

**PUBLIC INTEREST, PATIENT ENGAGEMENT AND THE TRANSPARENCY  
INITIATIVE OF THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO**

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## ABSTRACT

In recent years, patient-centredness has become a central focus in improving health care quality. In 2010, the Canadian Medical Association (CMA) launched a four-year action plan aimed at transforming Canada's health care through a framework aimed at creating a culture of patient-centred care, accountability and responsibility. Several of Canada's provincial governments proceeded to launch patient-centred action plans, including the Government of Ontario's "Patients First" framework, which prioritizes patient engagement and increased transparency. As an example of how organizations are putting these values into practice, the College of Physicians and Surgeons of Ontario (CPSO)'s transparency initiative, which aims to make more physician-specific information available to the public in order to help patients make informed decisions about their health care, was examined. This thesis asks how physicians and members of the public feel that the transparency initiative aligns with the CPSO's public interest mandate. Using discourse analysis, 226 responses by physicians, members of the public and organizations on a discussion forum in the Policy Consultations section of the CPSO's website were analyzed in order to identify the main themes in arguments for or against increased transparency. The results show that physicians and members of the public tended to differ in their views on the purposes and probable outcomes of the CPSO's transparency initiative. The majority of physicians worried about patients' ability to accurately understand and utilize the information being provided to them, and the negative impact that this might have on individual physicians and on the physician-patient relationship more broadly. Most members of the public had a more positive outlook on the potential for transparency to build public trust, help patients become informed and engaged decision-makers and improve patient safety.

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## CHAPTER 1: INTRODUCTION

### 1.1 The College of Physicians and Surgeons of Ontario's Transparency Initiative

Health care professionals in Canada are licensed and regulated by provincial colleges who are responsible for protecting and serving the public interest. Recently there has been a demand for increased transparency within these regulatory colleges, which has led to initiatives to make more information about regulatory processes and registered health care professionals available to the public. The information made available ranges from the online and print publication of disciplinary processes and outcomes to the education and practice restrictions of individual health professionals. Across all Canadian provinces, regulatory colleges for each health profession—ranging from medicine to nursing to physiotherapy—have in some way addressed the need for transparency as a means of increasing public trust. This thesis will examine the transparency initiative of the College of Physicians and Surgeons of Ontario (CPSO) in order to determine how members of the public, members of the medical profession and members of regulatory bodies decide which types of information about physicians are in the public's interest to have access to, and which types of information should be withheld from the general public.

Since 2013, the CPSO has been implementing a transparency initiative aimed at making more physician-specific information available to the public. The College collaborated with an interdisciplinary group of health care providers called the Advisory Group of Regulatory Excellence (AGRE) to develop a multi-staged transparency initiative based on a set of eight transparency principles. Examples of these principles include: that the public must have more access to information in order to trust that the system of self-regulation which governs the health care profession is trustworthy and effective; that providing this information to the public benefits

both patient choice and regulator accountability; and that information provided must be relevant, credible, accurate, and capable of enhancing the public's decision-making ability, personal risk assessment and confidence in their health care (College of Physicians and Surgeons of Ontario, 2013).

This initiative was responding in part to a demand for more transparency from Ontario's Minister of Health and Long-Term Care, Eric Hoskins, in 2014, in which he asked the Colleges and Councils regulating health professions in Ontario to share more information with the public and "make transparency a priority objective" in future strategic plans (Hoskins, 2014). The rationale provided for the objective was: that it would increase public confidence in Ontario's health care system and regulatory processes; that it would help the public to make informed decisions about their health care; and that it is in the public interest for transparency to be improved and prioritized (Hoskins, 2014). Within the same time period, the *Public Sector and MPP Accountability and Transparency Act, 2014*, was passed as part of Ontario's Open Government initiative that had launched in October 2013 (Treasury Board Secretariat, 2014).

The transparency initiative was announced in a 2013 issue of the College publication *Dialogue*, in which it was explained that in an "age of open information," the way that the public perceives institutions has changed, leading to scepticism about organizations that claim to act in the public interest. The proposed solution is increased transparency of information that was previously kept private in order to strengthen the accountability of regulatory bodies. However, it was noted that the protection of the public interest must always be balanced with the duty of fairness to physicians; as such, members of the medical profession as well as members of the public were encouraged to contribute to discussions posted on the College's website about each phase of the transparency initiative (College of Physicians and Surgeons of Ontario, 2017).

The CPSO's transparency initiative has been implemented in two phases—the first in 2013 and the second in 2015—with consultations at each step of the process, from the drafting of transparency principles to proposed amendments. Throughout the consultations, members of the public as well as physicians and other members of the medical profession contributed to discussion forums on the College's website (Consultations, 2016) in which they engaged in debates and provided feedback about which types of information were in the public interest to disclose. Examples of the types of information that have been made publicly available on the College website since 2013 include oral cautions received by physicians, criminal charges and convictions of physicians, outcomes and statuses of Out-of-Hospital Premises Inspections, and orders for specified continuing education and remediation programs (SCERPs).

