Concerns about MOU between OMA-PHP and CPSO

1 message

Ana Safavi <atihana@gmail.com> Thu, Jul 11, 2019 at 7:53 PM
To: "Dr. Nancy Whitmore, Registrar and CEO" <registrarceo@cpso.on.ca>
Cc: Jill Hefley <JHEFLEY@cpso.on.ca>

Dear Dr. Whitmore,

I am a medical resident writing to you out of great concern for the welfare of my fellow trainees.

As you may be aware, on June 30, 2019, a very brave resident came forward to tweet publicly about her negative experience with the OMA-PHP, to which she had been referred by the CPSO.

Her story, although shocking to many within our profession, was unfortunately not a surprise to me, at all.

Over the past 18 months, after I went public with my experience of sexual harassment in medical education, countless medical students and trainees across Ontario have reached out to me for advice and help about their own situations dealing with harassment and discrimination in the course of their training. Although their stories were all unique, a common theme quickly began to emerge — many of these trainees had been referred (usually by their medical school) for mandatory assessments by the OMA-PHP, and required to sign monitoring contracts with the OMA-PHP as a condition of their continued training.

In all of these cases, the residents were coercively referred to the OMA-PHP. Many times, the medical school referred the trainee without grounds to do so — often, it was done as a punitive measure intended to intimidate a trainee into silence about ongoing harassment from faculty members in their program. The monitoring contract — which appears to be forced upon every trainee referred to the OMA-PHP, as a matter of course, regardless of their actual diagnosis — is being routinely co-opted by abusive program directors and associate deans as a means of intentionally stigmatizing trainees with rumours of mental illness and exerting control over virtually every aspect of the trainee's professional and private life.

The methods and practices of the PHP (even as described in their own official documentation) are objectively unlawful. They run afoul of quasi-constitutional statutory laws, including the *Ontario Human Rights Code*, the *Personal Health Information Protection Act*, and the *Freedom of Information and Protection of Privacy Act*. Up until recently, most trainees have been too afraid to challenge these unlawful practices due to fear of reprisal — including from the CPSO.

However, I can advise you that, at the present time, the discriminatory practices of the OMA-PHP are a subject of at least 3 active legal proceedings before the Human Rights Tribunal of Ontario. I have spoken to other trainees who wish to take similar legal action in order to protect their rights — so many trainees, in fact, that we are considering the merits of initiating a Class Action.

On July 1, 2019, I publicly (via tweet) called on the CPSO to "immediately and publicly cut ties with the OMA-PHP program." The CPSO twitter account follows my twitter account, and has responded to me in the past when I tagged the CPSO (as I did here). Furthermore, the original tweet thread by the brave resident who told her story has been liked over 1600 times and re-tweeted 484 times. She has been invited to speak on various media platforms to raise awareness about this issue. Given the manner in which her tweet went viral overnight, I am very disappointed to see that the CPSO has remained entirely silent on this issue.

I understand that the CPSO essentially outsourced assessment and monitoring of physicians to the OMA-PHP via the 1998 Memorandum of Understanding. I appreciate that the CPSO may find it difficult to take on these vital tasks itself, particularly given resource constraints. However, assessments can (and should) be done by a physician's own treatment provider, with referral for an Independent Medical Examination only as a last resort. That is what the Human Rights jurisprudence in Ontario dictates, and there is no exception provided for health care providers. Furthermore, even a physician mandated to undergo an IME should be afforded some choice of provider. There is no legal

justification for granting the OMA-PHP a monopoly on this (no doubt lucrative) business, and such monopolies, as you can imagine, are prone to corruption and abuse. My own investigations into the OMA-PHP has revealed a disturbing pattern of financial conflicts of interest.

There may remain — at least in the short-term — a legitimate role for the OMA-PHP with respect to monitoring of physicians with confirmed substance-use disorders, as I imagine that the CPSO is not eager to figure out the logistics of administering a longitudinal urine drug testing program to monitor the sobriety of practicing physicians. Nevertheless, this sort of monitoring is, in fact, a small fraction of the OMA-PHP's activities, particularly as it relates to trainees. In fact, none of the trainees I have spoken with who were forced into monitoring contracts with OMA-PHP, were referred for, or diagnosed with, substance use of any kind. As such, I believe that the CPSO could easily disavow the referral of trainees to the OMA-PHP, with little to no resulting logistical complications.

Trainees, especially, are the most vulnerable to the OMA-PHP's predatory practices, as they must comply with all requirements if they want to complete their training. If they refuse to comply, either the CPSO won't issue them a license, or their training program won't allow them to return to training. Trainees are also in massive debt, and often cannot afford legal advice. As such their consent to the OMA-PHP's assessment and treatment program is rarely informed, and invariably given under duress — and therefore, legally invalid.

Mistrust of the OMA-PHP (and, by extension, the CPSO, which is seen by many to be complicit) has become so widespread among trainees that many are too fearful to seek any help at all for mental health concerns, or to take medical leave for any reason during their training. Trainees fear that self-disclosure to the CPSO, to their training program, or even to their own treatment providers may result in a referral to the OMA-PHP. This culture of institutionalized fear, shame, stigma, and secrecy is directly harmful to trainees, and thereby also impedes the CPSO's mandate to ensure that trainees are medically fit to practice. As such, the OMA-PHP's practices are not only exacerbating the epidemic of suicide among medical trainees, but also indirectly compromising patient safety.

The CPSO's continued association with the OMA-PHP exposes the CPSO to significant legal liability and bad PR. Given all of the above, I believe it would be in the best interest of the CPSO to publicly cut ties with the OMA-PHP — at the very least with respect to the vulnerable trainee population. Trainees want to see the CPSO step up and take a principled stand on this critically important issue. A public statement by the CPSO on this issue would go a long way toward fostering a relationship of reciprocal trust and good will between the new generation of Ontario's physicians and their regulatory body.

I would be pleased to discuss this matter further with anyone at the CPSO, including the CPSO's in-house counsel, so that we can come to a timely and mutually beneficial resolution on behalf of all trainees in the province.

Thank you for your attention to this crucial matter,

Ana

Dr. Ana Safavi | **MD**

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