

# The College of Physicians and Surgeons of Ontario

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## Delegation of Controlled Acts

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### Purpose

Under Ontario law, certain acts (more fully described below) may only be performed by certain health care professionals. However, under appropriate circumstances, these acts may be delegated to others. The purpose of this policy is to assist physicians to understand when and how they may delegate controlled acts. Since delegation sometimes takes place by way of a medical directive, the policy also offers guidelines for the use of medical directives.

### Scope

This policy applies to all physicians, regardless of practice setting or type.

### Controlled Acts

The *Regulated Health Professions Act*, which has governed the medical profession since 1993, sets out a number of "controlled acts" which may only be performed by certain of the regulated health professionals. Of the 13 controlled acts, physicians are entitled to perform 12 and may, in appropriate circumstances, delegate the performance of those acts to other individuals who may or may not be members of a regulated health profession.

The controlled acts set out in the *Regulated Health Professions Act (RHPA)* are:

1. Communicating to the individual or his or her personal representative a diagnosis identifying a disease or disorder as the cause of the symptoms of the individual in circumstances in which it is reasonably foreseeable that the individual or his or her personal representative will rely on the diagnosis.
2. Performing a procedure on tissue below the dermis, below the surface of a mucous

membrane, in or below the surface of the cornea, or in or below the surfaces of the teeth, including the scaling of teeth.

3. Setting or casting a fracture of a bone or a dislocation of a joint.
4. Moving the joints of the spine beyond the individual's usual physiological range of motion using a fast, low amplitude thrust.
5. Administering a substance by injection or inhalation.
6. Putting an instrument, hand or finger,
  - i. beyond the external ear canal,
  - ii. beyond the point in the nasal passages where they normally narrow,
  - iii. beyond the larynx,
  - iv. beyond the opening of the urethra,
  - v. beyond the labia majora,
  - vi. beyond the anal verge, or
  - vii. into an artificial opening in the body.
7. Applying or ordering the application of a form of energy prescribed by the regulations under the *RHPA*.
8. Prescribing, dispensing, selling or compounding a drug as defined in clause 117(1) of the *Drug and Pharmacies Regulation Act*, or supervising the part of a pharmacy where such drugs are kept.
9. Prescribing or dispensing, for vision or eye problems, subnormal vision devices, contact lenses or eye glasses other than simple magnifiers.

10. Prescribing a hearing aid for a hearing impaired person.
11. Fitting or dispensing a dental prosthesis, orthodontic or periodontal appliance or device used inside the mouth to prevent the teeth from abnormal functioning.<sup>1</sup>
12. Managing labour or conducting the delivery of a baby.
13. Allergy challenge testing of a kind in which a positive result of the test is a significant allergic response.

## Emergency Situations

Although the *RHPA* prohibits performance of controlled acts by those not specifically authorized to perform them, it does not apply if the person performing the act is doing so to render first aid or temporary assistance in an emergency.<sup>2</sup> For example, if a passer-by sees someone in cardiac arrest in an airport and uses an automatic external defibrillator to assist him or her, there is no breach of the *RHPA*. Although applying a form of energy prescribed in the regulations is a controlled act under the *RHPA*, when it is done in an emergency it is not prohibited.

## Principles of Delegation

The vision of the College is to ensure the best quality care for the people of Ontario by the doctors of Ontario. In order to most effectively meet patient needs, health care is often delivered by multidisciplinary teams. When controlled acts are delegated in appropriate circumstances, this process can result in more timely delivery of quality health care, and can make optimal use of health-care resources and personnel. In every instance of delegation, the primary consideration should be the best interests of the patient. Responsibility for the delegation of the controlled act always remains with the delegating physician.

### Delegation may take place in one of two ways:

#### 1. Direct Orders

The direct order provides instructions from an individual physician to another health care provider or a group of health care providers. The order relates to only one patient and initiates a specific intervention or treatment to be delivered at a specific time. It may be verbal<sup>3</sup> (over the telephone or in person) or written.<sup>4</sup> A direct order always takes place after a physician-patient relationship has been established.<sup>5</sup>

#### 2. Medical Directives

Medical directives are blanket instructions by physicians (often more than one) to other health care providers. They pertain to any patient who meets the criteria set out in the medical directive. The medical directive contains the delegation and provides the authority to carry out the treatments,

interventions or procedures that are specified in the directive, providing that certain conditions and circumstances exist.<sup>6</sup> In most cases, medical directives are used to ensure that health care can be delivered without a physician's direct assessment of the patient or direct supervision. Their use is especially frequent in institutional settings.<sup>7</sup>

A medical directive must always be written and must comply with the principles set out in this policy. Guidelines about the use and development of medical directives are found in Appendix 1 to this policy. A prototype of a medical directive can be found at Appendix 2.