## **1.2 Research Question**

It is important for physicians, regulators and members of the public to understand how the CPSO's transparency initiative fulfills (or does not fulfill) the College's public interest mandate, from the points of view of both the public and health care professionals, in order to understand what kinds of information help the public to make informed decisions about their health care and improved patient safety, as well as what kinds of information might undermine public trust in medical regulation or damage the physician-patient relationship. This thesis asks how respondents on a discussion forum about the second phase of the transparency initiative feel about the goals, purpose and probable outcomes of increased transparency on the CPSO's website, and whether this aligns with the public interest mandate of the organization.

The content of the discussion forums on the CPSO website about the different phases of the transparency initiative provides a means of uncovering the rationale behind which types of information about physicians and the regulatory standards that govern the medical profession are

beneficial (or not beneficial) for the public to have access to, and how the public and health professionals differ in their ideas about what should and should not be made transparent in order to serve the public interest.

### **1.3 Outline of Chapters**

In the second chapter of this thesis, a review of the literature contextualizes the CPSO's transparency initiative within a range of ongoing discussions about the benefits and purposes of transparency in general and in self-regulated professions in particular, as well as the changing nature of the physician-patient relationship in an increasingly consumerist health care context that is being mediated by technology. The literature review summarizes patient-centred health care initiatives from provincial governments within Canada and in other countries. These initiatives comprise a focus on patient safety, public trust, patient engagement and patient satisfaction, all of which are discussed throughout this thesis.

The third chapter outlines the methodology used to analyze the content of the discussion forums. Discourse analysis, organized through the creation of codes and themes into which individual responses on the discussion forums will be categorized, will be used in order to discern the main arguments made for or against transparency by physicians, patients and organizations. These themes will uncover patterns in the main arguments for or against the CPSO's transparency initiative being made by physicians and patients.

In the fourth chapter, the results of the discourse analysis are elaborated upon through the exploration of the codes and themes developed in relation to their theoretical contexts. Within the first cycle of analysis, the codes developed and the content of the responses categorized within each code allow for a more detailed look into the way that the CPSO's transparency initiative is positioned in relation to topics such as: patient complaints and patient satisfaction

surveys; doctor rating websites such as RateMDs; the publication of medical news in print, digital and online media; the role of trust in the physician-patient relationship and the mechanisms that build or undermine trust; and the ability of the public to accurately understand and utilize health care information provided on the Internet, among other topics. The second cycle of analysis narrows the broad range of codes developed in the first cycle into four distinct themes that describe the function, benefits and limitations of transparency within these contexts from the perspectives of both patients and health care professionals.

The fifth chapter concludes the thesis by breaking these themes down further into two main arguments, one of which is in favour of increased transparency and its potential benefit for patients, and another that is opposed to or cautious of transparency due to its potential ramifications for physicians. These final themes highlight the divergence in priorities, concerns and arguments between health care professionals and the general public. Throughout the analysis it becomes evident that those who feel that the transparency initiative does fulfill the CPSO's public interest mandate hold this opinion because they believe that any increase in transparency is beneficial to increasing patients' feelings of autonomy and authority in their health care encounters. Conversely, those who are critical of or opposed to the CPSO's transparency initiative believe that the potential for transparency to decrease physicians' feelings of autonomy within their profession and authority within health care encounters will be damaging to the physician-patient relationship, to individual physicians, and potentially to patients who are unable to reliably understand or utilize the information as well.

## CHAPTER 2: LITERATURE REVIEW

### 2.1 Introduction

This literature review provides context for the theoretical framework and health care policies that the CPSO's transparency initiative has arisen from. First, transparency is defined and then contextualized within the health care organizational setting. Then the issues that lead to demands for increased transparency—mainly patient safety, patient choice and patient engagement—are explored through previous research conducted on these issues as well as societal trends they relate to, such as consumerism in health care and developments in media. Additionally, the tenets of the CPSO's transparency initiative—self-regulation of the medical profession and encouraging public trust—are investigated through the history and theory behind these concepts.

### 2.2 Defining Transparency

While the proposed goal of these information-sharing initiatives is transparency, what is meant by “transparency” is often left undefined (Levay, 2016). Transparency is generally understood as an open, uninhibited sharing of information with the public (Ball, 2009; Leape et al., 2009). It is similar to, though not the same as, the notion of accountability: transparency is supposed to generate accountability, and the ideal outcome is that organizations, governments and institutions should be transparent with the stakeholders they are accountable to (Fox, 2007). Michener and Bersch (2011) propose two dimensions of transparency: visibility of information and inferability of information. Information must not only be made available, but it must lend itself to accurate interpretation by those it is made available to. In health care, transparency has most commonly been used to mean reporting about safety incidents and disclosure of adverse

events to patients. More recently, it has shifted toward an imperative to provide information about the health care profession openly to the public (Leape et al., 2009).

Christensen and Cheney (2014) argue that transparency can be understood as a social value, thought of as a stand-in for democracy. Politically, it is thought to lead to accountability, and to serve as another form of regulation and to help citizens make better, more informed choices (Etzioni, 2010). As Etzioni (2010) points out, the major disadvantage of transparency is that it assumes that those receiving the information will have the ability to properly decode it, draw accurate conclusions and use the information to make sound decisions; this assumption does not take into account the differing abilities and cognitive biases of the general public.

