential the information obtained in the practice of his profession ;
- (2) must refrain from holding or participating in indiscreet conversations concerning a patient or the services rendered him or from revealing that a person has called upon his services ;
- (3) must take reasonable means with respect to the persons with whom he works to maintain professional secrecy ;
- (4) must not use information of a confidential nature to the prejudice of a patient ;
- (5) may not divulge facts or confidences which have come to his personal attention, except when the patient or the law authorizes him to do so, or when there are compelling and just grounds related to the health or safety of the patient or of others ;
- (6) may not reveal a serious or fatal prognosis to a patient's family if the patient forbids him from so doing.

O.C. 1213-2002, s. 20.

21. A physician who communicates information protected by professional secrecy must, for each communication, indicate in the patient's record the following items:

- (1) the date and time of the communication;
- (2) the identity of the person exposed to danger or of the group of persons exposed to danger;
- (3) the identity of the person to whom the communication was made, specifying, according to the case, whether it was the person or persons exposed to danger, their representative or the persons likely to come to their assistance;

- (4) the act of violence he aimed to prevent;
- (5) the danger he had identified;
- (6) the imminence of the danger he had identified;
- (7) the information communicated.

O.C. 1213-2002, s. 21.

22. A physician must refrain from taking advantage of the professional relationship established with the person to whom he is providing services.

More specifically, the physician must, for the duration of the professional relationship established with the person to whom he is providing services, refrain from having sexual relations with that person or making improper gestures or remarks of a sexual nature.

O.C. 1213-2002, s. 22.

23. A physician may not refuse to examine or treat a patient solely for reasons related to the nature of the patient's deficiency or illness, 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; he may, however, refer the patient to another physician if he considers it to be in the patient's medical interest.

O.C. 1213-2002, s. 23.

24. A physician must, where his personal convictions 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.

The physician must then offer to help the patient find another physician.

O.C. 1213-2002, s. 24.

25. A physician must not interfere in the personal affairs of his patient in matters unrelated to the field of health.

O.C. 1213-2002, s. 25.

DIVISION II
FREEDOM OF CHOICE

26. A physician must acknowledge the patient's right to consult a colleague, another professional or any other competent person. He must not, by any means, interfere with the patient's freedom of choice.

O.C. 1213-2002, s. 26.

27. A physician must, when issuing a prescription, respect the patient's right to have it filled at the place and by the person of his choice.

O.C. 1213-2002, s. 27.

**DIVISION III
CONSENT**

28. 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.

O.C. 1213-2002, s. 28.

29. 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.

O.C. 1213-2002, s. 29.

30. A physician must, with respect to research subjects or their legal representative, ensure :

(1) that each subject is informed of the research project's objectives, its advantages, risks or disadvantages for the subject, the advantages provided by the usual care, if applicable, as well as the fact, as the case may be, that the physician will derive a material gain from enrolling or keeping the subject in the research projects;

(2) that free and enlightened written consent, which is revocable at all times, is obtained from each subject before he begins his participation in the research project or when there is any significant change in the research protocol.

O.C. 1213-2002, s. 30.

31. A physician must, before undertaking his research on humans, obtain approval of the project by a research ethics committee that respects existing standards, notably in its composition and procedures. He must also ensure that all those collaborating with him in the research project are informed of his ethical obligations.

O.C. 1213-2002, s. 31.

**DIVISION IV
MEDICAL MANAGEMENT AND FOLLOW-UP**

32. 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 a colleague or other competent professional can do so in his place.

O.C. 1213-2002, s. 32.

33. A physician who wishes to refer a patient to another physician must assume responsibility for that patient until the new physician takes responsibility for the latter.

O.C. 1213-2002, s. 33.

34. A physician who treats a patient requiring emergency care must ensure the medical management required by the patient's condition until the transfer is accepted by another physician.

CODE OF ETHICS OF PHYSICIANS

O.C. 1213-2002, s. 34.

35. A physician who can no longer provide the required medical follow-up of a patient must, before ceasing to do so, ensure that the patient can continue to receive the required care and contribute thereto to the extent necessary.

O.C. 1213-2002, s. 35.

36. A physician must, in the event of a complete or partial cessation of practice, inform his patients of such by giving them advance notice within a reasonable period of time.

O.C. 1213-2002, s. 36.

37. A physician must be diligent and display reasonable availability with respect to his patient and the patients for whom he accepts responsibility when he is on call.

O.C. 1213-2002, s. 37.

38. A physician must come to the assistance of a patient and provide the best possible care when he has reason to believe that the patient presents with a condition that could entail serious consequences if immediate medical attention is not given.

O.C. 1213-2002, s. 38.

39. A physician must report to the director of youth protection any situation where there is reasonable cause to believe that the security or development of a child is or may be considered to be in danger; he must then transmit to the director any information he considers pertinent to protecting the child.

The physician himself may also report to the police authorities the situation of a child whose physical integrity or life appears to him to be in danger.

O.C. 1213-2002, s. 39.

40. A physician who has reason to believe that the health of the population or of a group of individuals is threatened must notify the appropriate public health authorities.

O.C. 1213-2002, s. 40.

41. A physician must collaborate with his colleagues in maintaining and improving the availability and quality of the medical services to which a clientele or population must have access.

O.C. 1213-2002, s. 41.

DIVISION V **QUALITY OF PRACTICE**

42. A physician must, in the practice of his profession, take into account his capacities, limitations and the means at his disposal. He must, if the interest of his patient requires it, consult a colleague, another professional or any competent person, or direct him to one of these persons.

O.C. 1213-2002, s. 42.

43. A physician must refrain from practising his profession under circumstances or in any state that could compromise the quality of his practice or his acts or the dignity of the profession.

O.C. 1213-2002, s. 43.

44. A physician must practise his profession in accordance with the highest possible current medical standards; to this end, he must, in particular, develop, perfect and keep his knowledge and skills up to date.

O.C. 1213-2002, s. 44.

45. A physician who undertakes or participates in research on human beings must conform to the scientific principles and ethical standards generally recognized and justified by the nature and purpose of his research.

O.C. 1213-2002, s. 45.

46. A physician must make his diagnosis with the greatest care, using the most appropriate scientific methods and, if necessary, consulting knowledgeable sources.

O.C. 1213-2002, s. 46.

47. A physician must avoid omissions, procedures or acts which are unsuitable or contrary to the current information in medical science.

O.C. 1213-2002, s. 47.

48. A physician must not resort to insufficiently tested examinations, investigations or treatments, unless they are part of a recognized research project and carried out in a recognized scientific milieu.

O.C. 1213-2002, s. 48.

49. A physician must, with regard to a patient who wishes to resort to insufficiently tested treatments, inform him of the lack of scientific evidence relative to such treatments, of the risks or disadvantages that could result from them, as well as the advantages he may derive from the usual care, if any.

O.C. 1213-2002, s. 49.

50. A physician must only provide care or issue a prescription when these are medically necessary.

O.C. 1213-2002, s. 50.

51. A physician must refrain from providing, prescribing or permitting the obtainment of, in the absence of pathology or sufficient medical reason, psychotropic substances, including alcohol, or any other substance producing analogous effects, as well as any substance used to improve performance.

O.C. 1213-2002, s. 51.

52. A physician must refrain from using or stating that he uses secret substances or treatments or from promoting the dissemination thereof.

O.C. 1213-2002, s. 52.

53. A physician must, when performing an act requiring assistance, ensure that the person assisting him is qualified.

O.C. 1213-2002, s. 53.

54. A physician must not remain alone with a patient when he uses a method of examination or treatment that entails a significantly altered state of consciousness.

O.C. 1213-2002, s. 54.

55. A physician must not decrease the physical, mental or affective capacities of a patient except where such is required for preventive, diagnostic or therapeutic reasons.

O.C. 1213-2002, s. 55.

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

O.C. 1213-2002, s. 56.

57. A physician must inform the patient or, if the latter is unable to act, his legal representative, of a fatal or grave prognosis, unless there is just cause not to do so.

O.C. 1213-2002, s. 57.

58. A physician must, when the death of a patient appears to him to be inevitable, act so that the death occurs with dignity. He must also ensure that the patient obtains the appropriate support and relief.

O.C. 1213-2002, s. 58.

59. A physician must collaborate with the patient's relatives or any other person who shows a significant interest in the patient.

O.C. 1213-2002, s. 59.

60. A physician must refuse to collaborate or participate in any medical act not in the patient's interest as it pertains to his health.

O.C. 1213-2002, s. 60.

61. A physician must refuse to collaborate in any research activity where the risks to the health of subjects, healthy or ill, appear disproportionate to the potential advantages they may derive from such or the advantages they may derive from the usual care, if any.

O.C. 1213-2002, s. 61.

62. A physician may not, unless an Act or regulation authorizes it,

(1) select or keep in his position as associate, employee or assistant for the purpose of practising medicine, a person who is not a physician;

(2) confer upon a person who is not a physician the responsibility of performing acts belonging to the practice of medicine;

(3) collaborate with a person who illegally practises medicine.

O.C. 1213-2002, s. 62.

DIVISION VI

INDEPENDENCE AND IMPARTIALITY

63. A physician must safeguard his professional independence at all times and avoid any situation in which he would be in conflict of interest, in particular when the interests in question are such that he might tend to favour certain of them over those of his patient or where his integrity and loyalty toward the latter might be affected.

O.C. 1213-2002, s. 63.

64. A physician 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.

O.C. 1213-2002, s. 64.

65. A physician acting on behalf of a third party must communicate directly to the physician of the patient, with the latter's authorization, any information he considers important with respect to his state of health.

O.C. 1213-2002, s. 65.

66. A physician must, subject to existing laws, refrain from acting as physician on behalf of a third party in a lawsuit against his patient.

O.C. 1213-2002, s. 66.

67. A physician acting on behalf of a patient or a third party as expert or assessor, must :

(1) during an assessment, objectively and impartially acquaint the patient with the purpose of his work, what is being assessed and the means he intends to use to carry it out ; he must also tell him to whom the assessment report is being sent and how he may request a copy of such ;

(2) avoid obtaining any information from that person or making any interpretations or comments not pertinent to what is being assessed ;

(3) refrain from communicating to the third party any information, interpretations or comments not pertinent to what is being assessed ;

(4) refrain from any word or gesture that could undermine that person's confidence in his physician ;

(5) promptly, objectively and impartially communicate his report to the third party or person who requested the assessment.

O.C. 1213-2002, s. 67.

68. A physician must, in judging the aptitude of a person to perform work, confine himself to seeking information pertinent to this purpose.

O.C. 1213-2002, s. 68.

69. A physician acting on behalf of a third party as expert or assessor may not become the attending physician of the patient unless the latter requests it or expressly authorizes it, and not until his mandate from the third party is completed.

O.C. 1213-2002, s. 69.

70. A physician must, except in an emergency or in cases which are manifestly not serious, refrain from treating himself, or from treating any person with whom there is a relationship that could prejudice the quality of his practice, notably his spouse and his children.

O.C. 1213-2002, s. 70.

71. A physician must, either alone or with the physicians with whom he practises, assume responsibility for the practice of his profession; he may not accept any arrangement limiting that responsibility.

O.C. 1213-2002, s. 71.

72. 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.

Any agreement entered into by the physician or a partnership or join-stock company of which he is a partner or shareholder regarding the enjoyment of a building or a space for practice of the medical profession, must be entirely recorded in writing and include a statement that the obligations arising from the agreement comply with the provisions of the Code and a clause authorizing release of the agreement to the Collège des médecins upon its request.

O.C. 1213-2002, s. 72; O.C. 39-2008, s. 2.

73. A physician must refrain:

(1) from seeking or obtaining undue profit from the prescription of apparatus, examinations, medications or treatments;

(2) from granting, in the practice of his profession, any benefit, commission or rebate to any person whatsoever;

(3) from accepting, in his capacity as a physician or by using his title of physician, any commission, rebate or material benefit with the exception of customary presents and gifts of modest value.

O.C. 1213-2002, s. 73; O.C. 39-2008, s. 3.

73.1. Specifically constituting a material advantage as contemplated by paragraph 3 of section 73 is the enjoyment of a building or a space at no charge or at a discount for the practice of the

CODE OF ETHICS OF PHYSICIANS

medical profession granted to a physician or to a partnership or joint-stock company of which he is a partner or shareholder by:

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

Whether a rent is fair and reasonable is determined as a function of local socio-economic conditions at the time it is fixed.

O.C. 39-2008, s. 4.

74. A physician must not solicit clientele.

O.C. 1213-2002, s. 74.

75. A physician may not allow his title to be used for commercial purposes.

O.C. 1213-2002, s. 75.

76. A physician must refrain from selling any drug or product presented as having a benefit to health, except those he administers directly.

O.C. 1213-2002, s. 76.

77. A physician must inform the patient of the fact that he has interests in the enterprise providing the diagnostic or therapeutic services he prescribes for him.

A physician must respect the patient's freedom of choice by indicating to him, on request, the other places where he may receive such services, when he issues him a prescription or a referral form to that effect.

O.C. 1213-2002, s. 77.

78. A physician who undertakes or participates in a research project must state his interests and disclose any real, apparent or potential conflicts of interest to the research ethics committee.

In research-related activities, a physician must not be party to any agreement nor accept or grant any compensation that would call his professional independence into question.

Remuneration or compensation of a physician for the time and professional expertise he devotes to research must be reasonable and known to the ethics committee.

O.C. 1213-2002, s. 78.

79. A physician who obtains royalties or is part of an enterprise which is within his power to control and which manufactures or markets products having a benefit to health must so inform the persons to whom he prescribes them and the circles in which he promotes them.

O.C. 1213-2002, s. 79.

CODE OF ETHICS OF PHYSICIANS

80. A physician may not be party to any agreement or accept any benefit that could jeopardize his professional independence, particularly in the context of continuing medical education activities.

O.C. 1213-2002, s. 80.

81. A physician who organizes a continuing medical education activity or acts as a resource person in the context of such an activity must inform the participants of his affiliations or financial interests in a commercial enterprise in the performance of this activity.

O.C. 1213-2002, s. 81.

82. A physician who is to perform a graft or organ transplant must not participate in the determination or confirmation of death of the patient from whom the organ is to be removed.

O.C. 1213-2002, s. 82.

DIVISION VII

INTEGRITY

83. A physician must refrain from guaranteeing, explicitly or implicitly, the effectiveness of an examination, investigation or treatment, or the cure of a disease.

O.C. 1213-2002, s. 83.

84. A physician must refrain from entering, producing or using data that he knows to be erroneous in any document, particularly in any report, medical record or research record.

O.C. 1213-2002, s. 84.

85. A physician must refrain from issuing to any person and for any reason whatsoever a false certificate or any information, either verbal or written, which he knows to be erroneous.

O.C. 1213-2002, s. 85.

86. *(Revoked).*

O.C. 1213-2002, s. 86; O.C. 550-2010, s. 1.

87. A physician must not knowingly conceal the negative findings of a research project in which he has taken part.

O.C. 1213-2002, s. 87.

DIVISION VII.I

ADVERTISING AND PUBLIC STATEMENTS

O.C. 550-2010, s. 2.

88. A physician may not, by whatever means, advertise or make a representation to the public or to a person having recourse to his services or allow such to be made in his name, about him or for its benefit, that is false, misleading or incomplete, particularly as to his level or competence or

the scope of effectiveness of his services, or favouring a medication, products, or method of investigation or treatment.

O.C. 1213-2002, s. 88; O.C. 550-2010, s. 2.

88.0.1. A physician who addresses the public must communicate factual, exact and verifiable information. This information must not contain any comparative or superlative statement belittling or disparaging a service or product dispensed by another physician or other professionals.

O.C. 550-2010, s. 2.

88.1. A physician may not use or allow in an advertisement the expression in an unsuitable way of support or gratitude concerning him or his professional practice.

O.C. 550-2010, s. 2.

89. A physician, expressing medical opinions through any public information medium, must express opinions in keeping with current information in medical science on the subject and indicate the caution with respect to a new diagnostic, investigative or treatment procedure which has not been sufficiently tested.

O.C. 1213-2002, s. 89; O.C. 550-2010, s. 2.

90. *(Revoked).*

O.C. 1213-2002, s. 90; O.C. 550-2010, s. 3.

91. *(Revoked).*

O.C. 1213-2002, s. 91; O.C. 550-2010, s. 3.

92. A physician must clearly indicate in his advertising and on all other items of identification used to offer his professional services, his name as well as his status as family physician or specialist corresponding to a speciality category. He may also mention the services he offers.

O.C. 1213-2002, s. 92; O.C. 550-2010, s. 4.

93. A physician must keep a complete copy of every advertisement in its original form, as well as a copy of any relevant contracts, for a period of not less than 3 years following the date on which the advertisement was last published or broadcast. The copy must be submitted to a syndic of the Collège upon request.

O.C. 1213-2002, s. 93.

93.1. Advertising about the prices of services provided by a physician must be of a nature to inform a person who does not have special knowledge of medicine.

O.C. 550-2010, s. 5.

93.2. A physician who includes a price in his advertising must also indicate the following information:

- (1) the price of the treatment or service contemplated and, if any, the validity period;
- (2) any restrictions that apply;

(3) any additional services or fees that might be charged and are not already included in the fee or price;

(4) additional fees associated with the terms of payment, if any.

A physician may agree with a patient to charge a price below that published or circulated.

O.C. 550-2010, s. 5.

93.3. The physician may not in any way whatsoever make or allow advertising intended for vulnerable persons particularly due of their age, condition or the occurrence of a specific event.