A more comprehensive guide and toolkit is posted on the Federation of Health Regulatory College of Ontario's (FHRCO) website. This guide was developed by a working group of FHRCO in 2006.

The toolkit provides templates for construction of Medical Directives, as well as explanations of how to establish the prerequisites. The templates will have the most direct application for large institutional settings, but anyone who wishes to establish a Directive (or to learn more about delegation) will find them helpful. Their use is not mandatory, but any physician who delegates a controlled act pursuant to a Medical Directive developed using these templates will be in compliance with the legislation and College policy and will be providing the very best quality of care to patients.

## Guidelines for Delegation

### 1. Physician-Patient Relationship

The overriding principle of delegation is that it must **usually** occur in the context of a physician-patient relationship. In all instances where a controlled act is delegated, the act remains the responsibility of the physician who authorized it. In most cases, delegation will only occur after the physician has interviewed the patient, performed an assessment, made recommendations, obtained an informed consent to proceed, and instituted a course of therapy.

In some instances, the patient's interests will best be served by having the performance of the controlled act take place prior to assessment by the physician: in a hospital emergency room, for example, where it is commonplace for some tests to be ordered by a nurse before a physician has seen the patient. In such circumstances, the delegation may take place pursuant to a physician's direct order (where the physician has previously met the patient or engages in a consultation with the health care professional who will perform the delegated act) or a medical directive.<sup>8</sup> When this happens, it is expected that a physician under whose authority the controlled act has been performed will meet and assess the patient as soon after it has been performed as possible.

The use of medical directives to authorize performance of a controlled act in advance of establishing a physician-patient relationship is intended to capture only those situations where it is in the patient's best interests to do so. It is not intended to capture situations where, for pecuniary or convenience reasons, a physician wishes to delegate a controlled act (for example, the delegation of Botox injections in the absence of a contemporaneous face to face assessment would not be endorsed by the College).

There remains a presumption that delegation is inappropriate in the absence of a physician-patient relationship, but in limited circumstances and only where the timely delivery of medically necessary treatment is required, delegation may occur absent a physician-patient relationship. In such circumstances, delegation may take place when:

1. the quality of the act undertaken through delegation is as safe and effective as if it had been performed by the physician;
2. without delegation, it will not be possible to deliver the required care in a timely fashion;
3. the quality assurance protocols set out elsewhere in the policy are in place; and
4. it is in the patient's best interests to deliver the care by way of delegation.<sup>9</sup>

Examples where the College has explicitly identified appropriate circumstances in which to delegate in the absence of a physician-patient relationship include:

the provision of care by paramedics under the direct control of base hospital physicians;<sup>10</sup>

the administration of primary care in remote and isolated regions of the province by registered nurses acting in expanded roles;

the provision of public health programs operated under the authority of a Medical Officer of Health, such as vaccinations; and

post-exposure prophylaxis following potential exposure to a blood borne pathogen or the provision of the hepatitis B vaccine in the context of occupational health medicine.

Absent an established physician-patient relationship, the delegation of controlled acts for cosmetic procedures is unacceptable.

## **2. Delegate only those acts that form part of your regular practice.**

The *RHPA* requires the physician to confine medical practice to those areas of medicine in which he or she is suitably trained and experienced. A physician must not delegate the performance of an act he or she is not competent to perform personally, and which does not form part of his or her regular practice and daily competency.

## **3. Identify the individual performing the act and be aware of his or her skills.**

### **i. Ensure the individual receiving the delegation has the appropriate knowledge, skill and judgement to perform the delegated act.**

The physician should be satisfied that the individual to whom the act is being delegated has the appropriate knowledge, skill and judgement to perform the delegated act. A physician must not delegate an act where there is a question as to the knowledge, skill and judgement of the delegate.

The College recognizes that in some cases the physician may not personally know the individual to whom he or she is delegating. For example, in a public hospital setting, the hospital employs the delegates (nurses, respiratory technicians, etc.) and the medical staff are not involved in the hiring process. In this case, it is the institution's responsibility to ensure that its employees have the requisite

knowledge, skill and judgement.

**ii. Check with the relevant regulatory body of other health professionals where applicable.**

Before delegating performance of any aspect of delivery of health care, the physician should first determine whether it is a controlled act. Where the individual to whom the act is being delegated is a member of a regulated health profession, the physician should ensure the delegation conforms to the regulations, policies and/or guidelines of that health profession. If it does not, the delegate will not be able to carry out the delegation. Where the physician knows that the delegate is not permitted to perform the controlled act, the physician must not delegate the act.