Christensen and Cheney (2014) critique beliefs of what transparency projects can accomplish by analyzing transparency's communication process and unpacking its implicit linear model of communication, wherein the organization acts as a compliant sender of whatever information is requested from them, while the receiver is rarely considered in-depth. It is assumed that the audience will receive the messages as intended and be motivated to hold organizations accountable based on the information provided. Such transparency projects often make the public dependent on intermediaries who can "translate" the information for them; additionally, the authors argue that the demand for transparency can generate new forms of closure and manipulation, as organizations begin to select, frame, distort, control and monitor the new information they are required to provide.

### **2.2.1 Transparency in the Health Care Context**

Within the health care context, demands for increased transparency have arisen from medical scandals, malpractice litigation, media scrutiny of health care failings, an interest in disclosure of adverse events, and relationships with the pharmaceutical industry or other

conflicts of interest (Healey & Braithwaite, 2006; McGivern & Fischer, 2012). Desire for transparency is also linked to a growing concern for the idea of patient rights as well as government spending on health care (Blomgren, 2007; Blomgren & Sundén, 2008). Frequently, transparency is discussed in relation to the ideas of patient safety, quality improvement and professionalism, and is often contextualized through an examination of self-regulation (Chantler & Ashton, 2009; Kachalia, Mello, Nallamothu & Studdert, 2016). Movements toward greater transparency in health care are mostly carried out through disclosure of medical errors and public reporting of data. Publicly reported data often pertains to the quality and safety performance of physicians and health care institutions; this data is supposed to enable patients to make better decisions about where they will go to receive their health care (Kachalia, Mello, Nallamothu & Studdert, 2016).

### **2.3 Patient Safety**

Patient safety has been defined by the Royal College of Physicians and Surgeons of Canada as “the reduction and mitigation of unsafe acts within the health-care system as well as through the use of best practices shown to lead to optimal patient outcomes” (Davies, Hebert & Hoffman, 2003, p. 12). Bell, White, Jean, Joyce and Gallagher (2017) analyzed survey responses from 3038 physicians and residents in the United States and Canada regarding transparent communication practices following adverse events. They identified three transparent communication behaviours: disclosure of adverse events (including serious errors, minor errors and near misses) to patients, discussion of these events with colleagues, and reporting of these events to the institution. Their results showed that these communication behaviours are linked, but that there is a need for a more unified transparency strategy within organizations and

institutions in order to make transparency a cultural norm and expectation.

## **2.4 Patient Choice**

The ideas of patient choice and informed decision-making, which transparency in health care is supposed to enable, are often seen as evidence of a trend toward consumerism in health care. In terms of the physician-patient relationship, the model of shared decision-making between the physician and the patient that is idealized today demands that all information be provided to the patient, who is then liberated to make their own decisions about their health care (Roter, 2000; Emanuel & Emanuel, 1992).

### **2.4.1 Consumerism in Health Care**

While this model of the physician-patient relationship is supposed to empower the patient, it is also viewed as a consumerist model, which limits and narrows the physician's role to that of a consultant or advisor (Emanuel & Emanuel, 1992). According to Berry (2007), consumerism in health care focuses on patient rights and doctor obligations. Dr. Rocco Gerace, the CPSO's registrar, reflects this in a statement about the transparency initiative: "In order for the public to trust that the system works, we need to demonstrate that the system works. We need to show value to the public which we serve. After all, we live in a new era of expectations and the practices of health care regulations must reflect this reality" (College of Physicians and Surgeons of Ontario, 2015, p. 27).

Henderson and Petersen (2002) point out that consumerism in health care is often framed in terms of personal empowerment and freedom of choice, which generates this "right to know." The dialogue of "informed choice" is inextricably rooted in consumerism (Kapp, 2007), as is the significance of "patient choice" (Fischer, 2015). As Fischer notes, consumerism in health care implies that patients can "independently gather and rationally evaluate information in order to

make optimal decisions” (p. 174). The discourse of consumerism is present in nearly all initiatives focused on patient-centredness and patient rights.

While the link between health care and consumerism may appear more obvious in countries without universal health care, Coyte (2001) notes that the trend toward consumerism has increased per capita expenditures on health care as patients form expectations about favourable outcomes of medical intervention and more aggressively seek services that match their expectations; this can result in increased laboratory investigations and consultations with specialists which may yield minimal favourable health outcomes.

#### **2.4.2 Formal Complaints Process**

Gallagher and Mazor (2015) applied a patient safety lens to attitudes toward patient complaints. While the patient safety movement advocates for transparency, patient complaints are not viewed as adverse events. Complaints are handled primarily with the goal of appeasing the patient or avoiding litigation, which circumvents the opportunity to address patient complaints in a way that improves quality of care. Gallagher and Mazor argue that applying a patient safety lens to patient complaints by treating them as adverse events and undertaking efforts to prevent the circumstances leading to the complaint from reoccurring will ultimately improve care. Even when the cause of patient complaints may not fulfill the physician or organization’s definition of harm to a patient, the patient who issues the complaint often *believes* they have been harmed, and this can lead to emotional distress, loss of trust and a disruption of the patient’s life which is experienced as significant and damaging. The CPSO’s transparency policy aims to increase transparency of patient complaints by making the outcomes of some of the most high-risk complaints available to the public on their website, which could be perceived

as addressing the gap between what is perceived by physicians and institutions as an adverse event and what is perceived by patients as an adverse event.