O.C. 550-2010, s. 5.

DIVISION VIII

ACCESSIBILITY AND RECTIFICATION OF RECORDS

94. A physician must, promptly and within not more than 30 days of its receipt, respond to any request made by his patient to examine or obtain a copy of documents concerning him in any record established in his respect.

O.C. 1213-2002, s. 94.

95. A physician may demand from a patient reasonable fees no greater than the cost of reproducing or transcribing such documents and the cost of transmitting a copy of the latter.

A physician who intends to demand such fees must, before proceeding with any reproduction, transcription or transmission, inform his patient of the approximate amount he will be required to pay.

O.C. 1213-2002, s. 95.

96. A physician who refuses a patient access to information contained in a record established in his respect must, at the written request of the patient, inform him in writing of the reasons for his refusal and enter such reasons in the record.

O.C. 1213-2002, s. 96.

97. A physician must provide a patient who requests it, or such person designated by the latter, with all information allowing him to obtain a benefit to which he may be entitled.

O.C. 1213-2002, s. 97.

98. A physician must, at the patient's written request and within not more than 30 days of its receipt, hand over to the physician, employer, establishment, insurer or any other person designated by the patient, pertinent information from the patient's medical record which is in his possession and safekeeping.

O.C. 1213-2002, s. 98.

99. A physician must, promptly and within not more than 30 days of its receipt, respond to any request made by a patient to correct or delete inexact, incomplete, ambiguous, outdated or unjustified information in any document concerning him. He must also respect the right of the patient to make written comments in his record.

A physician must deliver to the patient, free of charge, a copy of the document or that part of the document which was duly dated and placed in the record and which allows the patient to see that the information was corrected or deleted or, depending on the case, an attestation that the patient's written comments have been entered in the record.

O.C. 1213-2002, s. 99.

100. A physician must, at the patient's written request, transmit a copy, without charge to the patient, of the corrected information or an attestation that the information was deleted or, if such be the case, that the written comments were entered in the record, to any person from whom the physician has received information that was the subject of correction, deletion or comments, as well as to any person to whom the information was communicated.

O.C. 1213-2002, s. 100.

101. A physician who refuses to assent to a request for correction or deletion of information must notify the patient in writing of the reasons for such refusal and inform him of any recourse available to him.

O.C. 1213-2002, s. 101.

102. A physician must respond promptly to any written request made by a patient to regain possession of a document the patient entrusted to him.

O.C. 1213-2002, s. 102.

DIVISION IX FEES

103. A physician must refrain from claiming fees from whomever for professional activities the cost of which has been or must be paid by a third party.

O.C. 1213-2002, s. 103.

104. A physician must claim only those fees justified by the nature and circumstances of the professional services rendered.

The physician must, without delay, advise the patient of any change in the estimated cost of services.

O.C. 1213-2002, s. 104.

105. A physician who does not participate or who has withdrawn from the Québec Health Insurance Plan or who claims fees for services not covered by this Plan, must give the patient sufficient prior information on the nature and scope of the services included in the price and specify the validity period, where applicable. A physician must provide the patient with all the necessary explanations for understanding his account and the terms and conditions of payment.

He must display for public view in the waiting room of the place where he practices the price of any services, supplies and accessory charges and medical care that he charges for.

O.C. 1213-2002, s. 105; O.C. 550-2010, s. 6.

106. A physician must refrain from claiming fees for professional services not rendered.

The physician contemplated in section 105 may, however, demand a reasonable advance to cover the costs and fees related to the performance of his professional services.

O.C. 1213-2002, s. 106.

107. A physician may share his fees only insofar as the sharing does not affect his professional independence.

O.C. 1213-2002, s. 107.

108. A physician must not sell or transfer his accounts for professional fees, unless it is to another physician or unless the patient agrees thereto or a regulation of the Collège authorizes it.

O.C. 1213-2002, s. 108.

109. A physician who appoints another person or agency to collect his fees must ensure that the latter proceeds with tact, moderation and a respect for the confidentiality and practices related to the collection of accounts authorized by law.

O.C. 1213-2002, s. 109.

DIVISION X

RELATIONS WITH COLLEAGUES AND OTHER PROFESSIONALS

110. A physician must not, in his relations with whomever in the practice of his profession, notably a colleague or member of another professional order, denigrate him, abuse his confidence, willingly mislead him, betray his good faith or use disloyal tactics.

O.C. 1213-2002, s. 110.

111. A physician must not harass, intimidate or threaten a person with whom he is connected in the practice of his profession.

O.C. 1213-2002, s. 111.

112. A physician must, when of his own initiative he refers a patient to another professional, provide the latter with any information he possesses which is pertinent to the examination, investigation and treatment of that patient.

O.C. 1213-2002, s. 112.

113. A physician who accepts a request for consultation from a physician must promptly provide the latter with the written results of his consultation and the recommendations he considers appropriate. He may also, if he considers it necessary, provide another health professional who refers a patient to him or to whom he refers a patient with any information useful to the care and services to be given to that patient.

O.C. 1213-2002, s. 113.

114. A physician must, in an emergency, assist a colleague or another health professional in the practice of his profession when the latter requests it.

O.C. 1213-2002, s. 114.

115. A physician must not take credit for work performed by a colleague or any other person.

O.C. 1213-2002, s. 115.

DIVISION XI
RELATIONS WITH THE COLLÈGE

116. A physician must collaborate with the Collège in the execution of the latter's mandate to protect the public.

O.C. 1213-2002, s. 116.

117. A physician must refrain from exerting any undue pressure, accepting or offering money or any other consideration, in order to influence a decision of the board of directors of the Collège, one of its committees or any person acting on behalf of the Collège.

O.C. 1213-2002, s. 117.

118. A physician may not intimidate, hinder or denigrate in any way whatsoever a representative of the Collège acting in the performance of the duties conferred upon him by the Professional Code (R.S.Q., c. C-26), the Medical Act (R.S.Q., c. M-9) or the regulations ensuing therefrom, or any person who has requested the holding of an inquiry, or any other person identified as a witness who could be summoned before a disciplinary body.

O.C. 1213-2002, s. 118.

119. A physician must report to the Collège any physician, medical student, resident, medical fellow or any person authorized to practise medicine whom he believes to be unfit to practise, incompetent or dishonest, or who has performed acts in contravention of the Professional Code (R.S.Q., c. C-26), Medical Act (R.S.Q., c. M-9) or regulations ensuing therefrom.

The physician must furthermore try to assist a colleague who presents a health problem likely to affect the quality of his practice.

O.C. 1213-2002, s. 119.

120. A physician must, as promptly as possible, reply in writing to any correspondence from the secretary of the Collège, from a syndic as well as a member of the review committee or professional inspection committee, or from an investigator, expert or inspector of this Committee, and make himself available for any meeting considered pertinent.

O.C. 1213-2002, s. 120.

121. A physician who is the subject of an inquiry or upon whom a complaint has been served by a syndic must not communicate with the person who requested that the inquiry be held, unless the physician has the prior, written permission of the person acting as syndic.

O.C. 1213-2002, s. 121.

122. A physician must respect any agreement he has concluded with the board of directors, the executive committee, the secretary of the Collège, a syndic, an assistant syndic or the professional inspection committee.

O.C. 1213-2002, s. 122.

123. A physician may not use the graphic symbol of the Collège in his advertising, unless he is authorized to do so by the secretary of the Collège, in which case the physician must add to such advertising the following notice:

“This advertisement is not an advertisement for the Collège des médecins du Québec and makes reference only to its authors.”.

O.C. 1213-2002, s. 123.

CHAPTER IV
FINAL PROVISIONS

124. This Code replaces the Code of ethics of physicians (R.R.Q., 1981, c. M-9, r.4).

O.C. 1213-2002, s. 124.

125. *(Omitted).*

O.C. 1213-2002, s. 125.

O.C. 1213-2002, 2002 G.O. 2, 5574

O.C. 39-2008, 2008 G.O. 2, 617

S.Q. 2008, c. 11, s. 212

O.C. 550-2010, 2010 G.O. 2, 1905

ALDO-Québec
References to Legislative Texts

The following regulations are available in the Collège des médecins du Québec's Web site.

- [Code of Ethics of Physicians](#)
- [Regulation respecting the keeping of records, physicians' rooms or offices and other effects](#)
- [Regulation respecting the professional inspection committee of the Collège des médecins du Québec](#)
- [Regulation respecting professional liability insurance \[of physicians\]](#)
- [Regulation respecting the standards relating to prescriptions made by a physician](#)
- [Regulation respecting the practice of the medical profession within a partnership or a company](#)

To facilitate consultation, excerpts from the laws mentioned in the document that are deemed most pertinent have been attached, along with certain forms (in French).

Note

These excerpts were up to date as of March 2009. To obtain the most recent version, consult the [Québec Government's Publications Web site](#).

- *Code civil du Québec*
- *Loi sur la protection des personnes dont l'état mental présente un danger pour elles-mêmes ou pour autrui*
- *Loi sur la protection de la jeunesse*
- *Loi sur la santé publique*
 - *Formulaire : MADO*
 - *Formulaire : Surveillance du sida à des fins de surveillance continue de l'état de santé de la population*
- *Code de la sécurité routière*
- *Loi sur l'assurance automobile*
- *Loi sur la recherche des causes et des circonstances des décès*
 - *Formulaire : Déclaration de décès*
 - *Formulaire : Bulletin de décès*
- *Loi sur la santé et la sécurité du travail*
- *Loi sur les accidents du travail et les maladies professionnelles*
- *Loi sur les services de santé et les services sociaux : articles concernant les centres médicaux spécialisés*
- *Règlement sur les traitements médicaux spécialisés dispensés dans un centre médical spécialisé*
- *Loi sur les services de santé et les services sociaux : articles concernant les cliniques médicales associées*

CHAPITRE PREMIER
DE L'INTÉGRITÉ DE LA PERSONNE

10. Toute personne est inviolable et a droit à son intégrité.
Sauf dans les cas prévus par la loi, nul ne peut lui porter atteinte sans son consentement libre et éclairé.

SECTION I
DES SOINS

11. Nul ne peut être soumis sans son consentement à des soins, quelle qu'en soit la nature, qu'il s'agisse d'exams, de prélèvements, de traitements ou de toute autre intervention.
Si l'intéressé est inapte à donner ou à refuser son consentement à des soins, une personne autorisée par la loi ou par un mandat donné en prévision de son inaptitude peut le remplacer.

12. Celui qui consent à des soins pour autrui ou qui les refuse est tenu d'agir dans le seul intérêt de cette personne en tenant compte, dans la mesure du possible, des volontés que cette dernière a pu manifester.
S'il exprime un consentement, il doit s'assurer que les soins seront bénéfiques, malgré la gravité et la permanence de certains de leurs effets, qu'ils sont opportuns dans les circonstances et que les risques présentés ne sont pas hors de proportion avec le bienfait qu'on en espère.

13. En cas d'urgence, le consentement aux soins médicaux n'est pas nécessaire lorsque la vie de la personne est en danger ou son intégrité menacée et que son consentement ne peut être obtenu en temps utile.
Il est toutefois nécessaire lorsque les soins sont inusités ou devenus inutiles ou que leurs conséquences pourraient être intolérables pour la personne.

14. Le consentement aux soins requis par l'état de santé du mineur est donné par le titulaire de l'autorité parentale ou par le tuteur.
Le mineur de quatorze ans et plus peut, néanmoins, consentir seul à ces soins. Si son état exige qu'il demeure dans un établissement de santé ou de services sociaux pendant plus de douze heures, le titulaire de l'autorité parentale ou le tuteur doit être informé de ce fait.

15. Lorsque l'inaptitude d'un majeur à consentir aux soins requis par son état de santé est constatée, le consentement est donné par le mandataire, le tuteur ou le curateur. Si le majeur n'est pas ainsi représenté, le consentement est donné par le conjoint, qu'il soit marié, en union civile ou en union de fait, ou, à défaut de conjoint ou en cas d'empêchement de celui-ci, par un proche parent ou par une personne qui démontre pour le majeur un intérêt particulier.

16. L'autorisation du tribunal est nécessaire en cas d'empêchement ou de refus injustifié de celui qui peut consentir à des soins requis par l'état de santé d'un mineur ou d'un majeur inapte à donner son consentement; elle l'est également si le majeur inapte à consentir refuse catégoriquement de recevoir les soins, à moins qu'il ne s'agisse de soins d'hygiène ou d'un cas d'urgence.
Elle est, enfin, nécessaire pour soumettre un mineur âgé de quatorze ans et plus à des soins qu'il refuse, à moins qu'il n'y ait urgence et que sa vie ne soit en danger ou son intégrité menacée, auquel cas le consentement du titulaire de l'autorité parentale ou du tuteur suffit.

17. Le mineur de quatorze ans et plus peut consentir seul aux soins non requis par l'état de santé; le consentement du titulaire de l'autorité parentale ou du tuteur est cependant nécessaire si les soins présentent un risque sérieux pour la santé du mineur et peuvent lui causer des effets graves et permanents.

18. Lorsque la personne est âgée de moins de quatorze ans ou qu'elle est inapte à consentir, le consentement aux soins qui ne sont pas requis par son état de santé est donné par le titulaire de l'autorité parentale, le mandataire, le tuteur ou le curateur; l'autorisation du tribunal est en outre nécessaire si les soins présentent un risque sérieux pour la santé ou s'ils peuvent causer des effets graves et permanents.

19. Une personne majeure, apte à consentir, peut aliéner entre vifs une partie de son corps pourvu que le risque couru ne soit pas hors de proportion avec le bienfait qu'on peut raisonnablement en espérer.

Un mineur ou un majeur inapte ne peut aliéner une partie de son corps que si celle-ci est susceptible de régénération et qu'il n'en résulte pas un risque sérieux pour sa santé, avec le consentement du titulaire de l'autorité parentale, du mandataire, tuteur ou curateur, et l'autorisation du tribunal.

20. Une personne majeure, apte à consentir, peut se soumettre à une expérimentation pourvu que le risque couru ne soit pas hors de proportion avec le bienfait qu'on peut raisonnablement en espérer.

21. Un mineur ou un majeur inapte ne peut être soumis à une expérimentation qui comporte un risque sérieux pour sa santé ou à laquelle il s'oppose alors qu'il en comprend la nature et les conséquences.

Il ne peut, en outre, être soumis à une expérimentation qu'à la condition que celle-ci laisse espérer, si elle ne vise que lui, un bienfait pour sa santé ou, si elle vise un groupe, des résultats qui seraient bénéfiques aux personnes possédant les mêmes caractéristiques d'âge, de maladie ou de handicap que les membres du groupe. Une telle expérimentation doit s'inscrire dans un projet de recherche approuvé et suivi par un comité d'éthique. Les comités d'éthique compétents sont institués par le ministre de la Santé et des Services sociaux ou désignés par lui parmi les comités d'éthique de la recherche existants; le ministre en définit la composition et les conditions de fonctionnement qui sont publiées à la *Gazette officielle du Québec*.

Le consentement à l'expérimentation est donné, pour le mineur, par le titulaire de l'autorité parentale ou le tuteur, et, pour le majeur inapte, par le mandataire, le tuteur ou le curateur. Lorsque l'inaptitude du majeur est subite et que l'expérimentation, dans la mesure où elle doit être effectuée rapidement après l'apparition de l'état qui y donne lieu, ne permet pas d'attribuer au majeur un représentant légal en temps utile, le consentement est donné par la personne habilitée à consentir aux soins requis par le majeur; il appartient au comité d'éthique compétent de déterminer, lors de l'examen d'un projet de recherche, si l'expérimentation remplit une telle condition.

Ne constituent pas des expérimentations les soins qui, selon le comité d'éthique, sont des soins innovateurs requis par l'état de santé de la personne qui y est soumise.

22. Une partie du corps, qu'il s'agisse d'organes, de tissus ou d'autres substances, prélevée sur une personne dans le cadre de soins qui lui sont prodigués, peut être utilisée aux fins de recherche, avec le consentement de la personne concernée ou de celle habilitée à consentir pour elle.

23. Le tribunal appelé à statuer sur une demande d'autorisation relative à des soins ou à l'aliénation d'une partie du corps, prend l'avis d'experts, du titulaire de l'autorité parentale, du mandataire, du tuteur ou du curateur et du conseil de tutelle; il peut aussi prendre l'avis de toute personne qui manifeste un intérêt particulier pour la personne concernée par la demande.

Il est aussi tenu, sauf impossibilité, de recueillir l'avis de cette personne et, à moins qu'il ne s'agisse de soins requis par son état de santé, de respecter son refus.

24. Le consentement aux soins qui ne sont pas requis par l'état de santé, à l'aliénation d'une partie du corps ou à une expérimentation doit être donné par écrit.

Il peut toujours être révoqué, même verbalement.

25. L'aliénation que fait une personne d'une partie ou de produits de son corps doit être gratuite; elle ne peut être répétée si elle présente un risque pour la santé.

L'expérimentation ne peut donner lieu à aucune contrepartie financière hormis le versement d'une indemnité en compensation des pertes et des contraintes subies.

SECTION II

DE LA GARDE EN ÉTABLISSEMENT ET DE L'ÉVALUATION PSYCHIATRIQUE

26. Nul ne peut être gardé dans un établissement de santé ou de services sociaux, en vue d'une évaluation psychiatrique ou à la suite d'une évaluation psychiatrique concluant à la nécessité d'une garde, sans son consentement ou sans que la loi ou le tribunal l'autorise.