Because quality care is the primary concern physicians must not delegate the performance of a controlled act to a person whose certificate to practise any health profession is revoked or suspended by the governing body of his or her discipline at the time of the delegation.

Delegation of acts which are not controlled are not subject to concerns about regulations, policies and/or guidelines of other health professions. However, it would be inappropriate to delegate any act to a person whose certificate to practise has been revoked or suspended.

**4. Establish a process for delegation, or ensure that there is one in place, that includes education, ensuring the maintenance of competence in the performance of the delegated act, and providing the appropriate supports.**

**i. The physician should satisfy him or herself that the delegation is in the best interests of the patient.**

Patient care must not be compromised by the delegation.

**ii. Identify the risk involved in delegating the act.**

The physician must analyse the potential harm associated with the performance of the delegated act and be satisfied that delegating the act does not increase the risk to the patient. Some procedures in some circumstances carry such a high risk that only a physician should perform them. In such instances, the physician must not delegate.

**iii. Quality assurance**

If the particular act is routinely delegated (for example, in a hospital pursuant to a medical directive or in an office setting where staff roles include performance of medical acts), the physician must ensure there is ongoing monitoring and evaluation of the delegation. This would include ensuring the currency of the delegate's knowledge and skills and that there is an objective and regularly scheduled assessment of those skills. It would also include evaluating the delegation process itself to ensure that the process is safe and effective.<sup>11</sup>

**iv. Ensure appropriate resources and equipment are available.**

As part of the risk analysis undertaken to determine whether the act can be appropriately delegated, the physician will identify certain resources or equipment as necessary to reduce risk. The physician must ensure that such resources and equipment are available on site where the delegated procedure is being performed.

#### **v. Develop written documentation about the delegation process.**

The physician should ensure that there is appropriate documentation of all steps taken to meet the above guidelines. This documentation would be a key resource in answering any concerns or questions about the delegation process.

#### **5. Ensure delegation occurs with the informed consent of the patient where feasible.**

In instances where there is an established physician-patient relationship, physicians must ensure that patients provide informed consent<sup>12</sup> for performance of the act by a delegate, rather than the physician. In circumstances where the delegation takes place pursuant to a medical directive, the protocol for the directive must include obtaining the appropriate patient consent.

The patient's consent must be documented on the medical record.

#### **6. Ensure proper supervision of the delegation**

It is important to remember that the accountability and responsibility for the act that has been delegated remain with the delegating physician. A physician delegating a controlled act must provide the appropriate level of supervision to ensure that the act is performed properly and safely. The nature of the supervision will vary according to the assessment of risk, taking into account the specific act being delegated, the circumstances under which the act will be performed and the qualifications and experience of the person performing it.

#### **7. Consider any liability issues that may arise from delegation.**

The physician might wish to be aware of whether or not the person to whom the controlled act is being delegated is appropriately covered by insurance or otherwise in a position to meet any liability which may arise from the performance of the delegated act. The Canadian Medical Protective Association can provide advice about a physician's own liability.

#### **8. Consider any billing issues that may arise from delegation.**

Physicians should be aware that the Schedule of Benefits of the Ontario Health Insurance Plan (OHIP) contains particular provisions as to the circumstances under which remuneration can be claimed from OHIP by physicians for the performance of acts that have been delegated to others. The Schedule of Benefits also indicates that applications for exceptions to these rules may be made upon the recommendation of the Ontario Medical Association (OMA) and the College. Physicians who bill OHIP and who are considering delegating performance of controlled acts to others should carefully review the provisions of the Schedule of Benefits. The OMA and the Provider Services Branch at OHIP are available to answer questions and give advice about such matters. Any request to have a procedure considered for exemption from the general requirements should be submitted directly to the Ministry of Health and Long-Term Care (MOHLTC). The College will respond to consultation requests from the MOHLTC only.

### **Exceptions for Programs Under Medical Officer of Health**

In extremely limited circumstances, a controlled act may be delegated in the absence of a physician

order and in the absence of the doctor-patient relationship. One example of such a circumstance is within programs operated under the authority of a Medical Officer of Health, such as influenza inoculation programs. In this example, the best interests of the patient is protected as long as the program operator adheres to the quality assurance protocols established by a Medical Officer of Health.

## **Appendix 1**

### **Developing a Medical Directive**

In many instances, medical directives are created by committees or groups of physicians who will ultimately sign and rely on the directive.<sup>13</sup> Whether the directive is developed personally by the physician who signs it and under whose authority it is used, or whether it is developed by hospital administration, any physician who signs a medical directive is ultimately responsible for a patient who receives care pursuant to the medical directive. It is important to remember that the accountability and responsibility for the directive and for the delegation of any controlled acts it contains remain with the signing physician.

