

Responsibility for a Medical Practice

Related Standards of Practice: [Responsibility for a Medical Practice](#)

The College of Physicians & Surgeons of Alberta (CPSA) provides advice to the profession to support physicians in implementing the *CPSA Standards of Practice*. This advice does not define a standard of practice, nor should it be interpreted as legal advice.

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Purpose

The *Responsibility for Medical Practice* standard of practice recognizes the full scope of medical practice extends beyond the provision of patient care to the professional and administrative activities, which support that care. While some responsibilities may be delegated to a non-physician, the College will always hold physicians ultimately accountable for all aspects of medical practice (with the exception of administrative responsibilities that clearly fall under the jurisdiction of Alberta Health Services or the provincial or federal government).

The standard acknowledges that practice setting may influence how physician responsibilities are managed, and the purpose of this advice is to help physicians better understand how the standard applies in their particular circumstances.

Basic physician responsibilities

Physicians are authorized to provide services to the public through the legislative authority of the [Health Professions Act \(HPA\)](#). Section 100(1) of the HPA holds physicians accountable for the care they provide to patients and their compliance with the laws, regulations and standards applicable to the practice of medicine, regardless of practice arrangement. Specifically, section 100(1) states:

“A regulated member is responsible, for the purposes of this Act, the code of ethics, the standards of practice and the bylaws, for how the member provides professional services and complies with this Act, the code of ethics, the standards of practice and the bylaws, and that responsibility is not affected, modified or diminished by the practice arrangements of the regulated member ...”

Clause 1 of the *Responsibility for a Medical Practice* standard confirms these responsibilities and is applicable to **all** physicians in Alberta regardless of practice setting.

Practice management responsibilities

While clauses 1(a) and (b) are fundamental, they do not describe everything included in a medical practice. Staffing, advertising, billing and medical records are all components of a physician’s medical practice, as outlined in clauses 2(a) through (h) of the standard.

It is also important to understand that “medical practice” is the exclusive domain of physicians and cannot be delegated to or owned by a non-physician person or business interest except as authorized by legislation, such as within an AHS or government facility.

‘Responsibility’ means where the ultimate accountability lies.

Many practice settings have a Medical Director who has a formal agreement with the facility owner or operator that includes most or all of the responsibilities identified in clause 2. This includes all accredited facilities, Alberta Health Services (AHS) facilities and some community practices.

The College will hold the Medical Director accountable for upholding their agreement as relevant to clause 2. All physicians in the practice should be clear on the Medical Director’s responsibilities, as individual physicians will be held accountable for any part of clause 2 not included in the Medical Director’s agreement with the facility.

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Additionally, the College would expect physicians in the practice to come forward if concerned the Medical Director isn't meeting their clause 2 responsibilities as per their agreement. Depending on the type of practice, this could mean reporting to the appropriate authority in the facility or to the College directly under the [Duty to Report a Colleague](#) standard of practice.

In other practice arrangements, responsibilities may be managed as follows:

- In a Primary Care Network (PCN) without a Medical Director, the PCN board may assume responsibility for specific components of clause 2 (e.g., hiring and supervision of non-AHS, non-medical staff) and may hire an Executive Director to carry out these functions. Unless there is evidence Alberta Health Services or Alberta Health accepts direct responsibility for these staff (e.g., they are employees of AHS), the College has no recourse but to look to individual physicians for accountability – either the physicians on the PCN board or the physician members of the PCN, according to the agreement between these parties.
- In a community-based practice without a Medical Director and not part of a PCN (or where the PCN board has not assumed any clause 2 responsibilities), physicians are individually responsible. In a multi-physician setting, the physicians may select a medical lead to assume responsibility for some or all of clauses 2(a) through (h).
- In a hospital or facility operated by the provincial or federal government or a provincial health authority, the organization itself assumes these responsibilities. For the purposes of this standard, this includes any organization authorized by legislation to deliver health services, including AHS, AHS-contracted providers (e.g., long-term care), First Nations and Inuit Health Branch settings and services, Workers' Compensation Board (WCB) facilities, etc. Many of these settings will also have a Medical Director.