Le consentement peut être donné par le titulaire de l'autorité parentale ou, lorsque la personne est majeure et qu'elle ne peut manifester sa volonté, par son mandataire, son tuteur ou son curateur. Ce consentement ne peut être donné par le représentant qu'en l'absence d'opposition de la personne.

27. S'il a des motifs sérieux de croire qu'une personne représente un danger pour elle-même ou pour autrui en raison de son état mental, le tribunal peut, à la demande d'un médecin ou d'un intéressé, ordonner qu'elle soit, malgré l'absence de consentement, gardée provisoirement dans un établissement de santé ou de services sociaux pour y subir une évaluation psychiatrique. Le tribunal peut aussi, s'il y a lieu, autoriser tout autre examen médical rendu nécessaire par les circonstances. Si la demande est refusée, elle ne peut être présentée à nouveau que si d'autres faits sont allégués.

Si le danger est grave et immédiat, la personne peut être mise sous garde préventive, sans l'autorisation du tribunal, comme il est prévu par la Loi sur la protection des personnes dont l'état mental présente un danger pour elles-mêmes ou pour autrui.

28. Lorsque le tribunal ordonne une mise sous garde en vue d'une évaluation psychiatrique, un examen doit avoir lieu dans les vingt-quatre heures de la prise en charge par l'établissement de la personne concernée ou, si celle-ci était déjà sous garde préventive, de l'ordonnance du tribunal.

Si le médecin qui procède à l'examen conclut à la nécessité de garder la personne en établissement, un second examen psychiatrique doit être effectué par un autre médecin, au plus tard dans les quatre-vingt-seize heures de la prise en charge ou, si la personne était initialement sous garde préventive, dans les quarante-huit heures de l'ordonnance.

Dès lors qu'un médecin conclut que la garde n'est pas nécessaire, la personne doit être libérée. Si les deux médecins concluent à la nécessité de la garde, la personne peut être maintenue sous garde, pour un maximum de quarante-huit heures, sans son consentement ou l'autorisation du tribunal.

29. Tout rapport d'examen psychiatrique doit porter, notamment, sur la nécessité d'une garde en établissement si la personne représente un danger pour elle-même ou pour autrui en raison de son état mental, sur l'aptitude de la personne qui a subi l'examen à prendre soin d'elle-même ou à administrer ses biens et, le cas échéant, sur l'opportunité d'ouvrir à son égard un régime de protection du majeur.

Il doit être remis au tribunal dans les sept jours de l'ordonnance. Il ne peut être divulgué, sauf aux parties, sans l'autorisation du tribunal.

30. La garde en établissement à la suite d'une évaluation psychiatrique ne peut être autorisée par le tribunal que si les deux rapports d'examen psychiatrique concluent à la nécessité de cette garde.

Même en ce cas, le tribunal ne peut autoriser la garde que s'il a lui-même des motifs sérieux de croire que la personne est dangereuse et que sa garde est nécessaire, quelle que soit par ailleurs la preuve qui pourrait lui être présentée et même en l'absence de toute contre-expertise.

30.1. Le jugement qui autorise la garde en fixe aussi la durée.

La personne sous garde doit, cependant, être libérée dès que la garde n'est plus justifiée, même si la période fixée n'est pas expirée.

Toute garde requise au-delà de la durée fixée par le jugement doit être autorisée par le tribunal, conformément aux dispositions de l'article 30.

31. Toute personne qui est gardée dans un établissement de santé ou de services sociaux et y reçoit des soins doit être informée par l'établissement du plan de soins établi à son égard, ainsi que de tout changement important dans ce plan ou dans ses conditions de vie.

Si la personne est âgée de moins de quatorze ans ou si elle est inapte à consentir, l'information est donnée à la personne qui peut consentir aux soins pour elle.

LOI SUR LA PROTECTION DES PERSONNES DONT L'ÉTAT MENTAL PRÉSENTE UN DANGER POUR ELLES-MÊMES OU POUR AUTRUI

DISPOSITION PRÉLIMINAIRE

Nécessité d'une garde.

1. Les dispositions de la présente loi complètent celles du Code civil du Québec portant sur la garde par un établissement de santé et de services sociaux des personnes dont l'état mental présente un danger pour elles-mêmes ou pour autrui et sur l'évaluation psychiatrique visant à déterminer la nécessité d'une telle garde.

CHAPITRE I L'EXAMEN PSYCHIATRIQUE

Psychiatre.

2. Tout examen psychiatrique auquel une personne est tenue de se soumettre en vertu de la loi ou d'une décision du tribunal doit être effectué par un psychiatre. Toutefois, s'il est impossible d'obtenir les services d'un psychiatre en temps utile, l'examen peut être fait par tout autre médecin.

Restriction.

Celui qui fait l'examen ne peut être le conjoint, un allié, un proche parent ou le représentant de la personne qui subit l'examen ou qui en fait la demande.

Rapport.

3. Tout rapport d'examen psychiatrique doit être signé par le médecin qui a fait l'examen. Celui-ci doit y préciser notamment:

1° qu'il a examiné lui-même la personne;

2° la date de l'examen;

3° son diagnostic, même provisoire, sur l'état mental de la personne;

4° outre ce qui est prévu à l'article 29 du Code civil du Québec (Lois du Québec, 1991, chapitre 64), son opinion sur la gravité de son état mental et ses conséquences probables;

5° les motifs et les faits sur lesquels il fonde son opinion et son diagnostic et, parmi les faits mentionnés, ceux qu'il a lui-même observés et ceux qui lui ont été communiqués par d'autres personnes.

Transmission au tribunal.

4. Lorsque l'examen psychiatrique a été requis d'un établissement, il appartient au directeur des services professionnels ou, à défaut d'un tel directeur, au directeur général de l'établissement, de transmettre le rapport du médecin au tribunal qui l'a imposé.

Accès au dossier.

5. La divulgation du rapport par l'établissement se fait conformément aux dispositions relatives à l'accès au dossier de la personne, prévues par les lois sur les services de santé et les services sociaux, sans qu'il soit nécessaire d'obtenir l'autorisation du tribunal prévue à l'article 29 du Code civil du Québec (Lois du Québec, 1991, chapitre 64).

CHAPITRE II LA GARDE

SECTION I GARDE PRÉVENTIVE ET GARDE PROVISOIRE

Établissements visés.

6. Seuls les établissements exploitant un centre local de services communautaires disposant des aménagements nécessaires ou un centre hospitalier peuvent être requis de mettre une personne sous garde préventive ou sous garde provisoire afin de lui faire subir un examen psychiatrique.

Responsabilité du médecin.

7. Tout médecin exerçant auprès d'un tel établissement peut, malgré l'absence de consentement, sans autorisation du tribunal et sans qu'un examen psychiatrique ait été effectué, mettre une personne sous garde préventive dans une installation maintenue par cet établissement pendant au plus soixante-douze heures, s'il est d'avis que l'état mental de cette personne présente un danger grave et immédiat pour elle-même ou pour autrui.

Information au directeur.

Le médecin qui procède à la mise sous garde de cette personne doit immédiatement en aviser le directeur des services professionnels ou, à défaut d'un tel directeur, le directeur général de l'établissement.

Période de garde.

À l'expiration de la période de 72 heures, la personne doit être libérée, à moins qu'un tribunal n'ait ordonné que la garde soit prolongée afin de lui faire subir une évaluation psychiatrique. Toutefois, si cette période se termine un samedi ou un jour non juridique, qu'aucun juge compétent ne peut agir et que cesser la garde présente un danger, celle-ci peut être prolongée jusqu'à l'expiration du premier jour juridique qui suit.

Agent de la paix.

8. Un agent de la paix peut, sans l'autorisation du tribunal, amener contre son gré une personne auprès d'un établissement visé à l'article 6:

1° à la demande d'un intervenant d'un service d'aide en situation de crise qui estime que l'état mental de cette personne présente un danger grave et immédiat pour elle-même ou pour autrui;

2° à la demande du titulaire de l'autorité parentale, du tuteur au mineur ou de l'une ou l'autre des personnes visées par l'article 15 du Code civil du Québec (Lois du Québec, 1991, chapitre 64), lorsque aucun intervenant d'un service d'aide en situation de crise n'est disponible, en temps utile, pour évaluer la situation. Dans ce cas, l'agent doit avoir des motifs sérieux de croire que l'état mental de la personne concernée présente un danger grave et immédiat pour elle-même ou pour autrui.

Prise en charge.

Sous réserve des dispositions de l'article 23 et des urgences médicales jugées prioritaires, l'établissement auprès duquel la personne est amenée doit la prendre en charge dès son arrivée et la faire examiner par un médecin, lequel peut la mettre sous garde préventive conformément à l'article 7.

«service d'aide en situation de crise».

Dans le présent article, on entend par «service d'aide en situation de crise» un service destiné à intervenir dans les situations de crise suivant les plans d'organisation de services en santé mentale prévus par les lois sur les services de santé et les services sociaux.

SECTION II

GARDE AUTORISÉE PAR UN TRIBUNAL EN APPLICATION DE L'ARTICLE 30 DU CODE CIVIL DU QUÉBEC

Établissements visés.

9. Seuls les établissements exploitant un centre hospitalier, un centre de réadaptation, un centre d'hébergement et de soins de longue durée ou un centre d'accueil et disposant des aménagements nécessaires pour recevoir et traiter les personnes atteintes de maladie mentale peuvent être requis de mettre une personne sous garde à la suite du jugement du tribunal rendu en application de l'article 30 du Code civil du Québec (Lois du Québec, 1991, chapitre 64).

Examens périodiques.

10. Lorsque le tribunal a fixé la durée d'une garde à plus de 21 jours, la personne sous garde doit être soumise à des examens périodiques, destinés à vérifier si la garde est toujours nécessaire, dont les rapports doivent être établis aux échéances suivantes:

1° 21 jours à compter de la décision prise par le tribunal en application de l'article 30 du Code civil du Québec (Lois du Québec, 1991, chapitre 64);

2° par la suite, à tous les trois mois.

Rapports.

Les rapports de ces examens psychiatriques sont conservés par l'établissement au dossier de la personne.

Transfert.

11. Une personne sous garde peut, à sa demande, être transférée auprès d'un autre établissement, si l'organisation et les ressources de cet établissement le permettent. Sous cette même réserve, le médecin traitant peut transférer cette personne auprès d'un autre établissement qu'il juge mieux en mesure de répondre à ses besoins. Dans ce dernier cas, le médecin doit obtenir le consentement de la personne concernée, à moins que ce transfert soit nécessaire pour assurer sa sécurité ou celle d'autrui. La décision du médecin à cet égard doit être motivée et inscrite au dossier de la personne.

Certificat du médecin.

Aucun de ces transferts ne peut avoir lieu sans que le médecin traitant atteste, par un certificat motivé, que selon lui cette mesure ne présente pas de risques sérieux et immédiats pour cette personne ou pour autrui.

Garde continuée.

Si le transfert a lieu, la garde se continue auprès du nouvel établissement, auquel est transmise une copie du dossier de la personne sous garde.

Fin de la garde.

12. La garde prend fin sans autre formalité:

1° aussitôt qu'un certificat attestant qu'elle n'est plus justifiée est délivré par le médecin traitant;

2° dès l'expiration d'un délai prévu à l'article 10, si aucun rapport d'examen psychiatrique n'a alors été produit;

3° dès la fin de la période fixée dans le jugement qui l'a ordonnée;

4° par décision du Tribunal administratif du Québec ou d'un tribunal judiciaire.

CHAPITRE IV
DISPOSITIONS DIVERSES

Rôle des établissements.

23. Tout établissement qui, en raison de son organisation ou de ses ressources, n'est pas en mesure de procéder à un examen psychiatrique ou de mettre une personne sous garde doit immédiatement diriger la personne pour qui on requiert ce service auprès d'un autre établissement qui dispose des aménagements nécessaires.

LOI SUR LA PROTECTION DE LA JEUNESSE

CHAPITRE III

ORGANISME ET PERSONNES CHARGÉS DE LA PROTECTION DE LA JEUNESSE

SECTION I

COMMISSION DES DROITS DE LA PERSONNE ET DES DROITS DE LA JEUNESSE

Responsabilités de la Commission.

23. La Commission exerce les responsabilités suivantes, conformément aux autres dispositions de la présente loi:

- a) elle assure, par toutes mesures appropriées, la promotion et le respect des droits de l'enfant reconnus par la présente loi et par la Loi sur le système de justice pénale pour les adolescents (Lois du Canada, 2002, chapitre 1);
- b) sur demande ou de sa propre initiative, elle enquête sur toute situation où elle a raison de croire que les droits d'un enfant ou d'un groupe d'enfants ont été lésés par des personnes, des établissements ou des organismes, à moins que le tribunal n'en soit déjà saisi;
- c) elle prend les moyens légaux qu'elle juge nécessaires pour que soit corrigée la situation où les droits d'un enfant sont lésés;
- d) elle élabore et applique des programmes d'information et d'éducation destinés à renseigner la population en général et les enfants en particulier sur les droits de l'enfant;
- e) elle peut, en tout temps, faire des recommandations notamment au ministre de la Santé et des Services sociaux, au ministre de l'Éducation et au ministre de la Justice;
- f) elle peut faire ou faire effectuer des études et des recherches sur toute question relative à sa compétence, de sa propre initiative ou à la demande du ministre de la Santé et des Services sociaux et du ministre de la Justice.

Pouvoirs des membres de la Commission.

25. Un membre de la Commission ou toute personne à son emploi peut, s'il obtient l'autorisation écrite d'un juge de paix, pénétrer dans un lieu où il a un motif raisonnable de croire qu'il s'y trouve un enfant dont la sécurité ou le développement est ou peut être considéré comme compromis et qu'il est nécessaire d'y pénétrer aux fins d'une enquête de la Commission.

Autorisation préalable.

Un juge de paix peut accorder cette autorisation aux conditions qu'il y indique, s'il est convaincu, sur la foi d'une déclaration sous serment du membre de la Commission ou de la personne à l'emploi de la Commission, qu'il existe un motif raisonnable de croire qu'il s'y trouve un enfant dont la sécurité ou le développement est ou peut être considéré comme compromis et qu'il est nécessaire d'y pénétrer aux fins d'une enquête. L'autorisation doit être rapportée au juge qui l'a accordée, qu'elle ait été exécutée ou non, dans les 15 jours de sa délivrance.

Urgence.

Toutefois, cette autorisation n'est pas requise si les conditions de sa délivrance sont remplies et si le délai pour l'obtenir, compte tenu de l'urgence de la situation, risque de compromettre la sécurité d'un enfant.

SECTION II

DIRECTEUR DE LA PROTECTION DE LA JEUNESSE

Responsabilités du directeur.

32. Le directeur et les membres de son personnel qu'il autorise à cette fin exercent, en exclusivité, les responsabilités suivantes:

- a) recevoir le signalement, procéder à une analyse sommaire de celui-ci et décider s'il doit être retenu pour évaluation;
- b) procéder à l'évaluation de la situation et des conditions de vie de l'enfant et décider si sa sécurité ou son développement est compromis;
- c) décider de l'orientation d'un enfant;

- d) réviser la situation d'un enfant;
- e) mettre fin à l'intervention si la sécurité ou le développement d'un enfant n'est pas ou n'est plus compromis;
- f) exercer la tutelle ou, dans les cas prévus à la présente loi, demander au tribunal la nomination d'un tuteur ou son remplacement;
- g) recevoir les consentements généraux requis pour l'adoption;
- h) demander au tribunal de déclarer un enfant admissible à l'adoption;
- i) décider de présenter une demande de divulgation de renseignements conformément aux dispositions du deuxième alinéa de l'article 72.5 ou de divulguer un renseignement conformément aux dispositions du deuxième ou du troisième alinéa de l'article 72.6 ou de l'article 72.7.

Mesures volontaires.

Lorsque la décision sur l'orientation de l'enfant implique l'application de mesures volontaires, le directeur peut, personnellement, décider de convenir d'une entente sur ces mesures avec un seul parent conformément au deuxième alinéa de l'article 52.1.

Exercice des responsabilités.

33. Le directeur peut, par écrit et dans la mesure qu'il indique, autoriser une personne physique à exercer une ou plusieurs de ses responsabilités à l'exception de celles qu'énumère l'article 32.

SECTION III

COMMUNAUTÉS AUTOCHTONES

Régime particulier.

37.5. Afin de mieux adapter les modalités d'application de la présente loi aux réalités autochtones, le gouvernement est autorisé à conclure, conformément à la loi, avec une nation autochtone représentée par l'ensemble des conseils de bande des communautés qui la constituent, avec une communauté autochtone représentée par son conseil de bande ou par le conseil du village nordique, avec un regroupement de communautés ainsi représentées ou, en l'absence de tels conseils, avec tout autre regroupement autochtone, une entente établissant un régime particulier de protection de la jeunesse applicable à un enfant dont la sécurité ou le développement est ou peut être considéré comme compromis au sens de la présente loi.

Dispositions applicables.

Le régime établi par une telle entente doit être conforme aux principes généraux et aux droits des enfants prévus à la présente loi et est soumis aux dispositions de la section I du chapitre III de celle-ci. Notamment, les pouvoirs prévus à l'article 26 peuvent être exercés à l'égard du dossier pertinent au cas d'un enfant visé dans le cadre de l'application d'une telle entente.

Contenu de l'entente.