When developing the directive, consider each of the following issues and ensure that this consideration is reflected in the document:

#### **1. Assess the risk.**

- a. What is the procedure, treatment or intervention being ordered?
- b. How predictable are the outcomes?
- c. Does safe management of the possible outcomes require physician involvement or intervention?
- d. Are the appropriate resources available to intervene as required?
- e. Will delegation of the controlled act (if any) increase the risk to patients?

If the risk assessment results in the conclusion that patients' best interests would not be compromised by a medical directive, the following considerations should be taken into account.

#### **2. Consider who should be involved in the development of a medical directive.**

Although the directive is, strictly speaking, a physician's order, it has a significant impact on a number of other health care professionals who will be involved in the patient's care. Accordingly, the development of medical directives should be undertaken with a collaborative team approach. All of the health care professionals who may be affected by the medical directive should be involved in its development.

#### **3. Determine the qualifications, skills or knowledge required to carry out the directive.**



#### **4. Ensure that the directive addresses the requirements of Consent to Medical Treatment.<sup>14</sup>**

A medical directive cannot be implemented until the patient has provided informed consent (which may be in writing or verbal). In a medical directive, a physician proposes that a specific treatment (i.e., an x-ray) be performed for a range of patients who meet certain conditions. Instituting a medical directive raises the possibility that a physician may not be available to obtain the patient's informed consent to the proposed treatment. Under these circumstances, the physician is also assigning to another person the responsibility for obtaining the patient's informed consent for the proposed treatment, intervention or procedure. Obtaining informed consent includes the provision of information and the ability to answer questions about the material risks and benefits of the procedure, treatment or intervention proposed. If the individual who will be enacting the medical directive is unable to provide the information that a reasonable person would want to know in the circumstances, the implementation of the medical directive is inappropriate.

#### **5. Consider who will sign the directive.**

The overriding principle of delegation is that it must occur in the context of a physician-patient relationship. Accordingly, a physician who is ultimately responsible for the patient's care must sign the medical directive. At least one of the signatories to the medical directive must be available (on site or by phone) at the time it is implemented in case clarification or further intervention is required.

In some hospitals medical directives are created and approved by Committees and signed only by Chiefs of departments or divisions. In the College's view this arrangement is unlikely to meet the requirement that the physician signing the medical directive must have a physician-patient relationship with the patient treated pursuant to the directive. Each physician responsible for the care of a patient who will receive the proposed treatment, intervention or procedure should sign the medical directive.

Medical directives must be updated each time there is a medical staff change within the department or division to which the directive applies.<sup>15</sup>

#### **6. Ensure that the directive will be practically applicable and that a copy of it will be available to those implementing it.**

For instance, in an emergency department of a hospital, unless all physicians in the department are signatories to the directive, it will be administratively difficult to institute. Hospital staff should not be expected to determine whether the physician on call is or is not a signatory to a particular medical directive. If administrative simplicity is not possible, it is likely that the risk of relying on the medical directive is too high to justify its use.

#### **7. Consider the communication path that will enable the individual implementing a directive to identify the physician responsible for the care of the patient to be able to contact him or her immediately if necessary.**

#### **8. Consider what documentation will be required when the directive is implemented.**

The patient's record should reflect what actions were taken and that the actions were pursuant to a medical directive.<sup>16</sup> It may be appropriate to place a copy of the directive in the patient's chart.

**9. Consider tracking/monitoring methods to identify when medical directives are being implemented inappropriately or are resulting in unanticipated outcomes.**

**Contents of Medical Directives**

The following information must always be included in a medical directive:

1. The name and a description of the procedure, treatment or intervention being ordered;
2. An itemized and detailed list of the specific clinical conditions that the patient must meet before the directive can be implemented;
3. An itemized and detailed list of any situational circumstances that must exist before the directive can be implemented;
4. A comprehensive list of contraindications to implementation of the directive;
5. Identification of the individuals authorized to implement the directive;<sup>17</sup>
6. The name and signature of the physician(s) authorizing and responsible for the directive and the date it becomes effective; and
7. A list of the administrative approvals that were provided to the directive. The dates and each Committee (if any) should be specifically listed.

A more comprehensive guide and toolkit is posted on the Federation of Health Regulatory College of Ontario's (FHRCO) website. This guide was developed by a working group of FHRCO in 2006.