Clauses 2(a), (b), (e), (g) and (h) are discussed below. Refer to the [Advertising](#), [Patient Record Content](#) and [Patient Record Retention](#) standards of practice for detailed information on professional expectations regarding these aspects of medical practice.

Non-regulated and regulated staff

A physician's responsibility for staff depends on whether the staff is non-regulated or a regulated member of a health profession under the *HPA*. As noted above, a PCN board with physician representation may assume responsibility for hiring non-AHS staff (regulated and non-regulated) through an Executive Director. In this scenario, the board's physician members remain accountable for the Executive Director's actions, approving appropriate processes and procedures to meet the standard.

For non-regulated staff: Physicians are responsible for supervising any person who assists them with duties related to the physician-patient relationship (e.g., receptionist, medical office assistant, billing clerk, etc.). Duties might

include booking appointments, following up with patients on the phone, or interacting with patient records as they relate to physician-patient encounters and billing for medical services.

Responsibility for supervising non-regulated staff with no involvement in patient-related duties (e.g., after-hours cleaning staff) belongs with the employer. If the physician hired the staff, the physician is responsible. If an organization hired the staff (e.g., social agency, university, PCN, etc.), the organization is responsible.

For regulated staff: Physicians are not responsible for supervising the activities of other regulated health professionals or the unregulated staff assisting them. However, they are responsible for ensuring the regulated health professionals working in the practice are in good standing with their regulatory body and for enabling their participation in patient care teams within their scope of practice.

Quality assurance and quality improvement

Government, the public and other stakeholders increasingly expect physicians to participate in quality assurance and continuing quality improvement to support optimal practice. Many physicians have embraced a commitment to quality and are actively engaged in these activities.

While this standard does not mandate physician participation in quality assurance and quality improvement, it recognizes that outside of legislation-authorized health facilities, these activities are part of medical practice and must therefore be overseen by a physician and not a non-physician with limited understanding of medical practice.

Notifying the College about changes to practice

Providing the College with notice in advance of relocating a practice helps us keep public information current and proactively support patient safety. Thirty days' notice is the absolute minimum; ideally, the College should be notified at the same time as patients (at least 45 days ahead, as per the [Relocating a Medical Practice](#) standard, or 90 days ahead if [closing or leaving a medical practice](#)).

The College also needs to know at least 30 days before new services or procedures are introduced. It takes time to meet patient safety requirements, and advance notice helps avoid unnecessary delays. Some services can only be provided in [accredited facilities](#), and [physicians need College approval](#) to perform certain procedures such as hair transplantation, acupuncture and [complementary and alternative medicine](#). We also follow-up with all clinics performing [medical device reprocessing](#) (learn more at [Infection Prevention and Control](#)).

Staff identification

Clear identification of staff reassures patients and prevents misunderstandings about the roles of individuals. It also supports accountability for the activities of staff and their interactions with patients. Posted credentials or nametags are acceptable, and both are the norm in many practices.

Delegation of responsibility

As noted above and mandated through the *HPA*, individual physicians will always be responsible for clauses 1(a) and (b) of the *Responsibility for a Medical Practice* standard, and the College will hold physicians accountable. This also applies when physicians are [supervising staff to carry out restricted activities](#).

Similarly, physicians who delegate some aspects of practice management identified in clauses 2(a) through (h) to staff remain accountable for the work performed by these delegates.

The role of medical lead is different, in that physicians in a multi-physician setting with no Medical Director may choose one regulated member to accept overall responsibility for any or all of clauses 2(a) through (h) for a defined period of time. As defined in the *Responsibility for a Medical Practice* standard, a multi-physician setting is any practice arrangement between regulated members in which they share the use, benefits or costs associated with any of the following:

- [advertising](#);
- office telephone number;
- [medical records](#);
- clinical or administrative functions, including [infection prevention and control](#), billing, etc.;
- premises, equipment, furnishings or other property; and/or
- staff.