L'entente prévoit les personnes à qui elle s'applique et définit le territoire sur lequel seront organisés et dispensés les services. Elle indique les personnes ou les instances à qui seront confiées pour l'exercice, en pleine autorité et en toute indépendance, de tout ou partie des responsabilités dévolues au directeur et peut prévoir des modalités d'exercice des responsabilités ainsi confiées, différentes de celles prévues par la présente loi. Elle contient des dispositions régissant la reprise en charge d'une situation en vertu du système de protection de la jeunesse prévu par la présente loi.

Contenu.

L'entente prévoit également des mesures visant à en évaluer l'application ainsi que les cas, conditions et circonstances dans lesquels ses dispositions cessent d'avoir effet.

Primauté de l'entente.

Dans la mesure où elles sont conformes aux dispositions du présent article, les dispositions d'une entente prévalent sur toute disposition inconciliable de la présente loi et, en matière d'organisation ou de prestation de services, de la

Loi sur les services de santé et les services sociaux (chapitre S-4.2) ou de la Loi sur les services de santé et les services sociaux pour les autochtones cris (chapitre S-5).

Dépôt à l'Assemblée nationale et publication.

Toute entente conclue en vertu du présent article est déposée à l'Assemblée nationale dans les 15 jours de sa signature ou, si elle ne siège pas, dans les 15 jours de la reprise de ses travaux. Elle est en outre publiée à la *Gazette officielle du Québec*.

CHAPITRE IV **INTERVENTION SOCIALE**

SECTION I **SÉCURITÉ ET DÉVELOPPEMENT D'UN ENFANT**

Sécurité ou développement compromis.

38. Pour l'application de la présente loi, la sécurité ou le développement d'un enfant est considéré comme compromis lorsqu'il se retrouve dans une situation d'abandon, de négligence, de mauvais traitements psychologiques, d'abus sexuels ou d'abus physiques ou lorsqu'il présente des troubles de comportement sérieux.

Interprétation:

On entend par:

«abandon»

a) abandon: lorsque les parents d'un enfant sont décédés ou n'en n'assument pas de fait le soin, l'entretien ou l'éducation et que, dans ces deux situations, ces responsabilités ne sont pas assumées, compte tenu des besoins de l'enfant, par une autre personne;

«négligence»

b) négligence:

1° lorsque les parents d'un enfant ou la personne qui en a la garde ne répondent pas à ses besoins fondamentaux:

i. soit sur le plan physique, en ne lui assurant pas l'essentiel de ses besoins d'ordre alimentaire, vestimentaire, d'hygiène ou de logement compte tenu de leurs ressources;

ii. soit sur le plan de la santé, en ne lui assurant pas ou en ne lui permettant pas de recevoir les soins que requiert sa santé physique ou mentale;

iii. soit sur le plan éducatif, en ne lui fournissant pas une surveillance ou un encadrement appropriés ou en ne prenant pas les moyens nécessaires pour assurer sa scolarisation;

2° lorsqu'il y a un risque sérieux que les parents d'un enfant ou la personne qui en a la garde ne répondent pas à ses besoins fondamentaux de la manière prévue au sous-paragraphe 1°;

«mauvais traitements psychologiques»

c) mauvais traitements psychologiques: lorsque l'enfant subit, de façon grave ou continue, des comportements de nature à lui causer un préjudice de la part de ses parents ou d'une autre personne et que ses parents ne prennent pas les moyens nécessaires pour mettre fin à la situation. Ces comportements se traduisent notamment par de l'indifférence, du dénigrement, du rejet affectif, de l'isolement, des menaces, de l'exploitation, entre autres si l'enfant est forcé à faire un travail disproportionné par rapport à ses capacités, ou par l'exposition à la violence conjugale ou familiale;

«abus sexuels»

d) abus sexuels:

1° lorsque l'enfant subit des gestes à caractère sexuel, avec ou sans contact physique, de la part de ses parents ou d'une autre personne et que ses parents ne prennent pas les moyens nécessaires pour mettre fin à la situation;

2° lorsque l'enfant encourt un risque sérieux de subir des gestes à caractère sexuel, avec ou sans contact physique, de la part de ses parents ou d'une autre personne et que ses parents ne prennent pas les moyens nécessaires pour mettre fin à la situation;

«abus physiques»

e) abus physiques:

1° lorsque l'enfant subit des sévices corporels ou est soumis à des méthodes éducatives déraisonnables de la part de ses parents ou de la part d'une autre personne et que ses parents ne prennent pas les moyens nécessaires pour mettre fin à la situation;

2° lorsque l'enfant encourt un risque sérieux de subir des sévices corporels ou d'être soumis à des méthodes éducatives déraisonnables de la part de ses parents ou d'une autre personne et que ses parents ne prennent pas les moyens nécessaires pour mettre fin à la situation;

«troubles de comportement sérieux».

f) troubles de comportement sérieux: lorsque l'enfant, de façon grave ou continue, se comporte de manière à porter atteinte à son intégrité physique ou psychologique ou à celle d'autrui et que ses parents ne prennent pas les moyens nécessaires pour mettre fin à la situation ou que l'enfant de 14 ans et plus s'y oppose.

Sécurité ou développement compromis.

38.1. La sécurité ou le développement d'un enfant peut être considéré comme compromis:

a) s'il quitte sans autorisation son propre foyer, une famille d'accueil ou une installation maintenue par un établissement qui exploite un centre de réadaptation ou un centre hospitalier alors que sa situation n'est pas prise en charge par le directeur de la protection de la jeunesse;

b) s'il est d'âge scolaire et ne fréquente pas l'école ou s'en absente fréquemment sans raison;

c) si ses parents ne s'acquittent pas des obligations de soin, d'entretien et d'éducation qu'ils ont à l'égard de leur enfant ou ne s'en occupent pas d'une façon stable, alors qu'il est confié à un établissement ou à une famille d'accueil depuis un an.

Signalement obligatoire.

39. Tout professionnel qui, par la nature même de sa profession, prodigue des soins ou toute autre forme d'assistance à des enfants et qui, dans l'exercice de sa profession, a un motif raisonnable de croire que la sécurité ou le développement d'un enfant est ou peut être considéré comme compromis au sens de l'article 38 ou au sens de l'article 38.1, est tenu de signaler sans délai la situation au directeur; la même obligation incombe à tout employé d'un établissement, à tout enseignant, à toute personne oeuvrant dans un milieu de garde ou à tout policier qui, dans l'exercice de ses fonctions, a un motif raisonnable de croire que la sécurité ou le développement d'un enfant est ou peut être considéré comme compromis au sens de ces dispositions.

Signalement obligatoire.

Toute personne autre qu'une personne visée au premier alinéa qui a un motif raisonnable de croire que la sécurité ou le développement d'un enfant est considéré comme compromis au sens des paragraphes *d et e* du deuxième alinéa de l'article 38 est tenue de signaler sans délai la situation au directeur.

Signalement discrétionnaire.

Toute personne autre qu'une personne visée au premier alinéa qui a un motif raisonnable de croire que la sécurité ou le développement d'un enfant est ou peut être considéré comme compromis au sens des paragraphes *a, b, c, ou f* de l'article 38 ou au sens de l'article 38.1, peut signaler la situation au directeur.

Secret professionnel.

Les premier et deuxième alinéas s'appliquent même à ceux liés par le secret professionnel, sauf à l'avocat qui, dans l'exercice de sa profession, reçoit des informations concernant une situation visée à l'article 38 ou 38.1.

CHAPITRE VII

DISPOSITIONS PÉNALES

Interdiction.

134. Nul ne peut:

a) refuser de se conformer à une décision ou à une ordonnance rendue en vertu de la présente loi ou conseiller, encourager ou inciter une personne à ne pas s'y conformer;

b) refuser de répondre au directeur, à toute personne autorisée en vertu des articles 32 ou 33, à toute personne ou instance à qui sont confiées, en vertu de l'article 37.5, des responsabilités dévolues au directeur ou à toute personne à

l'emploi de la Commission agissant en vertu du paragraphe b de l'article 23 ou de l'article 25, l'entraver ou tenter de l'entraver, le tromper par réticence ou fausse déclaration ou tenter de le faire, lorsque le directeur, cette instance ou cette personne agit dans l'exercice de ses fonctions;

c) entraver ou tenter d'entraver un membre de la Commission agissant dans l'exercice de ses fonctions;

d) étant tenu de le faire, omettre de signaler au directeur ou à toute personne ou instance à qui sont confiées, en vertu de l'article 37.5, des responsabilités dévolues au directeur la situation d'un enfant dont il a un motif raisonnable de croire que la sécurité ou le développement est ou peut être considéré compromis ou conseiller, encourager ou inciter une personne qui est tenue de le faire à ne pas faire de signalement au directeur ou à une telle personne ou instance;

e) conseiller, encourager ou inciter un enfant à quitter un établissement qui l'héberge en vertu de la présente loi;

f) retenir ou tenter de retenir un enfant lorsqu'une personne agissant en vertu de la présente loi demande qu'on lui remette cet enfant;

g) sciemment, donner accès à un renseignement confidentiel contrairement aux dispositions de la présente loi.

Infraction et peine.

Quiconque contrevient à une disposition du présent article commet une infraction et est passible d'une amende de 250 \$ à 2 500 \$.

CHAPITRE VII VACCINATION

SECTION II DÉCLARATION DES MANIFESTATIONS CLINIQUES INHABITUELLES

Déclaration au directeur de santé publique.

69. Tout médecin ou infirmier qui constate chez une personne qui a reçu un vaccin ou chez une personne de son entourage une manifestation clinique inhabituelle, temporellement associée à une vaccination et qui soupçonne un lien entre le vaccin et cette manifestation clinique inhabituelle, doit déclarer cette situation au directeur de santé publique du territoire dans les plus brefs délais.

Renseignements.

Le médecin ou l'infirmier doit fournir le nom et le numéro d'assurance maladie de la personne chez qui il a constaté une manifestation clinique inhabituelle et le nom et le numéro d'assurance maladie de la personne qui a été vaccinée s'il ne s'agit pas de la même personne. Il doit également fournir au directeur de santé publique une brève description de l'événement constaté et tout autre renseignement prescrit par règlement du ministre.

Inscription.

Lorsque c'est la personne qui a reçu le vaccin qui a eu une réaction inhabituelle et que celle-ci a consenti à participer au registre de vaccination, l'infirmier ou le médecin doit y inscrire cette réaction de la manière et dans les délais prévus par le règlement du ministre pris en vertu de l'article 68.

CHAPITRE VIII INTOXICATIONS, INFECTIONS ET MALADIES À DÉCLARATION OBLIGATOIRE

Liste.

79. Le ministre dresse, par règlement, une liste des intoxications, des infections et des maladies qui doivent faire l'objet d'une déclaration au directeur de santé publique du territoire et, dans certains cas prévus au règlement, au directeur national de santé publique ou à l'un et l'autre.

Critères.

80. Ne peuvent être inscrites à cette liste que des intoxications, des infections ou des maladies médicalement reconnues comme pouvant constituer une menace à la santé d'une population et nécessitant une vigilance des autorités de santé publique ou la tenue d'une enquête épidémiologique.

Déclaration.

81. La déclaration doit indiquer le nom et l'adresse de la personne atteinte et tous les autres renseignements, personnels ou non, prescrits par règlement du ministre. Elle doit être transmise de la manière, dans la forme et dans les délais qu'indique le règlement.

Déclarants.

82. Sont tenus de faire cette déclaration, dans les cas prévus au règlement du ministre:

1° tout médecin qui diagnostique une intoxication, une infection ou une maladie inscrite à la liste ou qui constate la présence de signes cliniques caractéristiques de l'une de ces intoxications, infections ou maladies, chez une personne vivante ou décédée;

2° tout dirigeant d'un laboratoire ou d'un département de biologie médicale, privé ou public, lorsqu'une analyse de laboratoire faite dans le laboratoire ou le département qu'il dirige démontre la présence de l'une de ces intoxications, infections ou maladies.

CHAPITRE IX

TRAITEMENT OBLIGATOIRE ET MESURES DE PROPHYLAXIE À RESPECTER POUR CERTAINES MALADIES OU INFECTIONS CONTAGIEUSES

SECTION I

MALADIES OU INFECTIONS CONTAGIEUSES À TRAITEMENT OBLIGATOIRE

Refus de l'examen.

86. Tout médecin ayant connaissance qu'une personne refuse ou néglige de se faire examiner alors qu'elle souffre vraisemblablement d'une maladie ou d'une infection visée par la présente section doit en aviser dans les plus brefs délais le directeur de santé publique du territoire.

Refus des soins.

Un tel avis doit également être donné lorsqu'un médecin constate qu'une personne refuse ou néglige de suivre le traitement médical requis, ou cesse de le suivre alors qu'il est nécessaire qu'il soit complété pour éviter la contagion ou une future récurrence de la contagion.

SECTION II

MESURES DE PROPHYLAXIE OBLIGATOIRES

Non-respect des mesures.

90. Tout professionnel de la santé qui constate qu'une personne omet, néglige ou refuse de respecter les mesures de prophylaxie prévues par le règlement visé à l'article 89 doit en aviser le directeur de santé publique du territoire dans les plus brefs délais.

Enquête.

Le directeur doit faire enquête et, à défaut par cette personne d'accepter de respecter les mesures de prophylaxie nécessaires, il peut demander à la cour une ordonnance enjoignant à cette personne de le faire.

Dispositions applicables.

Les dispositions de l'article 88 s'appliquent à cette situation, compte tenu des adaptations nécessaires.

Pouvoirs.

Le directeur peut aussi, en cas d'urgence, utiliser les pouvoirs qui lui sont conférés par l'article 103 et les articles 108 et 109 s'appliquent à cette situation.

CHAPITRE XIV

DISPOSITIONS PÉNALES

Omission.

138. Commet une infraction et est passible d'une amende de 600 \$ à 1 200 \$:

1° le médecin ou l'infirmier qui omet de faire une déclaration visée à l'article 69;

2° le médecin ou le dirigeant d'un laboratoire, public ou privé, ou d'un département de biologie médicale qui omet de faire une déclaration visée à l'article 82;

3° le médecin qui omet de donner un avis prévu à l'article 86;

4° le professionnel de la santé qui omet de donner un avis prévu à l'article 90.

À L'USAGE DU MÉDECIN

**DÉCLARATION D'UNE
MALADIE/INFECTION/INTOXICATION
À DÉCLARATION OBLIGATOIRE (MADO)
SELON LA LOI SUR LA SANTÉ PUBLIQUE**

Voir la liste au verso

Nom et prénom du patient			
N° d'assurance maladie		Date de naissance	
		Année	Mois Jour
Adresse (N°, rue)			
Ville			
Code postal	Ind. rég.	Téléphone	Sexe
			M <input type="checkbox"/> F <input type="checkbox"/>

Occupation du patient

Identification de la MADO			
Nom de la MADO		Date du début de la MADO	
		Année	Mois Jour
Prélèvement soumis au laboratoire : <input type="checkbox"/> Non <input type="checkbox"/> Oui Si oui :			
Date		Date	
Année	Mois Jour	Année	Mois Jour
Nom du laboratoire		Nom du laboratoire	
_____		_____	
_____		_____	

Pour une MADO transmissible par le sang, les produits sanguins, les organes ou les tissus : Voir la NOTE au verso			
Ce patient a-t-il donné du sang?	<input type="checkbox"/> Oui	<input type="checkbox"/> Non	<input type="checkbox"/> Ne sais pas
Ce patient a-t-il reçu du sang ou des produits sanguins?	<input type="checkbox"/> Oui	<input type="checkbox"/> Non	<input type="checkbox"/> Ne sais pas
Ce patient a-t-il donné des organes ou des tissus?	<input type="checkbox"/> Oui	<input type="checkbox"/> Non	<input type="checkbox"/> Ne sais pas
Ce patient a-t-il reçu des organes ou des tissus?	<input type="checkbox"/> Oui	<input type="checkbox"/> Non	<input type="checkbox"/> ne sais pas

Pour une déclaration d'un cas de syphilis :			
<input type="checkbox"/> Primaire	<input type="checkbox"/> Latente (moins de 1 an)	<input type="checkbox"/> Tertiaire	<input type="checkbox"/> Autres formes (préciser)
<input type="checkbox"/> Secondaire	<input type="checkbox"/> Latente (plus de 1 an)	<input type="checkbox"/> Congénitale	_____

Nom du médecin (en lettres moulées)	N° de permis	Ind. rég.	Ind. rég.
		Numéros de téléphone	

Année	Mois	Jour	
_____	_____	_____	_____
Date			M.D.
			Signature du déclarant

Ce formulaire ainsi que les coordonnées pour rejoindre les directions de santé publique de toutes les régions peuvent être trouvés sur le site Internet : www.msss.gouv.qc.ca

**À DÉCLARER D'URGENCE PAR TÉLÉPHONE OU PAR TÉLÉCOPIEUR SIMULTANÉMENT
AU DIRECTEUR NATIONAL DE SANTÉ PUBLIQUE ET AU DIRECTEUR DE SANTÉ PUBLIQUE
DE VOTRE TERRITOIRE ET À CONFIRMER DANS LES 48 HEURES À L'AIDE DU PRÉSENT FORMULAIRE :**

- Botulisme
- Choléra
- Fièvre jaune
- Fièvres hémorragiques virales *
(ex. : fièvre Ebola, fièvre de Marburg,
fièvre de Crimée-Congo, fièvre de Lhassa)
- Maladie du charbon (Anthrax)
- Peste
- Variole