One of the ways in which the CPSO serves the public is by receiving and addressing complaints made by members of the public about physicians. Beardwood, Walters, Eyles and French (1999) suggest that the ideological shift toward consumerism in health care increases the number of complaints that regulatory bodies receive against health care professionals. Their research found that within Ontario, since the 1980s, the professional colleges regulating various health professions are receiving a growing number of complaints from members of the public (as opposed to employers, supervisors or colleagues) against health care providers. They argue that this reflects a shift from the conception of health care as a social, collective right to the conception of health care as a consumer, individual right.

### **2.4.3 Doctor Rating Websites**

This trend is more clearly illustrated by doctor rating websites such as RateMDs. Doctor rating websites provide another means of learning more about physicians online: they allow patients to rate their doctors on a five-point scale and provide comments or complaints about their experience. Unlike the information provided on college websites, other health care professionals do not oversee or review these comments before they are posted online for anyone to read. Madison (2010) describes these websites as enabling patients to select highly rated health care providers and avoid those with low ratings, and even allowing patients to take on a regulatory role themselves by providing feedback about the type of care they expect to receive. Madison also notes that these websites further patients' roles as consumers, as they encourage patients to take a more active role in selecting physicians, rather than selecting a physician based on factors such as convenience or availability. The existence and use of these websites may also

imply diminished trust in the medical profession and its official regulators: patients want to evaluate doctors based on the experiences other patients have had with them, rather than based on the belief that any board-certified doctor will meet their needs and expectations (Madison, 2010; Shaw, Cassel, Black & Levinson, 2009).

## **2.5 Patient-Centred Care**

In recent years, patient-centredness has become a key objective in health care quality improvement initiatives. Across the world, government health care reform is being driven by the concept of patient-centred care (Kitson, Marshall, Bassett & Zeitz, 2013). In 2010, the Canadian Medical Association (CMA) issued a report titled “Health Care Transformation in Canada: Change that Works, Care that Lasts,” a transformational plan based on five pillars: 1) building a culture of patient-centred care, 2) incentives for enhancing and improving quality of care, 3) enhancing patient access and improving quality of care, 4) helping providers help patients and 5) building accountability/responsibility at all levels (Canadian Medical Association, 2010). The CMA defines patient-centred care as “seamless access to the continuum of care in a timely manner, based on need and not the ability to pay, that takes into consideration the individual needs and preferences of the patient and his/her family, and treats the patient with respect and dignity” (Canadian Medical Association, 2010, p. 7).

Within their 2010 report, the CMA established a *Charter for Patient-Centred Care* outlining the tenets of patient-centred care. These included dignity and respect, access to care (timeliness, continuity and comprehensiveness), safety and appropriateness, privacy and security of information, decision-making, insurability and planning of health services, concerns and complaints. In terms of decision-making, the CMA states that patients (or their appointed decision-maker, should they choose to let another person act on their behalf) must be active

participants in decisions about their medical care and treatment and that these decisions must be made with full disclosure of any relevant information. In addition, the CMA states that patients must be able to comment or lodge complaints about any aspect of their personal health care and to have their concerns investigated and addressed.

As a quality improvement initiative, patient-centredness is said to improve health care by advocating for patient rights, increasing patient satisfaction, being associated with better patient compliance and contributing to organizational learning (Groene, 2011). In a review and synthesis of literature on patient-centred care from health policy, medicine and nursing, Kitson, Marshall, Bassett and Zeitz (2013) found that the core themes of patient centredness are: patient participation and involvement, relationship between the patient and the health professional and the context where care is delivered. Patient participation and involvement included ideas such as respecting and developing care plans based on each individual patient's values, preferences and expressed physical and emotional needs, patient autonomy and active patient participation. The relationship between the patient and health professional comprised open communication, a genuine and continuous clinician-patient relationship and feedback mechanisms to measure patient experience. The context where care is delivered describes organizational and systemic influences on patient-centred care, such as the need for adequate staff, time and equipment and a supportive organizational system.

## **2.6 Patient Engagement**

Patient engagement, an element of patient-centred care, was identified as a priority by the Ontario government in the Ontario Ministry of Health and Long-Term Care's 2015 action plan. The plan proposed patient engagement as a means of generating a more accountable and transparent health care system in Ontario by ensuring that patient needs and concerns are fully

understood and addressed. It aims to make decisions that are informed by patients so that patients can play a role in creating system change, as well as to enable patients to make more informed decisions about their own health care (Ministry of Health and Long-Term Care, 2017).