The medical lead must be a regulated member of this College and may be selected by formal appointment or an informal arrangement. In a formal appointment, the medical lead signs a contract that includes a list of duties. In an informal arrangement, the physicians in the practice agree informally who will act as medical lead. The role may rotate among all members of the practice, but at all times all parties must understand their respective roles and responsibilities.

Contact person for College interactions

All physicians need to interact occasionally with the College, for example when renewing their practice permit or participating in a continuing competence process (i.e., Individual Practice Review or MSF+). The College also interacts with physicians involved in a complaint concerning professional conduct or care for a patient. All of these interactions relate directly to the individual physician responsibilities outlined in clause 1 of the standard: patient care and compliance with applicable laws, regulations and standards.

Other College interactions focus on office processes, such as infection prevention and control assessments, [Group Practice Reviews](#) and new office assessments. For these interactions, the College requires one person who is a regulated member to be the contact for the practice.

Ideally, this is the Medical Director. In other practices, it is the medical lead. In a multi-physician practice with neither a Medical Director nor a medical lead, one physician must be designated the contact person for the College. In this circumstance, all physicians in the practice remain individually responsible for clauses 2(a) through (h).

Example Scenarios

The *Responsibility for a Medical Practice* standard of practice is always interpreted in context. The following are a few common scenarios to clarify how the College applies the standard.

Scenario 1

Dr. A practises exclusively in an intensive care unit at a tertiary care hospital operated by AHS. The physician is privileged by AHS. The care provided in the ICU is delivered by a multidisciplinary team consisting of a number of regulated health professionals and some non-regulated staff, for instance the unit clerk who carries out some patient-related duties such as entering orders into the system.

All the non-regulated staff are employees of AHS and are supervised by AHS managers. The regulated professionals are a mix of AHS employees (nurses) and physicians with privileges. The ICU has a Medical Director hired by AHS who has a list of responsibilities, including quality improvement and quality assurance for the unit.

Dr. A is compensated for his work through the Alberta Health Care Insurance Plan (AHCIP) and third party payers as applicable (e.g., WCB, insurance companies, etc.). He bills AHCIP and other agencies for his services through his professional corporation and is paid directly by Alberta Health and third parties on a fee-for-service basis. The physician hires a part-time employee to do the billing on behalf of his corporation.

Dr. A is responsible for:

- the care he provides to patients and maintenance of his own competence;
- his own compliance with the *Code of Ethics*, *CPSA Standards of Practice*, *CPSA Code of Conduct* and CPSA and AHS bylaws; and
- the staff he hired to do his billing.

Dr. A is NOT responsible for:

- the care provided by other regulated health professionals or the actions of non-regulated AHS employees in the ICU;



- the custody of health information in AHS systems; or
- infection prevention and control or other clinical processes in the AHS facility.

Scenario 2

Dr. B works in a walk-in clinic operated by a non-physician. She works three shifts a week. There is no Medical Director or medical lead. The non-physician owner has hired several staff to support the physicians practising in the clinic:

- A receptionist who greets patients on arrival and collects information for the clinic EMR, such as current address, phone number and so on. The receptionist also answers the phone and directs calls.
- A medical office assistant (MOA) who places patients in examination rooms, prepares them to see the doctor and assists Dr. B as required. The MOA also books investigations, facilitates referrals, calls patients on behalf of Dr. B and reprocesses medical devices.
- An RN who assists Dr. B and carries out duties such as medical device reprocessing (MDR), injections, ear syringing, etc.
- An office cleaner who comes in after-hours. The cleaner is responsible only for general housekeeping, not medical device reprocessing.
- A billing clerk who submits billings to the AHCIP for all the physicians in the clinic.