**À DÉCLARER À L'AIDE DU PRÉSENT FORMULAIRE AU DIRECTEUR DE SANTÉ PUBLIQUE
DE VOTRE TERRITOIRE DANS LES 48 HEURES :**

- Amiantose
- Angiosarcome du foie
- Asthme dont l'origine professionnelle a été confirmée par un Comité spécial des maladies professionnelles pulmonaires
- Atteinte broncho-pulmonaire aiguë d'origine chimique (bronchiolite, pneumonite, alvéolite, bronchite, syndrome d'irritation bronchique ou œdème pulmonaire)
- Atteinte des systèmes cardiaque, gastro-intestinal, hématopoïétique, rénal, pulmonaire ou neurologique lorsque le médecin a des motifs sérieux de croire que cette atteinte est consécutive à une exposition chimique d'origine environnementale ou professionnelle par les :
 - Alcools (ex. : alcool isopropylique, alcool méthylique)
 - Aldéhydes (ex. : formaldéhyde)
 - Cétones (ex. : acétone, méthyle éthyle cétone)
 - Champignons (ex. : amanites, clitocybes)
 - Corrosifs (ex. : acide fluorhydrique, hydroxyde de sodium)
 - Esters (ex. : esters d'acides gras éthoxylés)
 - Gaz et asphyxiants (ex. : monoxyde de carbone, hydrogène sulfuré, acétylène)
 - Glycols (ex. : éthylène glycol)
 - Hydrocarbures et autres composés organiques volatiles (ex. : aliphatique, aromatique, halogéné, polycyclique)
 - Métaux et métalloïdes (ex. : plomb, mercure)
 - Pesticides (ex. : insecticides organophosphorés et carbamates)
 - Plantes (ex. : datura, stramoine, digitale)
- Babésiose *
- Béryllose
- Brucellose *
- Byssinose
- Cancer du poumon lié à l'amiante dont l'origine professionnelle a été confirmée par un Comité spécial des maladies professionnelles pulmonaires
- Chancre mou
- Coqueluche
- Diphtérie
- Éclosion à entérocoques résistants à la vancomycine
- Éclosion au *Staphylococcus aureus* résistant à la méthicilline
- Encéphalite virale transmise par arthropodes * (ex. : VNO, dengue)
- Fièvre Q *
- Fièvre typhoïde ou paratyphoïde
- Gastro-entérite épidémique d'origine indéterminée
- Granulome inguinal
- Hépatites virales * (ex. : VHA, VHB, VHC)
- Infection à *Chlamydia trachomatis*
- Infection à Hantavirus
- Infection à Plasmodium (malaria) *
- Infection gonococcique
- Infection invasive à *Escherichia coli*
- Infection invasive à *Hæmophilus influenzae*
- Infection invasive à méningocoques
- Infection invasive à streptocoques du Groupe A
- Infection invasive à *Streptococcus pneumoniae* (pneumocoque)
- Infection par le VIH seulement si la personne infectée a donné ou reçu du sang, des produits sanguins, des organes ou des tissus *
- Infection par le virus du Nil occidental *
- Légionellose
- Lèpre
- Lymphogranulomatose vénérienne
- Maladie de Chagas *
- Maladie de Creutzfeldt-Jakob et ses variantes *
- Maladie de Lyme *
- Mésothéliome
- Oreillons
- Paralyse flasque aiguë
- Poliomyélite
- Psittacose
- Rage *
- Rougeole
- Rubéole
- Rubéole congénitale
- Sida : seulement si la personne atteinte a donné ou reçu du sang, des produits sanguins, des organes ou des tissus *
- Silicose
- Syndrome respiratoire aigu sévère (SRAS)
- Syphilis *
- Tétanos
- Toxi-infection alimentaire et hydrique
- Trichinose
- Tuberculose *
- Tularémie
- Typhus

NOTE : Pour les MADO identifiées par un astérisque (*), le médecin doit fournir les informations sur les don(s) et réception(s) de sang, produits sanguins, tissus ou organes.

Selon l'article 93 de la Loi sur la santé publique, le médecin qui soupçonne une menace à la santé de la population (autre que les MADO) doit en aviser le directeur de santé publique de son territoire.

Désignations pour l'imprimeur (2 copies)

À TRANSMETTRE AU DIRECTEUR DE SANTÉ PUBLIQUE DE VOTRE TERRITOIRE

À CONSERVER DANS LE DOSSIER DU PATIENT

Surveillance du sida à des fins de surveillance continue de l'état de santé de la population Syndrome d'immunodéficience acquise (sida)

Le sida fait l'objet d'une collecte obligatoire de renseignements épidémiologiques à des fins de surveillance continue de l'état de santé de la population en vertu de l'article 14 du Règlement ministériel d'application de la Loi sur la santé publique.

À transmettre au responsable : Programme de surveillance du sida du Québec
Ministère de la Santé et des Services sociaux
201, boulevard Crémazie Est, bureau 2.03
Montréal (Québec) H2M 1L2

Ce formulaire est disponible sur le site Internet : www.msss.gouv.qc.ca
ou peut être commandé par télécopieur au (514) 873-9997.

Date de réception de la déclaration	Année	Mois	Jour	N° provincial PSSQ

SECTION 1 — DONNÉES DÉMOGRAPHIQUES	
N° de référence de ce patient :	Date de naissance
Sexe : <input type="checkbox"/> Masculin <input type="checkbox"/> Féminin <input type="checkbox"/> Autre <input type="checkbox"/> Inconnu	3 premiers caractères du code postal de résidence au diagnostic du sida :
Localité de résidence :	
Pays de naissance <input type="checkbox"/> Canada <input type="checkbox"/> Autre (préciser) :	Date d'arrivée au Canada
Origine ethnoculturelle	
<input type="checkbox"/> Canadienne	<input type="checkbox"/> Caraïbes
<input type="checkbox"/> Américaine	<input type="checkbox"/> Haïtienne
<input type="checkbox"/> Afro-américaine <input type="checkbox"/> Hispanique	<input type="checkbox"/> Jamaïcaine
<input type="checkbox"/> Autres : _____	<input type="checkbox"/> Autre : _____
<input type="checkbox"/> Européenne de l'Est	<input type="checkbox"/> Amérique latine, centrale et du Sud
<small>Arménien, Russe, Roumain, Polonais, Ukrainien, Hongrois, Tchèque, Slovaque, Balte</small>	<small>Argentin, Brésilien, Chilien, Colombien, Costaricain, Mexicain, Panaméen, Péruvien, Salvadorien, Vénézuélien, etc.</small>
<input type="checkbox"/> Européenne du Sud	<input type="checkbox"/> Asiatique de l'Est et du Sud-Est
<small>Espagnol, Grec, Italien, Portugais, Cyproite, Maltais</small>	<small>Chinois, Coréen, Indonésien, Japonais, Malaisien, Cambodgien, Laotien, Thaïlandais, Vietnamien, Philippin, Taïwanais, etc.</small>
<input type="checkbox"/> Européenne autre	<input type="checkbox"/> Asiatique du Sud
<small>Anglais, Écossais, Irlandais, Français, Allemand, Autrichien, Belge, Hollandais, Suisse, Scandinave, etc.</small>	<small>Afghan, indien, Bangladaïsi, Bengali, Cingalais, Indien (de l'Inde), Pakistanais, Sri-Lankais, Tamoul, etc.</small>
<input type="checkbox"/> Océanienne	<input type="checkbox"/> Africaine du Nord et Moyen-Orient
<small>Australien, Néo-zélandais, Îles du Pacifique (Fidjien, Polynésien)</small>	<small>Algérien, Libanais, Marocain, Jordanien, Syrien, Tunisien, Turc, Israélien, Égyptien, Irakien, etc.</small>
<input type="checkbox"/> Africaine sub-saharienne	<input type="checkbox"/> Africaine sub-saharienne
<small>Afrique du Sud, République démocratique du Congo, Béni, Éthiopie, Rwanda, etc.</small>	<small>Afrique du Sud, République démocratique du Congo, Béni, Éthiopie, Rwanda, etc.</small>
<input type="checkbox"/> Autochtone	<input type="checkbox"/> Autochtone
<input type="checkbox"/> Premières Nations	<input type="checkbox"/> Premières Nations
<input type="checkbox"/> Mèlis	<input type="checkbox"/> Mèlis
<input type="checkbox"/> Inuit	<input type="checkbox"/> Inuit
<input type="checkbox"/> Inconnu	<input type="checkbox"/> Inconnu
<input type="checkbox"/> Origine imprécise ou complexe	<input type="checkbox"/> Origine imprécise ou complexe
<input type="checkbox"/> Autre : _____	<input type="checkbox"/> Autre : _____
<input type="checkbox"/> Inconnu	<input type="checkbox"/> Inconnu
Statut vital <input type="checkbox"/> Vivant <input type="checkbox"/> Décédé <input type="checkbox"/> Inconnu	
<small>Dernière date connu(e) vivant(e)</small>	<small>Date du décès</small>
Année Mois Jour	Année Mois Jour

SECTION 2 — ATTEINTES RÉVÉLATRICES DE SIDA					
* Méthodes de diagnostic :					
1- Cytologie		3- Culture		5- Détection sérologique d'anticorps	
2- Histopathologie		4- Endoscopie		6- Détection d'antigènes	
7- Examen physique; clinique		8- Radiologie		9- Inconnue(s)	
Atteintes	Date du diagnostic	Méthodes de diagnostic *	Atteintes	Date du diagnostic	Méthodes de diagnostic *
	Année Mois			Année Mois	
Cancer invasif du col utérin			Leucoencéphalopathie multifocale progressive		
Candidose (bronches, trachée ou poumons)			Lymphome non-hodgkinien à cellules B OU lymphome à petites cellules à noyau non encoché (Burkitt ou non) OU lymphome immunoblastique, à grandes cellules, hystiocyttaire diffus ou indifférencié diffus		
Candidose oesophagienne			Lymphome cérébral primaire		
Coccidioïdomycose			Tuberculose GÉNÉRALISÉE OU EXTRAPULMONAIRE		
Complexe <i>Mycobacterium avium</i> ou maladie à <i>M. kansasii</i> (généralisée ou extrapulmonaire) ou infection à mycobactérie appartenant à d'autres espèces ou à une espèce non identifiée			préciser le(s) site(s) : _____		
Cryptococcose (extrapulmonaire)			Tuberculose PULMONAIRE		
Cryptosporidiose (intestinale, chronique, durée > 1 mois)			Pneumonie à <i>Pneumocystis carinii</i>		
Cytomégalovirose (touchant un organe autre que le foie, la rate ou les ganglions)			Pneumonie bactérienne RÉCIDIVANTE (inscrire les dates d'épisodes)		
Rétinite à cytomégalovirus			Sarcome de Kaposi		
Encéphalopathie au VIH (démence)			Septicémie à salmonelle RÉCIDIVANTE (inscrire les dates d'épisodes)		
Herpès simplex : ulcère(s) chronique(s) (durée > 1 mois) ou bronchite, pneumonite ou oesophagite			Syndrome d'émaciation au VIH		
Histoplasmose (généralisée ou extrapulmonaire)			Toxoplasmose cérébrale		
Isosporiose, intestinale chronique (durée > 1 mois)					
Maladies s'appliquant exclusivement aux enfants âgés de moins de 15 ans					
Atteintes	Date du diagnostic	Méthodes de diagnostic *	Atteintes	Date du diagnostic	Méthodes de diagnostic *
	Année Mois			Année Mois	
Infections bactériennes multiples ou récurrentes (autre que la pneumonie bactérienne récurrente)			Pneumonie interstitielle lymphoïde OU Hyperplasie lymphoïde pulmonaire		
Autre(s) maladie(s)					

SECTION 3 — DONNÉES DE LABORATOIRE					
** Méthode de détection du VIH :					
1- ELISA	2- Western blot	3- Immunofluorescence (IFA)	4- RIPA 5- PCR 6- Antigène p24		
		7- Culture virale	8- Autre : _____ 9- Inconnue		
Historique de tests de détection du VIH					
Méthode **	Date			Résultat	Nom du laboratoire
	Année	Mois	Jour		
Autres données de laboratoire pertinentes disponibles au moment du diagnostic					

SECTION 4a — RISQUE(S) LIÉ(S) À LA TRANSMISSION	
• Indiquer le(s) comportement(s)/catégorie(s) d'exposition du patient	
A- EXPOSITION SEXUELLE	
<i>Relations sexuelles avec :</i>	
Un ou des hommes	<input type="checkbox"/> Oui <input type="checkbox"/> Non <input type="checkbox"/> Ne sais pas/ne s'applique pas
Une ou des femmes	<input type="checkbox"/> Oui <input type="checkbox"/> Non <input type="checkbox"/> Ne sais pas/ne s'applique pas
Un homme bisexuel	<input type="checkbox"/> Oui <input type="checkbox"/> Non <input type="checkbox"/> Ne sais pas/ne s'applique pas
Un(e) utilisateur(trice) de drogues par injection	<input type="checkbox"/> Oui <input type="checkbox"/> Non <input type="checkbox"/> Ne sais pas/ne s'applique pas
Une personne :	
• Transfusée ayant une infection par le VIH confirmée	<input type="checkbox"/> Oui <input type="checkbox"/> Non <input type="checkbox"/> Ne sais pas/ne s'applique pas
• Hémophile ou ayant un trouble de coagulation	<input type="checkbox"/> Oui <input type="checkbox"/> Non <input type="checkbox"/> Ne sais pas/ne s'applique pas
• Née dans un pays endémique _____	<input type="checkbox"/> Oui <input type="checkbox"/> Non <input type="checkbox"/> Ne sais pas/ne s'applique pas
<small>Préciser le pays</small>	
• Ayant une infection par le VIH confirmée ou atteinte de sida	<input type="checkbox"/> Oui <input type="checkbox"/> Non <input type="checkbox"/> Ne sais pas/ne s'applique pas
Travailleur(euse)s du sexe	<input type="checkbox"/> Oui <input type="checkbox"/> Non <input type="checkbox"/> Ne sais pas/ne s'applique pas
Partenaires inconnus/anonymes	<input type="checkbox"/> Oui <input type="checkbox"/> Non <input type="checkbox"/> Ne sais pas/ne s'applique pas
Partenaires à risque élevé non précisé	<input type="checkbox"/> Oui <input type="checkbox"/> Non <input type="checkbox"/> Ne sais pas/ne s'applique pas
<i>Pour le patient lui-même :</i>	
Originaire d'un pays endémique	<input type="checkbox"/> Oui <input type="checkbox"/> Non <input type="checkbox"/> Ne sais pas/ne s'applique pas
Travailleur(euse)s du sexe	<input type="checkbox"/> Oui <input type="checkbox"/> Non <input type="checkbox"/> Ne sais pas/ne s'applique pas
B- EXPOSITION PARENTÉRALE ***	
Utilisation de drogues par injection (UDI)	<input type="checkbox"/> Oui <input type="checkbox"/> Non <input type="checkbox"/> Ne sais pas/ne s'applique pas
Receveur de facteur de coagulation	<input type="checkbox"/> Oui <input type="checkbox"/> Non <input type="checkbox"/> Ne sais pas/ne s'applique pas
Receveur de transfusion ou produits sanguins	<input type="checkbox"/> Oui <input type="checkbox"/> Non <input type="checkbox"/> Ne sais pas/ne s'applique pas
Pays de réception du produit sanguin : _____	
C- AUTRES RISQUE(S) LIÉ(S) À LA TRANSMISSION	
Exposition en milieu de travail à du sang ou des liquides biologiques contaminés par le VIH ou à une préparation concentrée de virus	<input type="checkbox"/> Oui <input type="checkbox"/> Non <input type="checkbox"/> Ne sais pas/ne s'applique pas
Exposition liée à un acte médical ou dentaire	<input type="checkbox"/> Oui <input type="checkbox"/> Non <input type="checkbox"/> Ne sais pas/ne s'applique pas
Autre exposition (par exemple : tatouage, perçage corporel, insémination artificielle)	<input type="checkbox"/> Oui <input type="checkbox"/> Non <input type="checkbox"/> Ne sais pas/ne s'applique pas
Préciser : _____	

SECTION 4b — CAS DE TRANSMISSION MÈRE-ENFANT – RISQUE(S) LIÉ(S) À LA TRANSMISSION DE LA MÈRE	
Utilisatrice de drogues par injection	<input type="checkbox"/> Oui <input type="checkbox"/> Non <input type="checkbox"/> Ne sais pas/ne s'applique pas
Originaire d'un pays endémique _____	<input type="checkbox"/> Oui <input type="checkbox"/> Non <input type="checkbox"/> Ne sais pas/ne s'applique pas
<small>Préciser le pays</small>	
Receveuse de sang ou produits sanguins	<input type="checkbox"/> Oui <input type="checkbox"/> Non <input type="checkbox"/> Ne sais pas/ne s'applique pas
Receveuse de facteur de coagulation	<input type="checkbox"/> Oui <input type="checkbox"/> Non <input type="checkbox"/> Ne sais pas/ne s'applique pas
Insémination artificielle	<input type="checkbox"/> Oui <input type="checkbox"/> Non <input type="checkbox"/> Ne sais pas/ne s'applique pas
Relations avec un ou des partenaires à risque	
• Utilisateur de drogue par injection (UDI)	<input type="checkbox"/> Oui <input type="checkbox"/> Non <input type="checkbox"/> Ne sais pas/ne s'applique pas
• Homme bisexuel	<input type="checkbox"/> Oui <input type="checkbox"/> Non <input type="checkbox"/> Ne sais pas/ne s'applique pas
• Homme transfusé ayant une infection par le VIH confirmée	<input type="checkbox"/> Oui <input type="checkbox"/> Non <input type="checkbox"/> Ne sais pas/ne s'applique pas
• Homme originaire d'un pays endémique _____	<input type="checkbox"/> Oui <input type="checkbox"/> Non <input type="checkbox"/> Ne sais pas/ne s'applique pas
<small>Préciser le pays</small>	
• Homme ayant une infection par le VIH confirmée ou atteint de sida	<input type="checkbox"/> Oui <input type="checkbox"/> Non <input type="checkbox"/> Ne sais pas/ne s'applique pas
• Partenaires inconnus/anonymes	<input type="checkbox"/> Oui <input type="checkbox"/> Non <input type="checkbox"/> Ne sais pas/ne s'applique pas
• Partenaires à risque élevé non précisé	<input type="checkbox"/> Oui <input type="checkbox"/> Non <input type="checkbox"/> Ne sais pas/ne s'applique pas

SECTION 5 — IDENTIFICATION DU MÉDECIN DÉCLARANT					
Nom du médecin	N° de téléphone		Date de la déclaration		
	N° de permis de pratique	Ind. rég.	Année	Mois	Jour

SECTION 6 — AUTRES RENSEIGNEMENTS OU OBSERVATIONS CONCERNANT LA TRANSMISSION DU VIH OU AUTRES SUJETS PERTINENTS

*** En vertu de l'article 4 du Règlement ministériel d'application de la Loi sur la santé publique, un médecin est tenu de déclarer par écrit dans les 48 heures au Directeur de santé publique de son territoire un cas de sida qui a reçu ou donné du sang, des produits sanguins, des organes ou des tissus.