Fooks, Obarski, Hale and Hylmar (2015) define patient engagement as “the way in which individual providers or healthcare organizations solicit patient needs and preferences to ensure they are delivering patient-centred care,” with patient-centred care defined as “an overall philosophy and approach that ensures that everything individual providers or healthcare organizations do clinically or administratively is based on patient needs and preferences” (p. 9). The CPSO’s invitation for patients to comment on their policy initiatives, including the transparency initiative, represents just one of the many shifts being made in Ontario to engage patients more directly in all aspects of health care, in addition to the inclusion of patients on advisory panels. Part of the push for patient engagement initiatives across Canada’s health care organizations is the aging population: by 2036, the percentage of individuals aged 65 and over living in Canada is expected to reach 24%, increasing the demand for home care and long-term care services (Fooks, Obarski, Hale & Hylmar, 2015).

### **2.6.1 “Patients First”: the Ontario Government Framework**

Ontario’s *Patients First: Action Plan for Health Care*, launched in February 2015, has four key objectives aimed at making Ontario’s health care system more patient-centred: increasing access, connecting care, informing patients and protecting the health care system. The same year, Ontario created a Patient Ombudsman, which provides an additional means for patients to make complaints about the health care system when their complaints have not been resolved through existing mechanisms. The objective of informing patients is defined as “providing the education, information and transparency [patients] need to make the right

decisions about their health” (Ministry of Health and Long-Term Care, 2017). This positions transparency as a priority objective in Ontario health care, as well as an integral component to what the Ministry defines as “patient-centred care” in that it is supposed to enable patients to be better decision makers when it comes to their health care needs.

### **2.6.2 Other “Patients First” Policies**

In 1996, over a decade before Ontario’s “Patients First” framework was publicized, the American Association of Health Plans (AAHP)—which has since merged with the Health Insurance Association of America (HIAA) to form America’s Health Insurance Plans (AHIP)—launched its “Putting Patients First” initiative, which called for disclosure of physician payment arrangements and managed care agreements (Mechanic, 1998). This initiative was meant to enable patient-centred care by making health plan providers more transparent. Like the CPSO’s transparency initiative, the “Putting Patients First” initiative was also met with the criticism that it was more about public relations than about patients; however, the initiative did bring about policy changes aimed at providing patients with greater control over their health care decisions than they had previously held (Jones, 1997). For example, some health plans in the United States had contractual provisions which prevented physicians from discussing treatment options or services with their patients which weren’t covered by the health plan. At the time, the AAHP developed a policy that affirmed that health plans could not prohibit or limit physician-patient communication concerning medical care and treatment options, whether those options were insured by the plan or not, enabling patients to be more informed about their health care options and able to choose, with the help of their physician, the most appropriate treatment option.

In England, the National Health Service (NHS) launched a “Putting Patients First” business plan in 2013, which was aimed at simultaneously improving patient-centred care by

focusing on patient satisfaction and outcomes, and transforming the way that health care is delivered under significant financial pressures as the need for services grows faster than the amount of funding available to the NHS (NHS England, 2013). In this plan, the NHS describes its organizational ambition as enabling “an open, transparent, participative and inclusive NHS that delivers high quality care to every patient, every time” (p. 9). Their goal in being more transparent is to allow the public to judge for themselves the quality of the service that they receive, and to increase the availability of information and data for patients.

## **2.7 Self-Regulation**

One of the goals of the CPSO’s transparency initiative is to strengthen public trust in the self-regulation of the medical profession. Self-regulation and demands for transparency have long been linked, and much has been said about the need for transparency and accountability in self-regulated industries. In particular, the need for transparency may arise from suspicions that self-regulation serves the industry over the public interest (Gunningham & Rees, 1997; Salter, 1999). One of the proposed goals of transparency in self-regulated industries is greater discipline in setting and maintaining professional standards, and more thorough performance reviews measuring adherence to these standards. According to Gunningham and Rees (1997), through public announcement of standards and the results of performance reviews, regulator accountability is better maintained. In other words, if the public has access to both the standards set out for self-regulated professions as well as the results of internal evaluations, regulatory bodies are better able to secure the public’s trust. Many calls for transparency began following scandals receiving media attention, after which legislative demands for transparency were introduced and the Internet became one of the most popular means of disclosure of self-regulatory processes (Bothwell, 2001).

Medicine has traditionally been a self-regulating profession, in which professional standards are developed, maintained and monitored by the profession itself. In Canada, this regulatory authority lies with the provincial colleges that are responsible for the licensing of health practitioners (Shaw, Cassel, Black & Levinson, 2009). Within Ontario, the *Regulated Health Professions Act* (1991) defines medicine, as well as other health professions, as self-governing, and defines the duty of the regulatory Colleges as being “to serve and protect the public interest.” The *Medicine Act* (1991) regulates the practice of medicine and pertains to physicians, whose College is the College of Physicians and Surgeons of Ontario (CPSO). The College of Physicians and Surgeons of Ontario views the self-regulated nature of the medical profession as the basis for its responsibility as a regulatory body to be accountable to the public (College of Physicians and Surgeons of Ontario, 2017).