**Appendix 2: Medical Directive Prototype**

**Medical Directive**

**Management of Possible Ectopic Pregnancy**

**Background:**

This section may contain a description of why the medical directive has been created and/or how it best serves the patients' interests.

**Authorizing Physician(s):**

all individual names of ER physicians should be listed

**To:**

Emergency Room Nurses

Medical Radiation Technologists

**Clinical Conditions Required:**

Female patients

Childbearing years

Amenorrhea

Vaginal “spotting”

Abdominal/pelvic pain

**Situational Conditions Required:**

Consent

**Contraindications:**

Patient’s vital signs must be stable. If they are, the following apply:

Draw haemoglobin, blood for possible grouping and matching. B-HCG;

If vital signs are abnormal, hold patient until assessed by E.R. physician;

If vital signs are normal, send patient to Diagnostic Imaging, accompanied by RHA, for ultrasound of pelvis.

**Physician’s Order:**

Complete blood count and differential.

Serum B HCG.

Pelvic ultrasound.

**Approvals:**

Emergency Department Committee - July/03

Medical Advisory Committee - July/03

**Signatures:**

All ER physicians (ensure dated once signed).

## Endnotes

<sup>1</sup>This is the only controlled act that physicians are not authorized to perform.

<sup>2</sup>*RHPA*, section 29(1)(a)

<sup>3</sup>Verbal orders should be noted in the patient's chart by the recipient of the order and must be renewed or confirmed in accordance with the policy of the institution in which they are used.

<sup>4</sup>The order may rely on a protocol established by the physician or institution that describes the steps to be taken in delivering treatment. A protocol is a generic set of instructions about a specific health care scenario. The protocol itself is generic, but it is only used for a patient when it is called for by a direct order.

<sup>5</sup>Orders given to paramedics by designated base hospital physicians are an exception to this expectation.

<sup>6</sup>Not all medical directives contain delegation of controlled acts. Depending on the circumstances, medical orders may be required for controlled acts within the domain of the health care professional receiving the delegation. In such situations, the medical directive contains the order to perform the controlled act, but does not delegate it.

<sup>7</sup>While it is not impossible to use a medical directive in a non-institutional setting, the College expects this would rarely arise. A medical directive should be used only when it is in the patient's best interests to do so. It is a fundamental principle of the practice of medicine that the patient's interests must come first. Where a medical directive is created primarily in order to serve the physician's best interests, the College would consider it inappropriate whether or not it actually jeopardized the patient's wellbeing.

<sup>8</sup>A medical directive is a prescription for a drug, treatment, procedure or intervention that may be performed for a range of patients when specific conditions and circumstances exist. See below for further details.

<sup>9</sup> A financial benefit to the physician or a benefit in terms of convenience that occurs as a result of delegation may raise questions about whether delegation is for the benefit of the patient or the physician. Where doubt arises, the physician should not delegate a controlled act in the absence of the doctor-patient relationship or any of the other provisions set out in the policy.

<sup>10</sup> This exception to the general principal that a physician-patient relationship is required is established by the *Regulations to the Ambulance Act*. That legislation defines the term paramedic and stipulates that paramedics must be authorized by the medical director of a base hospital program to perform controlled acts.

<sup>11</sup>As with the requirement to identify the individual receiving the delegation, the College recognizes that in some cases, usually in hospital settings, the physician will not bear the responsibility for the quality assurance of staff. In these circumstances, the physician will meet the College's expectations if he or she satisfies him or herself that an appropriate quality assurance process is in place in the institution.

<sup>12</sup>See Consent to Medical Treatment Policy for detail.

<sup>13</sup>This is not always the case – the same principles apply to private practice settings.

<sup>14</sup>See the [Consent to Medical Treatment Policy](#).

<sup>15</sup>Where it is impractical for a hospital to have all new staff and locums sign a copy of each medical directive, it is acceptable if these individuals receive copies of each directive and sign one statement indicating that they have read and agreed with them.

<sup>16</sup>See the [Medical Records Policy](#).

<sup>17</sup>The individuals need not be named but may be described by qualification or position in the workplace.

## **Related Information**

### **Key Words**

Delegation, Controlled acts, Medical directives

### **Related Topics**

Medical Directives

### **Legislative References**

*Regulated Health Professions Act, 1991*, sections 27, 28, 29, 30;

*Ambulance Act Regulations*, section 1

### **Other References**

[Comprehensive Guide and Toolkit for Medical Directives](#)

[Delegating the administration of anesthesia for teeth scaling to dental hygienists](#)

[Delegating the prescription and administration of the influenza vaccine](#)

[Delegating the provision of anti-virals](#)

[Medical Directives pertaining to narcotics and other controlled drugs and substances](#)