CODE DE LA SÉCURITÉ ROUTIÈRE

TITRE VIII RÈGLES DE CIRCULATION ROUTIÈRE

CHAPITRE II DISPOSITIONS GÉNÉRALES CONCERNANT LA CIRCULATION DES VÉHICULES

SECTION III CEINTURE DE SÉCURITÉ

Certificat médical.

398. Lorsque des raisons médicales exceptionnelles le justifient, la Société peut, sur recommandation écrite d'un médecin spécialiste que la Société peut désigner nommément, délivrer un certificat dispensant une personne du port de la ceinture de sécurité ou de l'utilisation d'un ensemble de retenue. Le médecin spécialiste formule sa recommandation après examen de la personne qui a demandé la dispense.

TITRE XI COMMUNICATION DE RENSEIGNEMENTS

Rapport d'inaptitude.

603. Tout professionnel de la santé peut, selon son champ d'exercice, faire rapport à la Société du nom, de l'adresse, de l'état de santé d'une personne de 14 ans ou plus qu'il juge inapte à conduire un véhicule routier, en tenant compte notamment des maladies, déficiences et situations incompatibles avec la conduite d'un véhicule routier telles qu'établies par règlement.

Divulgateion de renseignements.

Pour l'application du présent article, tout professionnel de la santé est autorisé à divulguer à la Société les renseignements qui lui ont été révélés en raison de sa profession.

Décision.

604. La Société peut divulguer au professionnel de la santé qui lui a fait rapport en vertu de l'article 603, la décision qu'elle a prise à la suite des renseignements qu'il lui a transmis.

Recours prohibé.

605. Aucun recours en dommages-intérêts ne peut être intenté contre un professionnel de la santé pour s'être prévalu des dispositions de l'article 603.

LOI SUR L'ASSURANCE AUTOMOBILE

TITRE II INDEMNISATION DU PRÉJUDICE CORPOREL

CHAPITRE VI PROCÉDURE DE RÉCLAMATION

Rapport d'examen.

83.14. Le professionnel de la santé qui examine une personne à la demande de la Société doit faire rapport à celle-ci sur l'état de santé de cette personne et sur toute autre question pour laquelle l'examen a été requis.

Transmission d'une copie.

Sur réception de ce rapport, la Société doit en transmettre une copie à tout professionnel de la santé désigné par la personne qui a subi l'examen visé au premier alinéa.

Rapport à la Société.

83.15. Tout établissement au sens de la Loi sur les services de santé et les services sociaux (chapitre S-4.2) ou au sens de la Loi sur les services de santé et les services sociaux pour les autochtones cris (chapitre S-5), tout professionnel de la santé qui a traité une personne à la suite d'un accident ou qui a été consulté par une personne à la suite d'un accident doit, à la demande de la Société, lui faire rapport de ses constatations, traitements ou recommandations.

Délai.

Ce rapport doit être transmis dans les six jours qui suivent la demande de la Société.

Autre document.

Il doit également fournir à la Société, dans le même délai, tout autre rapport qu'elle lui demande relativement à cette personne.

Application.

Le présent article s'applique malgré l'article 19 de la Loi sur les services de santé et les services sociaux (chapitre S-4.2).

LOI SUR LA RECHERCHE DES CAUSES ET DES CIRCONSTANCES DES DÉCÈS

CHAPITRE II AVIS AU CORONER

Devoir d'un médecin.

34. Le médecin qui constate un décès dont il ne peut établir les causes probables ou qui lui apparaît être survenu dans des circonstances obscures ou violentes doit en aviser immédiatement un coroner ou un agent de la paix.

Décès.

35. Lorsqu'un décès survient dans une installation maintenue par un établissement qui exploite un centre hospitalier, le directeur des services professionnels de cet établissement ou une personne sous son autorité peut prendre les mesures pour faire établir par un médecin les causes probables de ce décès.

Autorisation d'un coroner.

Toutefois, si le décès est visé à l'article 36, le directeur des services professionnels ou une personne sous son autorité doit préalablement obtenir l'autorisation d'un coroner avant de prendre les mesures pour faire établir les causes probables du décès.

Circonstances obscures d'un décès.

36. À moins qu'elle n'ait des motifs raisonnables de croire qu'un coroner, un médecin ou un agent de la paix en a déjà été averti, toute personne doit aviser immédiatement un coroner ou un agent de la paix d'un décès dont elle a connaissance lorsqu'il lui apparaît que ce décès est survenu dans des circonstances obscures ou violentes ou lorsque l'identité de la personne décédée lui est inconnue.

CHAPITRE III INVESTIGATION

SECTION II EXAMENS, AUTOPSIES ET AUTRES EXPERTISES

Examen ou autopsie.

73. Le coroner peut procéder ou ordonner qu'il soit procédé à l'examen ou à l'autopsie d'un corps ou à une expertise.

Demande par le ministre de la Sécurité publique.

Le ministre de la Sécurité publique ou le coroner en chef peut exiger du coroner qu'il fasse procéder à un examen, à une autopsie ou à une expertise.

Prélèvement.

74. Un médecin peut effectuer sur un corps un prélèvement requis pour une expertise ordonnée par le coroner.

Mesures nécessaires.

76. Le directeur des services professionnels d'un établissement qui exploite un centre hospitalier prend les mesures nécessaires pour qu'il soit procédé avec diligence à l'examen, à l'autopsie ou au prélèvement qui doit être fait dans une installation maintenue par cet établissement.

Mesures nécessaires.

Le directeur du Laboratoire de médecine légale du Québec et le directeur du Laboratoire de police scientifique du Québec sont soumis à la même obligation lorsque, selon le cas, l'examen, l'autopsie, le prélèvement ou l'expertise doit être fait sous leur autorité.

Remplir la Déclaration en lettres moulées avec un stylo
ou à la machine à écrire.
Appuyer fortement.
Lire les instructions au verso avant de remplir le document.

LIEU, DATE ET HEURE DU DÉCÈS

1. Établissement où la personne est décédée		2. Code d'établissement	
3. Endroit où la personne est décédée, si hors d'un établissement (n°, rue, municipalité, province ou pays)			4. Date du décès Année Mois Jour
Code postal			5. Heure du décès Heure(s) Minute(s)

IDENTIFICATION DE LA PERSONNE DÉCÉDÉE (Inscrire le nom de famille et le ou les prénoms selon l'acte de naissance.)

6. Nom de famille		7. Prénom usuel et autres prénoms		8. Sexe de la personne décédée <input type="checkbox"/> 1. Masculin <input type="checkbox"/> 2. Féminin	
9. Adresse du domicile (n°, rue, municipalité, province ou pays)					
10. Date de naissance Année Mois Jour		11. Lieu de naissance (municipalité, province ou pays)			
12. Lieu d'inscription de la naissance (lieu de culte, municipalité, province ou pays)				13. État civil <input type="checkbox"/> 1. Célibataire <input type="checkbox"/> 2. Marié(e) <input type="checkbox"/> 3. Veuf(ve) <input type="checkbox"/> 4. Divorcé(e) <input type="checkbox"/> 5. Séparé(e)	
14. Numéro d'assurance sociale		15. Numéro d'assurance maladie			
16. Nom de famille et prénom du père de la personne décédée			17. Nom de famille et prénom de la mère de la personne décédée		

REMPLEZ CETTE SECTION SEULEMENT SI LA PERSONNE DÉCÉDÉE ÉTAIT MARIÉE, SÉPARÉE OU UNIE CIVILEMENT.

18. Lieu du dernier mariage ou de l'union civile (nom du lieu de culte, de la municipalité et du district judiciaire)			19. Date du mariage ou de l'union civile Année Mois Jour		
Identification du conjoint de la personne décédée (Inscrire le nom de famille et le ou les prénoms selon l'acte de naissance.)					
20. Nom de famille		21. Prénom usuel et autres prénoms		22. Sexe du conjoint <input type="checkbox"/> 1. Masculin <input type="checkbox"/> 2. Féminin	
23. Date de naissance Année Mois Jour		24. Lieu de naissance (municipalité, province ou pays)			
25. Lieu d'inscription de la naissance (lieu de culte, municipalité, province ou pays)					
26. Numéro d'assurance sociale		27. Numéro d'assurance maladie			
28. Nom de famille et prénom du père du conjoint			29. Nom de famille et prénom de la mère du conjoint		

IDENTIFICATION ET SIGNATURE DU DÉCLARANT (Inscrire le nom de famille et le prénom usuel selon l'acte de naissance.)

30. Nom de famille		31. Prénom usuel		32. Ind. régional N° de téléphone (travail)	
33. Adresse du domicile (n°, rue, municipalité, province ou pays)				34. Ind. régional N° de téléphone (domicile)	
Code postal		35. Qualité du déclarant <input type="checkbox"/> 1. Conjoint <input type="checkbox"/> 3. Allié <input type="checkbox"/> 2. Proche parent <input type="checkbox"/> 4. Autre (préciser)		36. Carte d'assurance maladie remise <input type="checkbox"/> Oui <input type="checkbox"/> Non	
37. Le Directeur de l'état civil communique les renseignements rajoutés au décès aux organismes inscrits au verso de la copie DÉCLARANT aux fins qui y sont mentionnées.			38. Signature du déclarant X		39. Date de la signature Année Mois Jour

DISPOSITION DU CORPS

40. Mode de disposition du corps <input type="checkbox"/> 1. Inhumation <input type="checkbox"/> 3. Étude anatomique <input type="checkbox"/> 2. Crémation <input type="checkbox"/> 4. Autre (préciser)		41. N° de permis du directeur de funérailles		42. Date de disposition du corps Année Mois Jour	
43. Lieu de disposition du corps (Indiquer le nom du cimetière, du crématorium ou autre.)				44. N° du constat	
45. Adresse du cimetière ou du crématorium (n°, rue, municipalité, province ou pays)				46. N° de téléphone du directeur de funérailles	
47. Nom du directeur de funérailles ou de son représentant (en lettres moulées)			48. Signature du directeur de funérailles ou de son représentant		

IDENTIFICATION ET ATTESTATION DU TÉMOIN (Inscrire le nom de famille et le ou les prénoms selon l'acte de naissance.)

J'atteste que la déclaration a été faite et signée devant moi et, qu'à ma connaissance, les renseignements donnés ci-dessus sont exacts.		49. Nom de famille		50. Prénom usuel	
X		51. Signature du témoin		52. Date de la signature Année Mois Jour	

SECTION RÉSERVÉE À L'USAGE EXCLUSIF DU DIRECTEUR DE L'ÉTAT CIVIL (Ne pas écrire dans cette section.)

53. N° d'inscription de l'acte de naissance de la personne décédée		54. N° d'inscription de l'acte de mariage ou d'union civile de la personne décédée			
55. Signature du Directeur de l'état civil		56. Date de la signature Année Mois Jour		57. N° d'inscription	
58. Mentions					

Bien vouloir remplir le formulaire en lettres moulées avec un stylo ou à la machine à écrire. Appuyer fortement.

LIEU DU DÉCÈS

1. Nom de l'installation où a eu lieu le décès

2. Code d'installation

3. Adresse de l'endroit où a eu lieu le décès (n°, rue, municipalité, province ou pays)

Code postal

IDENTIFICATION DE LA PERSONNE DÉCÉDÉE (Inscrire le nom de famille et le(s) prénom(s) selon l'acte de naissance)

4. Nom de famille

5. Prénom usuel

6. N° d'assurance maladie

7. Date de naissance

8. Âge au décès

9. État matrimonial

10. Lieu de naissance (province ou pays)

11. Langue d'usage à la maison

12. Nom du (de la) conjoint (e) de la personne décédée

13. Si la personne décédée était mariée, indiquer l'âge de son (sa) conjoint (e)

14. Adresse du domicile de la personne décédée

15. Nom de famille de la mère (selon acte de naissance)

16. Prénom usuel de la mère

17. Nom de famille du père

18. Prénom usuel du père

CERTIFICATION MÉDICALE DU DÉCÈS

19. Date et heure du décès

20. Sexe de la personne décédée

21. Avis au coroner (voir l'acte de décès au verso de la copie 1)

22. Causes du décès

23. Y a-t-il eu autopsie?

24. Présence de radio-isotopes

25. S'il s'agit d'une femme, le décès est-il survenu au cours d'une grossesse ou dans les 42 jours?

26. Si mort violente, cocher À DES FINS STATISTIQUES SEULEMENT

27. Personne décédée atteinte d'une maladie à déclaration obligatoire

28. Lieu (ferme, usine, etc.) et circonstances (noyade, strangulation, etc.)

29. Qualité de l'auteur de la certification médicale

30. Nom de famille et prénom usuel de l'auteur de la certification médicale

31. N° de téléphone où l'auteur peut être rejoint

32. Adresse (n°, rue, municipalité, province)

J'ai rédigé au meilleur de ma connaissance les causes et les circonstances du décès de cette personne. Les renseignements colligés sont transmis à l'Institut de la statistique du Québec, au ministère de la Santé et des Services sociaux, au directeur de funérailles, à Statistique Canada, au Directeur de l'état civil ainsi qu'aux autorités responsables des données de l'état civil de la province de résidence de la personne décédée s'il y a lieu. Les renseignements transmis sont soumis aux conditions de la Loi sur l'accès aux documents des organismes publics et sur la protection des renseignements personnels, sauf en ce qui concerne le Directeur de l'état civil et l'autorité responsable des données civiles de la province de résidence de la personne décédée s'il y a lieu qui ne sont pas assujettis à cette loi. Les conditions sont énumérées au verso de la page 2.

33. Signature de l'auteur de la certification médicale

34. Date de la signature

35. Si médecin, n° de permis de la Corp. des médecins

DISPOSITION DU CORPS / DIRECTEUR DE FUNÉRAILLES

36. Mode de disposition

37. Nom de la maison funéraire

38. N° de permis (dir. de funérailles)

39. Adresse de la maison funéraire (n°, rue, municipalité, province ou pays)

40. Date de la prise en charge

41. Nom et prénom du représentant de la maison funéraire

42. Signature du représentant

CHAPITRE III DROITS ET OBLIGATIONS

SECTION I LE TRAVAILLEUR

§ 3. — *Retrait préventif*

Travailleur exposé à un contaminant.

32. Un travailleur qui fournit à l'employeur un certificat attestant que son exposition à un contaminant comporte pour lui des dangers, eu égard au fait que sa santé présente des signes d'altération, peut demander d'être affecté à des tâches ne comportant pas une telle exposition et qu'il est raisonnablement en mesure d'accomplir, jusqu'à ce que son état de santé lui permette de réintégrer ses fonctions antérieures et que les conditions de son travail soient conformes aux normes établies par règlement pour ce contaminant.

Certificat du médecin responsable.

33. Le certificat visé dans l'article 32 peut être délivré par le médecin responsable des services de santé de l'établissement dans lequel travaille le travailleur ou par un autre médecin.

Avis au médecin du travailleur.

Si le certificat est délivré par le médecin responsable, celui-ci doit, à la demande du travailleur, aviser le médecin qu'il désigne.

Consultation entre médecins.

S'il est délivré par un autre médecin que le médecin responsable, ce médecin doit consulter, avant de délivrer le certificat, le médecin responsable ou, à défaut, le directeur de santé publique de la région dans laquelle se trouve l'établissement, ou le médecin que ce dernier désigne.

§ 4. — *Retrait préventif de la travailleuse enceinte*

Travailleuse enceinte.

40. Une travailleuse enceinte qui fournit à l'employeur un certificat attestant que les conditions de son travail comportent des dangers physiques pour l'enfant à naître ou, à cause de son état de grossesse, pour elle-même, peut demander d'être affectée à des tâches ne comportant pas de tels dangers et qu'elle est raisonnablement en mesure d'accomplir.

Certificat.

La forme et la teneur de ce certificat sont déterminées par règlement et l'article 33 s'applique à sa délivrance.

Dangers pour l'allaitement de l'enfant.