## **2.8 Public Trust**

Hall, Dugan, Zheng and Mishra (2001) explain trust as “a global attribute of treatment relationships, one that encompasses subsidiary features such as satisfaction, communication, competency, and privacy” (p. 613). While varying definitions exist, a commonality is that trust represents “the *optimistic* acceptance of a *vulnerable* situation in which the truster believes the trustee will *care* for the truster’s interests” (p. 615). Trust can also be defined as “the expectation that institutions and professionals will act in one’s interests” (Mechanic, 1998), which links public trust to public interest. Instrumentally, trust is essential to the efficacy of health care encounters as it affects patients’ willingness to seek care, to openly provide sensitive information, to comply with treatment and to continue to see and recommend their current health care providers. The authors also note that with increased risk comes increased possibility for trust or distrust—because trust and vulnerability are inseparable, and because the health care

context intensifies vulnerability to an extent that goes beyond what might be expected in other professions, trust is of paramount importance in the patient-provider relationship (Hall, Dugan, Zheng & Mishra, 2001).

Regulatory organizations such as the CPSO can serve as an alternative to trust in situations where trust between individuals is lacking (Mechanic, 1998). These organizations seek to address patient anxieties about placing their trust in the health care system and in specific physicians by providing certification of physicians' performance and abilities. These regulatory activities are often framed by law and the threat of malpractice litigation, all of which are meant to deter and address wrongdoing. There are links between trust in physicians and trust in organizations: physicians who work at reputable, trustworthy organizations are often perceived as more trustworthy by association. It follows that when regulatory organizations enact policies aimed at appearing more trustworthy, such as increasing transparency, the idea is that individual trust in the system as a whole should be increased.

Trust is problematized by its non-rational, emotional component. Hall, Dugan, Zheng and Mishra (2001) note that because interpersonal trust is derived from a belief that the other person's intentions are benevolent and caring, "it is perfectly possible to trust an unskilled but very caring doctor or to distrust one who is highly competent but aloof" (p. 616-67). This notion resurfaces in literature on patient complaints, where it is noted that patient complaints about physicians can often be rooted more in the physician's personality and communication style than in their skill and performance (Ambady, LaPlante, Nguyen, Rosenthal, Chaumeton & Levinson, 2002).

## **2.9 The Role of the Media**

Hesse et al. (2005) note the role of the Internet within the public sphere as placing “unprecedented amounts of health information within reach of general consumers” (p. 2618). Consumers’ trust in health information found on the Internet is divided; about one fourth of respondents in their study expressed a high degree of trust, while one fourth expressed no trust. However, the Internet was shown to be trusted more than other forms of media such as the radio. When seeking information about specific diseases such as cancer, given the choice between health care providers and the Internet, respondents aged 18 to 34 and 34 to 64 were almost equally divided in which information source they would consult first, with the Internet being the most common first choice. Individuals aged 65 and over, however, showed preference for seeking information from their physicians first. Individuals who are young, female, educated and have higher incomes are shown to be more likely to use the Internet for health information seeking (Hesse et al., 2005). In addition, patient satisfaction plays a role in Internet health information seeking: patients who report dissatisfaction with their health care providers are more likely to rate the Internet as a better source of health information (Tustin, 2010).

### **2.9.1 Providing Specialized Information to the General Public**

Transparency initiatives have often been criticized for assuming an overly linear model of communication, in which context and explanation are lacking and individuals are left to their own interpretations of the information provided to them (Levay, 2016). This concern has often been cited as an argument against the publication of information such as physician billings to provincial health care plans (i.e. Boyle, 2014). Members of the public vary in their levels of health literacy and degrees of understanding of how the health care system works, and this is a common rebuttal to the idea that making more information about health care professionals publicly available is in the public interest. The main argument seen against transparency in

health care is that information without context does not help the public to understand the health care system better, but rather undermines trust in the physician-patient relationship (Levay & Waks, 2005).

When it comes to providing health information on the Internet, much skepticism has been expressed about patients' ability to properly understand and digest the information provided to them, as well as the credibility of information found online (Cline & Haynes, 2001). In addition, access to the Internet is not equal, so providing health information on the Internet excludes those with barriers to access as well as those with limited computer skills (Eng et al, 1998). This poses issues for a transparency policy in which greater quantities of information are being posted exclusively on the Internet: in order for this to benefit all patients equally, patients must first know that the information is there and be able to access it. Without a way to access the information offline, some patient groups will be excluded from information that is supposed to enable them to make better choices about their health care.