Dr. B is responsible for:

- the care she provides to patients and maintenance of her own competence;
- her own compliance with the *Code of Ethics, CPSA Standards of Practice, Code of Conduct and Bylaws*;
- the clinic's compliance with the *CPSA Standards of Practice* (includes responsibility to not sign a contract with the clinic that may interfere with her ability to comply with the standards);
- the actions of the receptionist, the MOA and the billing clerk in their duties related to the patients she provides care for;
- the proper custody, storage and security of the EMR, including the records she creates;
- security of medications and medical devices in the clinic;
- ensuring MDR and other clinical processes performed by the receptionist and MOA are conducted to the appropriate standard, even though working only 3 shifts a week and not the employer;
- quality assurance and quality improvement activities;
- clinic advertising;
- notification to the College if the clinic relocates; and
- in collaboration with her colleagues, selection of a regulated member to be a contact person for the College in the event of an interaction, for example an IPAC inspection.

Dr. B is NOT responsible for:

- supervision of the RN, who is responsible to the College of Registered Nurses of Alberta (CARNA); or
- supervision of the office cleaner, who has no patient involvement.

Scenario 3

Same as Scenario 2, except the non-physician clinic owner has hired a Medical Director.

Dr. B is responsible for:

- the care she provides to patients and maintenance of her own competence;
- her own compliance with the *Code of Ethics, CPSA Standards of Practice, Code of Conduct and Bylaws*;
- understanding the responsibilities of the Medical Director with respect to clauses 2(a) through (h), as outlined in their agreement with the facility;
- meeting all remaining responsibilities under clause 2; and
- in the event the Medical Director isn't upholding their agreement as relevant to clause 2, bringing this to the attention of the clinic owner and, if not resolved, the College.

Scenario 4

Drs. C, D and E work in a PCN clinic. They hire and oversee a receptionist, two MOAs, an RN and a billing clerk. The PCN provides a pharmacist and chronic disease nurse, both regulated professionals. The PCN also provides a non-regulated referral coordinator to help triage and facilitate referrals.

The pharmacist, chronic disease nurse and referral coordinator were hired by the PCN. The PCN has an Executive Director, a non-physician, who reports to the PCN board. The PCN board includes several physicians, as well as representatives from Alberta Health and AHS. The board chair is a physician.

Drs. C, D and E are responsible for:

- the care they provide to patients and maintenance of their own competence;
- their own compliance with the *Code of Ethics, CPSA Standards of Practice, Code of Conduct and Bylaws*;
- the staff they hire:
 - ensuring appropriate roles, responsibilities, qualifications and performance of the receptionist, two MOAs and billing clerk (the College will hold them accountable for the actions of these staff); and
 - verifying the RN they hire is a regulated member in good standing with CARNA;
- compliance with clauses 2(c) through (h); and

- if there is no Medical Director, choosing one physician to represent the practice in interactions with the College, as per clause 3 of the *Responsibility for a Medical Practice* standard.

Drs. C, D and E are NOT responsible for:

- Staff hired by the PCN board and Executive Director. Because the College has jurisdiction only over physicians, we will hold the physicians on the PCN board accountable for ensuring clauses 2(a) and (b) are met, unless these staff are hired and supervised by Alberta Health or AHS.

Scenario 5

Dr. F is hired by WCB to provide services in a WCB rehabilitation centre. Dr. F sees WCB claimants in the facility one afternoon a week for disability assessments. Other employees in the facility include reception staff, a registered nurse and physiotherapists, all staff hired and supervised by the WCB. The physician is paid by WCB.

Dr. F is responsible only for clauses 1 (a) and (b), which includes:

- the care he provides to patients and maintenance of his own competence;
- his own compliance with the *Code of Ethics*, *CPSA Standards of Practice*, *CPSA Code of Conduct* and CPSA and AHS bylaws.

As WCB is authorized through a legislative act, the College considers the WCB rehabilitation centre a “government facility” for the purposes of this standard. WCB thereby assumes responsibility for clauses 2(a) through (h).