46. Une travailleuse qui fournit à l'employeur un certificat attestant que les conditions de son travail comportent des dangers pour l'enfant qu'elle allaite peut demander d'être affectée à des tâches ne comportant pas de tels dangers et qu'elle est raisonnablement en mesure d'accomplir.

Certificat.

La forme et la teneur de ce certificat sont déterminées par règlement et l'article 33 s'applique à sa délivrance.

CHAPITRE III INDEMNITÉS

SECTION IV AUTRES INDEMNITÉS

Frais de déplacements.

115. La Commission rembourse, sur production de pièces justificatives, au travailleur et, si son état physique le requiert, à la personne qui doit l'accompagner, les frais de déplacement et de séjour engagés pour recevoir des soins, subir des examens médicaux ou accomplir une activité dans le cadre de son plan individualisé de réadaptation, selon les normes et les montants qu'elle détermine et qu'elle publie à la Gazette officielle du Québec.

CHAPITRE V ASSISTANCE MÉDICALE

Paiements par la Régie de l'assurance maladie.

196. Les services rendus par les professionnels de la santé dans le cadre de la présente loi et visés dans le quatorzième alinéa de l'article 3 de la Loi sur l'assurance maladie (chapitre A-29), édicté par l'article 488, y compris ceux d'un membre du Bureau d'évaluation médicale, d'un comité des maladies professionnelles pulmonaires ou d'un comité spécial agissant en vertu du chapitre VI, à l'exception des services rendus par un professionnel de la santé à la demande de l'employeur, sont payés à ces professionnels par la Régie de l'assurance maladie du Québec conformément aux ententes intervenues dans le cadre de l'article 19 de la Loi sur l'assurance maladie.

CHAPITRE VI PROCÉDURE D'ÉVALUATION MÉDICALE

SECTION I DISPOSITIONS GÉNÉRALES

Diagnostic.

199. Le médecin qui, le premier, prend charge d'un travailleur victime d'une lésion professionnelle doit remettre sans délai à celui-ci, sur le formulaire prescrit par la Commission, une attestation comportant le diagnostic et:

1° s'il prévoit que la lésion professionnelle du travailleur sera consolidée dans les 14 jours complets suivant la date où il est devenu incapable d'exercer son emploi en raison de sa lésion, la date prévisible de consolidation de cette lésion; ou

2° s'il prévoit que la lésion professionnelle du travailleur sera consolidée plus de 14 jours complets après la date où il est devenu incapable d'exercer son emploi en raison de sa lésion, la période prévisible de consolidation de cette lésion.

Choix du médecin.

Cependant, si le travailleur n'est pas en mesure de choisir le médecin qui, le premier, en prend charge, il peut, aussitôt qu'il est en mesure de le faire, choisir un autre médecin qui en aura charge et qui doit alors, à la demande du travailleur, lui remettre l'attestation prévue par le premier alinéa.

Rapport sommaire.

200. Dans le cas prévu par le paragraphe 2° du premier alinéa de l'article 199, le médecin qui a charge du travailleur doit de plus expédier à la Commission, dans les six jours de son premier examen, sur le formulaire qu'elle prescrit, un rapport sommaire comportant notamment:

- 1° la date de l'accident du travail;
- 2° le diagnostic principal et les renseignements complémentaires pertinents;
- 3° la période prévisible de consolidation de la lésion professionnelle;
- 4° le fait que le travailleur est en attente de traitements de physiothérapie ou d'ergothérapie ou en attente d'hospitalisation ou le fait qu'il reçoit de tels traitements ou qu'il est hospitalisé;
- 5° dans la mesure où il peut se prononcer à cet égard, la possibilité que des séquelles permanentes subsistent.

Rapport sommaire.

Il en est de même pour tout médecin qui en aura charge subséquemment.

Information à la Commission.

201. Si l'évolution de la pathologie du travailleur modifie de façon significative la nature ou la durée des soins ou des traitements prescrits ou administrés, le médecin qui a charge du travailleur en informe la Commission immédiatement, sur le formulaire qu'elle prescrit à cette fin.

Rapport à la Commission.

202. Dans les 10 jours de la réception d'une demande de la Commission à cet effet, le médecin qui a charge du travailleur doit fournir à la Commission, sur le formulaire qu'elle prescrit, un rapport qui comporte les précisions qu'elle requiert sur un ou plusieurs des sujets mentionnés aux paragraphes 1° à 5° du premier alinéa de l'article 212.

Rapport final.

203. Dans le cas du paragraphe 1° du premier alinéa de l'article 199, si le travailleur a subi une atteinte permanente à son intégrité physique ou psychique, et dans le cas du paragraphe 2° du premier alinéa de cet article, le médecin qui a charge du travailleur expédie à la Commission, dès que la lésion professionnelle de celui-ci est consolidée, un rapport final, sur un formulaire qu'elle prescrit à cette fin.

Contenu.

Ce rapport indique notamment la date de consolidation de la lésion et, le cas échéant:

- 1° le pourcentage d'atteinte permanente à l'intégrité physique ou psychique du travailleur d'après le barème des indemnités pour préjudice corporel adopté par règlement;
- 2° la description des limitations fonctionnelles du travailleur résultant de sa lésion;
- 3° l'aggravation des limitations fonctionnelles antérieures à celles qui résultent de la lésion.

Information au travailleur.

Le médecin qui a charge du travailleur l'informe sans délai du contenu de son rapport.

Désignation du professionnel.

204. La Commission peut exiger d'un travailleur victime d'une lésion professionnelle qu'il se soumette à l'examen du professionnel de la santé qu'elle désigne, pour obtenir un rapport écrit de celui-ci sur toute question relative à la lésion. Le travailleur doit se soumettre à cet examen.

Paiement par la Commission.

La Commission assume le coût de cet examen et les dépenses qu'engage le travailleur pour s'y rendre selon les normes et les montants qu'elle détermine en vertu de l'article 115.

Approbation de la liste.

205. La liste des professionnels de la santé que la Commission peut désigner aux fins de l'article 204 est soumise annuellement à l'approbation du conseil d'administration de la Commission, qui peut y ajouter ou y retrancher des noms.

Défaut.

À défaut par celui-ci d'approuver la liste à la séance suivant celle où elle est déposée, la Commission utilise la liste qui a été déposée.

Nombre insuffisant.

Le président du conseil d'administration et chef de la direction peut ajouter à la liste visée au premier ou au deuxième alinéa les noms de professionnels de la santé, autres que ceux qui ont été retranchés par le conseil d'administration, lorsqu'il estime que leur nombre est insuffisant. Dans ce cas, il en informe le conseil d'administration.

Liste en vigueur.

La liste des professionnels de la santé que la Commission peut désigner aux fins de l'article 204 pour une année reste en vigueur jusqu'à ce qu'elle soit remplacée.

Rapport complémentaire.

205.1. Si le rapport du professionnel de la santé désigné aux fins de l'application de l'article 204 infirme les conclusions du médecin qui a charge du travailleur quant à l'un ou plusieurs des sujets mentionnés aux paragraphes 1° à 5° du premier alinéa de l'article 212, ce dernier peut, dans les 30 jours de la date de la réception de ce rapport, fournir à la Commission, sur le formulaire qu'elle prescrit, un rapport complémentaire en vue d'étayer ses conclusions et, le cas échéant, y joindre un rapport de consultation motivé. Le médecin qui a charge du travailleur informe celui-ci, sans délai, du contenu de son rapport.

Transmission au Bureau d'évaluation.

La Commission peut soumettre ces rapports, incluant, le cas échéant, le rapport complémentaire au Bureau d'évaluation médicale prévu à l'article 216.

Transmission du rapport.

206. La Commission peut soumettre au Bureau d'évaluation médicale le rapport qu'elle a obtenu en vertu de l'article 204, même si ce rapport porte sur l'un ou plusieurs des sujets mentionnés aux paragraphes 1° à 5° du premier alinéa de l'article 212 sur lequel le médecin qui a charge du travailleur ne s'est pas prononcé.

Perte de la rémunération.

207. Malgré l'article 22 de la Loi sur l'assurance maladie (chapitre A-29), le médecin qui fait défaut de fournir une attestation ou un rapport dans le délai prescrit, perd le droit d'être rémunéré pour l'examen médical qui aurait dû donner lieu à cette attestation ou à ce rapport.

Refus de paiement.

La Régie de l'assurance maladie du Québec, sur réception d'un avis de la Commission établissant le défaut, refuse le paiement de tel examen médical ou se rembourse par compensation ou autrement, selon le cas.

CHAPITRE VI PROCÉDURE D'ÉVALUATION MÉDICALE

SECTION I DISPOSITIONS GÉNÉRALES

Contestation par l'employeur.

212. L'employeur qui a droit d'accès au dossier que la Commission possède au sujet d'une lésion professionnelle dont a été victime un travailleur peut contester l'attestation ou le rapport du médecin qui a charge du travailleur, s'il obtient un rapport d'un professionnel de la santé qui, après avoir examiné le travailleur, infirme les conclusions de ce médecin quant à l'un ou plusieurs des sujets suivants:

- 1° le diagnostic;
- 2° la date ou la période prévisible de consolidation de la lésion;
- 3° la nature, la nécessité, la suffisance ou la durée des soins ou des traitements administrés ou prescrits;
- 4° l'existence ou le pourcentage d'atteinte permanente à l'intégrité physique ou psychique du travailleur;
- 5° l'existence ou l'évaluation des limitations fonctionnelles du travailleur.

Rapport à la Commission.

L'employeur transmet copie de ce rapport à la Commission dans les 30 jours de la date de la réception de l'attestation ou du rapport qu'il désire contester.

Bureau d'évaluation médicale.

216. Est institué le Bureau d'évaluation médicale.

Liste des professionnels.

Sur recommandation des ordres professionnels concernés, le Conseil consultatif du travail et de la main-d'oeuvre soumet annuellement au ministre, avant le 15 mars, une liste des professionnels de la santé qui acceptent d'agir comme membres de ce Bureau.

Ajout à la liste.

Le ministre peut ajouter à cette liste le nom d'autres professionnels de la santé.

Défaut.

À défaut par le Conseil consultatif de soumettre cette liste, le ministre la dresse lui-même.

Liste en vigueur.

La liste des professionnels de la santé qui acceptent d'agir comme membres de ce Bureau pour une année reste en vigueur jusqu'à ce qu'elle soit remplacée.

LOI SUR LES SERVICES DE SANTÉ ET LES SERVICES SOCIAUX

PARTIE II

PRESTATION DES SERVICES DE SANTÉ ET DES SERVICES SOCIAUX

TITRE I.1

LES CENTRES MÉDICAUX SPÉCIALISÉS

CHAPITRE IV

RÈGLES APPLICABLES AUX ACTES CONSTITUTIFS DES ÉTABLISSEMENTS

SECTION V

DISSOLUTION

«Centre médical spécialisé».

333.1. Dans la présente loi, on entend par «centre médical spécialisé» un lieu aménagé hors d'une installation maintenue par un établissement aux fins de permettre à un ou plusieurs médecins de dispenser à leur clientèle les services médicaux nécessaires pour effectuer une arthroplastie-prothèse de la hanche ou du genou, une extraction de la cataracte avec implantation d'une lentille intra-oculaire ou tout autre traitement médical spécialisé déterminé par règlement du gouvernement.

Règlement.

Ce règlement peut préciser qu'une chirurgie visée au premier alinéa ou qu'un autre traitement médical spécialisé ainsi déterminé ne peut être dispensé que dans l'un des centres visés à l'article 333.3 et, dans le cas d'un centre visé au paragraphe 1° du premier alinéa de cet article, que dans le cadre d'une entente conclue en application de l'article 349.3.

Traitement médical spécialisé.

Aux fins de déterminer un traitement médical spécialisé, le gouvernement doit prendre en compte notamment les risques généralement associés à ce traitement, l'importance du personnel et de l'équipement nécessaires pour le dispenser de même que, le cas échéant, le type d'anesthésie normalement utilisé lors du traitement et la durée de l'hébergement habituellement requise à la suite de celui-ci.

Consultation.

Le gouvernement doit, avant de prendre un règlement en application du premier alinéa, consulter le Collège des médecins du Québec.

Traitement médical spécialisé.

333.1.1. Un traitement médical spécialisé non prévu à un règlement pris en application du premier alinéa de l'article 333.1 ne peut être fourni que par un établissement qui exploite un centre hospitalier, lorsqu'il est effectué sous anesthésie générale ou sous anesthésie régionale du type tronculaire ou du type bloc à la racine d'un membre, excluant le bloc digital.

Exploitant.

333.2. Seul un médecin membre du Collège des médecins du Québec peut, comme personne physique, exploiter un centre médical spécialisé. Lorsque l'exploitant du centre est une personne morale ou une société, plus de 50% des droits de vote rattachés aux actions ou aux parts de cette personne morale ou de cette société doivent être détenus:

1° soit par des médecins membres de cet ordre professionnel;

2° soit par une personne morale ou société dont les droits de vote rattachés aux actions ou aux parts sont détenus en totalité:

a) par des médecins visés au paragraphe 1°; ou

b) par une autre personne morale ou société dont les droits de vote rattachés aux actions ou aux parts sont détenus en totalité par de tels médecins;

3° soit à la fois par des médecins visés au paragraphe 1° et une personne morale ou société visée au paragraphe 2°.

Conseil d'administration.

Les affaires d'une personne morale ou d'une société qui exploite un centre médical spécialisé doivent être administrées par un conseil d'administration ou un conseil de gestion interne, selon le cas, formé en majorité de médecins qui exercent leur profession dans le centre; ces médecins doivent en tout temps constituer la majorité du quorum d'un tel conseil.

Convention d'actionnaires.

Les actionnaires d'une personne morale ou les associés d'une société qui exploite un centre médical spécialisé ne peuvent, par convention, restreindre le pouvoir des administrateurs de cette personne morale ou de cette société.

Interdiction.

Le producteur ou le distributeur d'un bien ou d'un service relié au domaine de la santé et des services sociaux, autre qu'un médecin visé au premier alinéa, ne peut détenir, directement ou indirectement, d'actions du capital-actions d'une personne morale exploitant un centre médical spécialisé ou de parts d'une société exploitant un tel centre si un tel bien ou un tel service peut être requis par la clientèle du centre avant la dispensation d'un service médical, lors de sa dispensation ou à la suite de celle-ci.

Forme d'exploitation.

333.3. Un centre médical spécialisé ne peut être exploité que suivant l'une ou l'autre des formes suivantes:

1° un centre médical spécialisé où exercent exclusivement des médecins soumis à l'application d'une entente conclue en vertu de l'article 19 de la Loi sur l'assurance maladie (chapitre A-29);

2° un centre médical spécialisé où exercent exclusivement des médecins non participants au sens de cette dernière loi.

Respect des exigences.

L'exploitant d'un centre médical spécialisé doit, selon la forme sous laquelle le centre est exploité, s'assurer du respect des exigences prévues au paragraphe 1° ou 2° du premier alinéa.

Agrément.

333.4. L'exploitant d'un centre médical spécialisé doit, dans un délai de trois ans à compter de la délivrance du permis requis en application de l'article 437, obtenir l'agrément des services qui sont dispensés dans le centre auprès d'un organisme d'agrément reconnu par le ministre. Il doit conserver cet agrément en tout temps par la suite.

Standards de qualité et de sécurité.

333.4.1. L'exploitant d'un centre médical spécialisé doit s'assurer que les services médicaux dispensés dans ce centre respectent les standards de qualité et de sécurité généralement reconnus.

Directeur médical.

333.5. L'exploitant d'un centre médical spécialisé doit nommer un directeur médical. Ce dernier doit être choisi parmi les médecins qui y exercent leur profession.

Responsabilités.

Sous l'autorité de l'exploitant, le directeur médical est responsable:

1° d'organiser les services médicaux dispensés dans le centre;

2° de s'assurer de la qualité et de la sécurité de ces services;

3° de voir à la mise en place et au respect de procédures médicales normalisées pour toute chirurgie ou tout autre traitement médical spécialisé dispensé dans le centre;

4° de prendre toute autre mesure nécessaire au bon fonctionnement du centre.

Services préopératoires et postopératoires.

333.6. L'exploitant d'un centre médical spécialisé visé au paragraphe 2° du premier alinéa de l'article 333.3 doit offrir aux personnes qui y reçoivent une chirurgie ou un autre traitement médical spécialisé visé à l'article 333.1, soit directement, soit par l'intermédiaire d'une autre ressource privée avec laquelle il a conclu une entente et vers laquelle il dirige ces personnes, tous les services préopératoires et postopératoires normalement associés à cette chirurgie ou à cet autre traitement médical spécialisé, à l'exclusion des complications, de même que tous les services de réadaptation et de soutien à domicile nécessaires à leur complet rétablissement. L'exploitant du centre doit informer toute personne qui désire y recevoir une telle chirurgie ou un tel traitement médical spécialisé qu'elle doit obtenir ces services préopératoires, postopératoires, de réadaptation et de soutien à domicile dans le centre ou auprès d'une autre ressource privée. L'exploitant du centre doit également informer cette personne de l'ensemble des coûts prévisibles des services préopératoires, postopératoires, de réadaptation et de soutien à domicile qu'elle devra obtenir dans le centre ou auprès de cette autre ressource privée.

Traitements médicaux non assurés.