## **2.10 Summary**

Transparency is an open, uninhibited sharing of information with the public that is supposed to generate organizational or governmental accountability and to help the public to make better, more informed choices (Leape et al., 2009; Fox, 2007). Within health care, demands for greater transparency have been motivated by concerns for patient safety and patient rights (Blomgren, 2007; Chantler & Ashton, 2009). Creating a more accountable and transparent health care system in Ontario that puts patients' needs first and prioritizes patient engagement is part of Ontario's *Patients First: Action Plan for Health Care*, launched in February 2015 (Ministry of Health and Long-Term Care, 2017), while patient-centred health care was recognized as a key element in the Canadian Medical Association's transformational plan for health care in 2010

(Canadian Medical Association, 2010). In Ontario's *Patients First* action plan, transparency is positioned as a key objective in order to help patients make more informed decisions about their health care. This focus on enabling patients to make their own choices mirrors the idealized physician-patient relationship in which all information is provided to the patient by their physician, allowing the patient to decide which health care options best suit their needs. A downfall of this type of physician-patient relationship is that it is linked to a consumerist view of health care wherein the patient is a client with consumer rights and the physician is a service provider with obligations to satisfy their client's requests, which can create tensions when the physician or the patient do not feel that these roles are appropriate (Roter, 2000; Emanuel & Emanuel, 1992; Berry, 2007).

The trend toward consumerism in health care has led to the development of doctor rating websites such as RateMDs, where patients can rate and provide feedback about their physicians online. According to Madison (2010), the purpose of these websites is to allow patients to select highly-rated and peer-approved physicians and to avoid those with low ratings. Similarities between this type of website and the CPSO's public register can be seen in the items the transparency initiative proposes to include on the public register, such as a history of cautions or remediation programs. It is possible that physicians who do not have this information associated with their name will be seen as more trustworthy than those that do. It has been suggested that the need to appraise physicians' trustworthiness by consulting online resources and reviews implies diminishing public trust in the health care profession (Madison, 2010; Shaw, Cassel, Black & Levinson, 2009). The CPSO's transparency initiative aims to strengthen public trust in the self-regulation of the medical profession (College of Physicians and Surgeons of Ontario, 2017).

Trust is also comprised of the hope that institutions and professionals will act in the best interests of the public (Mechanic, 1998). Trust can be built or compromised in a number of ways, but a concern in using transparency of information provided on the Internet in order to foster public trust is that the public's varying abilities to understand the information provided to them could have the opposite of the desired effect and actually undermine the physician-patient relationship (Levay & Waks, 2005). Nonetheless, strengthening public trust is the goal that CPSO Registrar Dr. Rocco Gerace describes for the transparency initiative: "in order for the public to trust that the system works, we need to demonstrate that the system works" (College of Physicians and Surgeons of Ontario, 2015).

Two significant gaps in the literature exist: the provision of physician-specific information online in order to increase transparency has not been explored. Research on transparency in health care focuses primarily on the transparent reporting of patient safety incidents and routine regulatory reviews (such as hospital premises inspections). The CPSO's transparency initiative proposes to provide details about remedial actions such as cautions against physicians or the undertaking of educational programs to correct deficiencies in practice, and this type of information sharing over the Internet is not represented in the literature. Additionally, much of the literature focuses on the impacts of transparency on the general public—its benefits, potential risks, and limitations of understanding. There is sparse exploration of the way that increased transparency is regarded by those individuals whose information is being shared—in this case, physicians. This thesis asks how organizations, physicians and members of the public feel that the CPSO's transparency initiative and the specific types of information it proposes to provide fulfills or does not fulfill the organization's mandate, which is to protect and serve the public interest.

### CHAPTER 3: METHODOLOGY

In order to understand the way in which physicians, members of the public and members of regulatory bodies perceive the transparency initiative as fulfilling the CPSO's public interest mandate, this thesis applies discourse analysis to the feedback provided through the discussion forums on the CPSO's website (<http://www.cpso.on.ca>). The CPSO's discussion forums ([http://policyconsult.cpso.on.ca/?page\\_id=5062](http://policyconsult.cpso.on.ca/?page_id=5062)) outline the proposals the regulatory body has made to have new information available to the public, and invite feedback about these proposals from physicians, members of the public and organizations. An analysis of the discussion forums will identify common themes, with the aim of discovering the ways in which the content of the discussion forums responds to the goals set out by the CPSO's transparency initiative.

Themes are identified within the discussion forums in order to discern whether the same themes are being addressed in the discussion forums and the CPSO's publications on their transparency policy, which helps to answer the question of how the transparency initiative is supposed to fulfill the CSPO's public interest mandate. Discourse analysis is most appropriate for this task because it studies "language-in-use": the ways in which language is used to accomplish certain goals, social practices or projects (Gee, 2014; Starks & Trinidad, 2007). While many approaches to discourse analysis exist, this thesis focuses on the content of the language being used to identify common topics of discussion, rather than analyze the structure of the language itself (Gee, 2010). Discourse analysis also takes into consideration the context in which communication takes place—the shared knowledge of those involved in the communication (Gee, 2014). In the case of this thesis, the discourse analyzed concerns those involved in and/or affected by the practice of medicine in Ontario.

### 3.1 Data Collection

Data were collected from the second phase of consultations about the transparency initiative. The second phase of consultations about the transparency initiative generated 226 responses on the CPSO's discussion forums between December 2014 and April 2015. These are the responses that will be analyzed. This phase of consultations introduced a number of new additions to the CPSO's public register, including the details of cautions against physicians, specified continuing education or remediation programs (SCERPs) ordered for physicians, criminal charges against physicians, and discipline findings or medical licences held by physicians in other jurisdictions. These 226 responses are compared to the CPSO's publications regarding the transparency initiative to determine whether the themes discussed on the forums are responding to the themes present in the CPSO's official publications.

