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A COMMENTARY ON LEGAL ISSUES AFFECTING PROFESSIONAL REGULATION

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Insights, Misconceptions or Both?

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Imposing disciplinary sanctions may be one of the more challenging activities for regulators. Discipline panels and the courts have developed a nuanced approach that has three main components:

1. Identifying the types of orders that will achieve the goals of discipline, including protecting the public, maintaining confidence in the profession and the regulator, and, where appropriate, facilitating the rehabilitation of the registrant.
2. Considering the factors that apply in the individual matter, such as the nature of the misconduct, the registrant's level of insight, and the registrant's past conduct history. These have often been called aggravating and mitigating factors.
3. Ensuring that the overall sanction is proportional to the circumstances and to orders made in other matters.

Given the challenges, it is sometimes useful to receive the considered views of those not involved in the discipline process on a day-to-day basis. A recent report by Dr. Danielle Buell et. al., entitled: *Assessing severity of physician misconduct and subsequent disciplinary actions: a cross-sectional survey and analysis of discipline summaries* may be of interest. It reports on a two-phased research project. The first phase was a survey of 17 physicians and 11 patients and family members to obtain their input on how severe the sanctions should be for various categories of misconduct. The second phase involved an analysis of over 200 discipline decision summaries from the College of Physicians and Surgeons of Ontario. The goal of the research was "to identify variables that may influence disciplinary action severity to determine if there was physician misconduct adjudication bias in Ontario, Canada."

The survey first ranked the seriousness of nine types of misconduct as follows (from most serious to least serious):

- Sexual misconduct
- Unlicensed activity / breach of a condition of registration
- Conviction of a crime
- Fraudulent behaviour / prevarication

- Self-use of drugs and alcohol
- Unprofessional behaviour
- Inappropriate prescribing
- Standard of care
- Mental illness interfering with practice.

The authors noted that the patients / family members rated standard of care issues and inappropriate prescribing as materially more serious than did the physicians who were surveyed.

The survey also ranked types of disciplinary sanctions according to severity. The ranking from most severe to least severe is as follows:

- Revocation
- Surrender of licence
- Suspension of licence
- Formal reprimand
- Restriction of licence
- Retraining / course / assessment
- Cost / fine
- Psychotherapy / counselling / professional support.

The authors noted that physicians rated surrender of license and restriction of licence as materially more severe than did the patients / family members.

The case summaries were assessed according to type of misconduct, severity of sanction, and the following characteristics of physicians:

- Gender identity (only male or female as there was insufficient data for non-binary physicians))
- Years of practice
- Place of training (Canada or outside of Canada)
- Specialty
- Previous discipline history.

The authors observed that sexual misconduct was much more common among male physicians than female physicians, and inappropriate prescribing was more common among female physicians.

In terms of physician characteristics, male physicians received more severe sanctions than female physicians (this may be largely attributable to their higher rate of finding for sexual misconduct and other more serious forms of misconduct). There were fewer material differences in the severity of the sanction based on the other variables (i.e., general practice vs. specialists, training in Canada, years of practice, and repeated misconduct).

The severity rating of the sanctions in the actual decisions was materially lower than that identified as appropriate by those surveyed for types of misconduct.

The authors concluded that more public members should serve on disciplinary adjudication panels based, in part, on the survey results finding that patients / family members characterized some types of misconduct (e.g. standard of care) as more serious than physician respondents did. However, as noted above, the sample size of the survey was quite small. It is also interesting, as noted by the authors, that the period covered by the research (ending in 2019) occurred two years before the creation of the Discipline Tribunal at the College of Physicians and Surgeons of Ontario, which now almost always results in a majority of non-physicians on hearing panels.

While subject to several qualifications, the observation that physicians trained outside of Canada do not receive more severe sanctions provides some assurance of fair treatment in the discipline sphere.

The authors also suggest that it might be beneficial “to establish a hierarchy of severity based on feedback from diverse individuals who have a stake in the healthcare system, including patients and families. This approach is critical in evaluating disciplinary

procedures and promoting equity in the self-regulatory process."

In addition to the small survey sample size, there are additional significant limitations to the research. The authors noted that the categories of misconduct are quite broad. For example, sexual misconduct could include criminal sexual assault, sexual relationships that are inherently abusive, and crossing of boundaries through comments or gestures of a sexual nature. Thus, assigning a severity score to a broad category of misconduct may not always be meaningful. Also, two of the types of the misconduct considered (i.e., mental illness interfering with practice and self-use of drugs and alcohol) are almost always handled through a different process (i.e., fitness to practise) and are generally only referred to discipline where there is other concerning conduct.

It is also noteworthy that the researchers relied only on the discipline summaries rather than the full text of disciplinary decisions available on CanLII. The complete decisions would provide a more detailed rationale for why a particular sanction was imposed in an individual matter.

Perhaps most significantly, the research focused on the severity of disciplinary sanctions. As noted above, the severity of misconduct is only one consideration that goes into formulating a disciplinary sanction. Furthermore, deterrence (which is often the principle relied upon to justify severe sanctions) alone is an inadequate rationale for achieving the goals of disciplinary sanction including protecting the public and maintaining public confidence in the regulator and the profession. A severe sanction may also be counter-productive to the rehabilitation of a physician when they are not permanently removed from the profession. It is, therefore, not a surprise that when, as legally required, one considers factors other than the seriousness of the misconduct, the severity of the sanction is often reduced.

Having said that, this research could point the way to additional studies that might contribute to more effective disciplinary sanctions.

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