Les obligations prévues au premier alinéa s'appliquent également à l'exploitant d'un centre médical spécialisé visé au paragraphe 1° du premier alinéa de l'article 333.3 à l'égard des traitements médicaux spécialisés visés à l'article 333.1 et dispensés dans ce centre qui sont non assurés ou considérés comme non assurés en vertu de la Loi sur l'assurance maladie (chapitre A-29).

Ressource privée.

Le coût des services médicaux obtenus auprès d'une ressource privée en application du premier ou du deuxième alinéa ne peut être assumé par la Régie de l'assurance maladie du Québec.

Obligations non applicables.

Toutefois, lorsqu'une chirurgie ou un autre traitement médical spécialisé est dispensé dans le cadre d'une entente visée au deuxième alinéa de l'article 108 ou d'un mécanisme particulier d'accès mis en place en application de l'article 431.2, le ministre peut permettre que les obligations prévues au présent article ne s'appliquent pas.

Services médicaux dispensés.

333.7. Seuls les services médicaux suivants peuvent être dispensés dans un centre médical spécialisé:

1° les services médicaux nécessaires pour effectuer une chirurgie ou un autre traitement médical spécialisé visé à l'article 333.1 et indiqué au permis délivré à l'exploitant du centre médical spécialisé en application de l'article 441;

2° ceux visés à l'article 333.6 et qui sont associés à une telle chirurgie ou à un tel traitement médical spécialisé;

3° ceux qui correspondent aux activités permises en cabinet privé de professionnel.

Respect du premier alinéa.

L'exploitant d'un centre médical spécialisé doit s'assurer du respect du premier alinéa.

Rapport d'activités.

333.7.1. L'exploitant d'un centre médical spécialisé doit, au plus tard le 31 mars de chaque année, transmettre au ministre et à l'agence de son territoire un rapport de ses activités pour l'année civile précédente. Ce rapport indique le nom du directeur médical, celui des médecins omnipraticiens et des médecins spécialistes, par spécialité, qui y ont exercé leur profession, le nombre de traitements médicaux spécialisés qui y ont été dispensés, pour chaque traitement indiqué au permis, ainsi que tout autre renseignement requis par le ministre.

Confidentialité.

Les renseignements ainsi fournis ne doivent pas permettre d'identifier la clientèle du centre.

Avis.

333.8. Le ministre peut demander au Conseil d'administration d'un ordre professionnel un avis sur la qualité et la sécurité des services professionnels dispensés par les membres de cet ordre dans un centre médical spécialisé.

Avis.

Le ministre peut également requérir du Conseil d'administration d'un ordre professionnel un avis sur les normes à suivre pour relever le niveau de qualité et de sécurité des services professionnels dispensés par les membres de cet ordre dans un tel centre.

PARTIE III

COORDINATION, SURVEILLANCE ET RÉGLEMENTATION DES SERVICES DE SANTÉ ET DES SERVICES SOCIAUX

TITRE I

LES INSTITUTIONS RÉGIONALES

CHAPITRE I

LES AGENCES DE LA SANTÉ ET DES SERVICES SOCIAUX

SECTION II

FONCTIONS PARTICULIÈRES

§ 3.1. — Fonctions reliées aux services des *cliniques médicales associées*

Proposition d'une agence.

349.1. Dans le but d'améliorer l'accessibilité aux services médicaux spécialisés et après consultation de la table régionale des chefs de département de médecine spécialisée, une agence peut proposer au ministre qu'un établissement de sa région qui exploite un centre hospitalier et qui y consent puisse s'associer à l'exploitant de l'un des lieux suivants afin que soient dispensés dans ce lieu certains services médicaux spécialisés aux usagers de cet établissement:

1° un cabinet privé de professionnel;

2° un laboratoire visé par la Loi sur les laboratoires médicaux, la conservation des organes, des tissus, des gamètes et des embryons et la disposition des cadavres (chapitre L-0.2);

3° un centre médical spécialisé visé au paragraphe 1° du premier alinéa de l'article 333.3.

«clinique médicale associée».

Pour l'application de la présente sous-section, l'un ou l'autre des lieux mentionnés au premier alinéa est indistinctement nommé «clinique médicale associée».

Avis du ministre.

349.2. Avant d'accepter la proposition de l'agence, le ministre doit être d'avis qu'elle est de nature à améliorer l'accessibilité aux services médicaux spécialisés concernés et qu'elle n'affectera pas la capacité de production du réseau public de santé et de services sociaux, notamment en regard de la main-d'oeuvre requise pour le fonctionnement de ce réseau. Il est également tenu de prendre en compte les gains d'efficience et d'efficacité conséquents à la mise en oeuvre de cette proposition.

Procédure.

La décision du ministre d'accepter la proposition de l'agence doit préciser la procédure qui devra être suivie par l'agence pour déterminer la clinique médicale associée offrant des services médicaux spécialisés selon le meilleur rapport qualité/coût.

Disposition applicable.

Le deuxième alinéa s'applique malgré la Loi sur les contrats des organismes publics (chapitre C-65.1).

Entente.

349.3. L'agence et tout établissement concerné par la proposition doivent, au terme de la procédure visée au deuxième alinéa de l'article 349.2 et après avoir obtenu l'autorisation du ministre, conclure une entente avec l'exploitant de la clinique médicale associée retenue. Cette entente doit prévoir les éléments suivants:

1° la nature des services médicaux spécialisés devant être dispensés dans le cadre de l'entente;

2° les nombres minimal et maximal de services médicaux spécialisés pouvant être dispensés annuellement dans la clinique de même que la répartition trimestrielle de ces services requise pour assurer la disponibilité continue de ceux-ci;

3° le montant unitaire versé par l'agence pour couvrir les frais reliés à chaque service médical spécialisé dispensé dans la clinique, selon sa nature, ainsi que les modalités de versement de ce montant;

4° des mécanismes de surveillance permettant à l'établissement, ou à l'un de ses conseils ou comités déterminé dans l'entente, de s'assurer de la qualité et de la sécurité des services médicaux dispensés dans la clinique;

5° les sommes, déterminées conformément à l'article 349.6, qui peuvent être exigées d'un usager qui obtient un service médical spécialisé dans la clinique et les modalités d'information de l'usager à l'égard du paiement de ces sommes;

6° les exigences en matière de tenue de livres et de systèmes d'information auxquelles l'exploitant de la clinique devra se conformer ainsi que la nature, la forme, le contenu et la périodicité des rapports et des informations qu'il devra transmettre aux autres parties signataires et au ministre;

7° un mécanisme de règlement des différends portant sur l'interprétation ou l'application de l'entente.

Procédure d'examen des plaintes.

Les services faisant l'objet de l'entente sont soumis, selon le cas, à la procédure d'examen des plaintes de l'établissement qui dirige l'usager vers la clinique médicale associée ou à celle de l'agence, de même qu'aux dispositions de la Loi sur le Protecteur des usagers en matière de santé et de services sociaux (chapitre P-31.1).

Durée maximale de l'entente.

L'entente a une durée maximale de cinq ans. Les parties ne peuvent y mettre fin avant l'arrivée du terme, la modifier ou la renouveler sans l'autorisation du ministre. Dans ce dernier cas, un projet de renouvellement d'entente doit être transmis au ministre au moins six mois avant l'arrivée du terme de l'entente.

Communication de renseignements.

Un établissement partie à l'entente peut communiquer un renseignement contenu au dossier d'un usager à un médecin qui dispense, dans la clinique, des services médicaux spécialisés prévus à l'entente si la communication de ce renseignement est nécessaire pour assurer la dispensation de ces services. Malgré toute disposition inconciliable, ce médecin peut, une fois les services médicaux spécialisés dispensés, communiquer à cet établissement tout renseignement contenu au dossier de son patient et qui est nécessaire afin d'assurer la continuité des services par l'établissement.

Médecins.

349.4. Tous les médecins qui exercent leur profession dans une clinique médicale associée doivent être soumis à l'application d'une entente conclue en vertu de l'article 19 de la Loi sur l'assurance maladie (chapitre A-29).

Sommes réclamées.

349.5. Malgré l'article 22.0.0.1 de la Loi sur l'assurance maladie (chapitre A-29), les seules sommes d'argent qui peuvent être réclamées d'un usager qui obtient un service médical spécialisé dans une clinique médicale associée en application d'une entente sont celles qu'aurait normalement exigées l'établissement partie à l'entente à l'occasion de la dispensation de ces mêmes services, pourvu toutefois que ces sommes aient été prévues à l'entente.

Exigences.

349.6. Tout médecin qui dispense dans une clinique médicale associée des services médicaux spécialisés prévus dans une entente doit préalablement être titulaire d'une nomination lui permettant d'exercer sa profession dans un centre hospitalier exploité par un établissement auquel cette clinique est associée, satisfaire entièrement aux besoins du centre hospitalier selon l'appréciation faite par le directeur des services

professionnels et remplir en tout temps les obligations rattachées à la jouissance des privilèges qui lui sont accordés.

Obligation de l'exploitant.

L'exploitant d'une clinique médicale associée ne doit pas permettre qu'un médecin qui ne se conforme pas aux dispositions du présent article dispense dans cette clinique des services médicaux spécialisés prévus dans l'entente.

Liste de médecins.

349.7. Lors de la signature d'une entente, l'exploitant de la clinique médicale associée doit remettre à l'établissement signataire la liste des médecins membres du conseil des médecins, dentistes et pharmaciens de cet établissement qui y dispenseront des services médicaux spécialisés. L'exploitant de la clinique doit tenir cette liste à jour et informer sans retard le directeur général de l'établissement de toute modification qui y est apportée.

Communication de la liste.

Le directeur général s'assure que la liste est remise aux membres du conseil d'administration et les informe de tout changement qui y est apporté.

Pouvoir de mettre fin à une entente.

349.8. Malgré le troisième alinéa de l'article 349.3, une agence peut mettre fin à une entente lorsqu'elle a des motifs raisonnables de croire que la qualité ou la sécurité des services médicaux spécialisés dispensés dans la clinique médicale associée n'est pas satisfaisante ou que l'exploitant d'une clinique médicale associée ou un médecin qui y exerce sa profession ne se conforme pas aux dispositions de l'un des articles 349.4 à 349.7.

Demande du ministre.

Le ministre peut demander à l'agence de mettre fin à l'entente lorsqu'il a des motifs raisonnables de croire qu'une situation visée au premier alinéa se produit.

Observations.

Avant de mettre fin à l'entente, l'agence doit donner à l'établissement et à l'exploitant de la clinique médicale associée l'occasion de présenter leurs observations par écrit.

Objet de l'entente.

349.9. Malgré les dispositions de la Loi sur l'assurance maladie (chapitre A-29), l'entente visée à l'article 349.3 peut avoir pour objet des services assurés considérés comme non assurés lorsque rendus hors d'une installation maintenue par un établissement si l'agence estime qu'il existe des difficultés d'accès à ces services auprès des établissements de sa région.

Présomption.

En outre, les services dispensés par un médecin dans le cadre de l'entente visée à l'article 349.3 sont réputés, aux seules fins de la rémunération de ce médecin, rendus dans l'installation de l'établissement qui dirige l'usager vers la clinique médicale associée.

RÈGLEMENT SUR LES TRAITEMENTS MÉDICAUX SPÉCIALISÉS DISPENSÉS DANS UN CENTRE MÉDICAL SPÉCIALISÉ

1. Pour l'application de l'article 333.1 de la *Loi sur les services de santé et les services sociaux* (L.R.Q., c. S-4.2), constitue un traitement médical spécialisé:

1° tout traitement mentionné à la partie I de l'annexe, quel que soit le type d'anesthésie utilisé lors de ce traitement;

2° tout traitement mentionné à la partie II de l'annexe, lorsque dispensé sous anesthésie générale ou sous anesthésie régionale du type tronculaire ou du type bloc à la racine d'un membre, excluant le bloc digital;

3° (*paragraphe abrogé*).

2. À moins d'être dispensé dans une installation maintenue par un établissement dans le cadre de sa mission, un traitement médical spécialisé ne peut être effectué ailleurs que dans un centre médical spécialisé et que dans la seule mesure où il est indiqué expressément au permis qui lui est délivré conformément à l'article 437 de la Loi.

3. Un traitement médical spécialisé dont la durée d'hébergement postopératoire habituellement requise est de plus de 24 heures de même que l'arthroplastie-prothèse de la hanche ou du genou ne peuvent être dispensés que dans un centre médical spécialisé visé au paragraphe 2 du premier alinéa de l'article 333.3 de la Loi.

4. Le présent règlement entre en vigueur le 31 mars 2010.

ANNEXE

PARTIE I

LISTE DES TRAITEMENTS MÉDICAUX SPÉCIALISÉS DISPENSÉS SANS ÉGARD AU TYPE D'ANESTHÉSIE UTILISÉ

1° Chirurgies esthétiques:

1.1 Liposuccion

1.2 Lipoinjection

2° Chirurgies gynécologiques: (*non en vigueur*)

2.1 Interruption de grossesse (*non en vigueur*)

PARTIE II

LISTE DES TRAITEMENTS MÉDICAUX SPÉCIALISÉS DISPENSÉS SOUS ANESTHÉSIE GÉNÉRALE OU SOUS ANESTHÉSIE RÉGIONALE DU TYPE TRONCULAIRE OU DU TYPE BLOC À LA RACINE D'UN MEMBRE, EXCLUANT LE BLOC DIGITAL

3° Chirurgies mammaires:

3.1 Mastectomie chez la femme et chez l'homme

3.2 Exérèse de prothèse/capsulectomie

3.3 Augmentation mammaire

3.4 Réduction mammaire

3.5 Autre reconstruction mammaire

4° Chirurgies esthétiques:

4.1 Lipectomie abdominale

4.2 Abdominoplastie/redrapage cutané autres régions

4.3 Rhytidectomie (modelage facial)

5° Chirurgies orthopédiques:

5.1 Chirurgie pour lésions bénignes des os, muscles, ligaments, tendons, bourses synoviales et fascias et arthroplastie d'hallux

5.2 Exérèse de fil, clou, plaque et vis

5.3 Arthrotomie ou arthroscopie diagnostique ou thérapeutique, excluant la colonne vertébrale

5.4 Chirurgie pour maladie de Dupuytren

5.5 Chirurgie pour tunnel carpien

5.6 Reconstruction ligamentaire du genou

5.7 Acromioplastie, reconstruction de la coiffe

6° Chirurgies des voies respiratoires supérieures:

6.1 Chirurgie du nez pour lésions bénignes ou troubles respiratoires

6.2 Rhinoplastie

6.3 Chirurgie des sinus

7° Chirurgies des systèmes vasculaire et lymphatique:

7.1 Ligature, section et exérèse pour varices

7.2 Excision de ganglions superficiels

8° Chirurgies du système digestif:

8.1 Chirurgie des lèvres, de la bouche et de la langue pour lésions bénignes ou précancéreuses

8.2 Chirurgie anorectale pour fissure, fistule, hémorroïdes ou prolapsus

8.3 Excision de glandes salivaires pour lésions bénignes

8.4 Laparoscopie diagnostique

8.5 Chirurgie herniaire

8.6 Chirurgie bariatrique

9° Chirurgies gynécologiques:

9.1 Exérèse de kystes, de tumeurs bénignes ou malignes

9.2 Plastie des petites et grandes lèvres

9.3 Cure de cystocèle toute voie d'approche, entéroçèle ou rectocèle

9.4 Ligature tubaire toute voie d'approche

9.5 Dilatation et curetage

9.6 Hystérocopie diagnostique et thérapeutique

9.7 Laparoscopie diagnostique et thérapeutique

9.8 Hystérectomie vaginale simple

9.9 Salpingo-ovariectomie ou ovariectomie toute voie d'approche

10° Chirurgies du système nerveux:

10.1 Chirurgie pour lésion ou réparation de nerfs périphériques

11° Chirurgies de l'appareil visuel:

11.1 Au laser

11.2 Kératectomie superficielle de la cornée

11.3 Exérèse de lésions cutanées de la paupière

11.4 Blépharoplastie

11.5 Tarsorrhaphie et séparation des paupières

11.6 Chirurgie pour strabisme

11.7 Chirurgie de la rétine

12° Chirurgies de l'appareil auditif:

12.1 Réparation d'oreilles décollées (prominauris)

13° Chirurgies à des fins de transsexualisme:

13.1 Vaginoplastie

13.2 Phalloplastie avec insertion de prothèse pénienne

13.3 Scrotoplastie avec insertion de prothèses testiculaires

14° Chirurgies cutanées:

14.1 Chirurgie pour abcès, tumeur, kyste, plaie, fistule superficielle ou profonde, glandes sudoripares, avec ou sans greffe, et débridement de plaie

14.2 Greffe

14.3 Correction chirurgicale ou au laser de cicatrices

14.4 Exérèse avec ou sans plastie de sinus pilonidal

15 ° Biopsies mammaires

ALDO-Québec

The 35 Medical Specialties in Québec

Anatomical-Pathology	Microbiology and Infectious Diseases
Anesthesiology	Nephrology
Cardiac Surgery	Neurology
Cardiology	Neurosurgery
Clinical Immunology and Allergy	Nuclear Medicine
Community Health	Obstetrics and Gynecology
Dermatology	Ophthalmology
Diagnostic Radiology	Orthopedic Surgery
Emergency Medicine	Otolaryngology
Endocrinology	Pediatrics
Gastroenterology	Physiatry
General Surgery	Plastic Surgery
Geriatric Medicine	Pneumology
Hematology	Psychiatry
Internal Medicine	Radiation Oncology
Medical Biochemistry	Rheumatology
Medical Genetics	Urology
Medical Oncology	