Within the discussion forums, physicians, members of the public and organizations were given the opportunity to react to these new additions before they were officially added to the public register on the CPSO website. The content of the responses were typically an opinion in favour of, or against, adding one or more of the types of information listed above to the public register, along with an explanation as to why access to that particular type of information does or does not benefit the public. Significantly, during the first phase of consultations, most members of the public were in favour of the information the CPSO proposed adding to the public register, while most physicians were against the proposals (College of Physicians and Surgeons of Ontario, 2015).

Of the 226 responses, 137 were stand-alone responses or the beginnings of threads; the remaining 89 responses were replies to comments made by others. Those who posted on the discussion forums are not identified by name; instead, the author of each post is allowed to

identify as a physician, a member of the public, and organization, or anonymous. Of the 226 responses, 97 were issued by physicians; 39 by a member of the public; 5 by an organization; and the remaining 85 were anonymous. The proposed additions to the public register that these responses are responding to include cautions (which are verbal warnings issued to physicians following investigations of patient complaints which determine that the physician has engaged in conduct that needs correcting), SCERP orders (the ordering of specified continuing education and remediation programs following investigations of patient complaints which determine that the physician has engaged in conduct that needs correcting), criminal charges (any criminal charge made against a physician), licenses in other jurisdictions (the possession of non-Ontario medical practice licenses), and discipline findings in other jurisdictions (disciplines against the physician which took place outside of Ontario). Within the discussion forum containing all 226 responses, the word “caution” appears 205 times; “criminal” appears 67 times; “SCERP” appears 46 times; “licence/license” appears 42 times; and “discipline” appears 25 times. Discourse analysis will help to further analyze the content of these discussions by identifying common themes.

### **3.2 Analytic Strategy**

In order to identify the themes, the responses and the CPSO publications were read through in order to discern the topics of discussion that occur most frequently. For example, one general topic that emerged within the discussion forums was that of fairness to physicians. Many of the posts supported or opposed the idea that the new additions to the CPSO’s public register were “unfair” or “punitive” to physicians. Another topic that was prominent in both the discussion forums and CPSO publications was trust. Within the CPSO’s publications, the need to secure public trust is frequently repeated; within the discussion forums, patients often speak of

their need to trust their physicians as a reason for being in support of the new additions to the public register. Another topic was patient choice: with one of the goals of the transparency initiative being “to help patients make informed choices” (College of Physicians and Surgeons of Ontario, 2017), many of the posts on the discussion forum addressed patients’ needs to choose a trustworthy and competent physician.

Before themes were identified, the 226 responses on the discussion forum were coded. According to Saldaña (2015), “a theme is an outcome of coding, categorization, and analytic reflection” (p. 13), and not something that emerges from the first step of analysis. The first step was to undertake first cycle coding methods. Saldaña (2015) breaks first cycle coding methods into seven subcategories. The most appropriate method for this thesis is descriptive coding (also referred to as topic coding), as it will be the most useful in helping to uncover the themes of conversation. Descriptive coding analyzes the topics that emerge from the data in order to answer general questions about what is being discussed (Saldaña, 2015). A descriptive code is a word or short phrase that summarizes “the basic topic of a passage of qualitative data” (Saldaña, 2015, p. 70). These codes help build the foundation for second cycle coding methods and further analysis, including the identification of common themes.

Second cycle coding methods reorganize and reanalyze the data that was coded during initial analysis (Saldaña, 2015). The goal of second cycle coding “is to develop a sense of categorical, thematic, conceptual, and/or theoretical organization from your array of first cycle codes” (Saldaña, 2015, p. 149). During the second cycle of coding, the list of codes becomes smaller and more select, identifying the broader themes and concepts that emerge from the data. The most appropriate second cycle coding method for this study is pattern coding, which is an explanatory or inferential method that often follows descriptive coding. Pattern coding works to

identify major themes that emerge from the data (Saldaña, 2015). To carry out this method of coding, similar codes from the first cycle are grouped together in order to analyze what the data has in common, then develop and select a pattern code. This way, the codes from the first cycle are narrowed into a smaller list that more selectively describes the patterns present in the discussions.

During this second cycle of coding, themes may be identified. Saldaña (2015) describes a theme as “a phrase or sentence that identifies what a unit of data is about and/or what it means” (p. 139). Themes are longer phrases that elaborate on the meaning of shorter codes. According to Saldaña (2015), two strategies that are recommended for identifying themes include adding the verbs “means” and “is” after the phenomenon a code is describing. For example, if “Trust in physicians” is an idea that emerges from this data, a theme would expand on the idea by making a statement such as “Trust in physicians is important for patients’ decision-making.”

Discourse analysis was then used to compare the themes that emerged from the discussion forum to the themes that emerged from the CPSO publications in order to answer the question of how the transparency initiative fulfills the CPSO’s public interest mandate from the point of view of the College and from the point of view of its audience (physicians, health care professionals and members of the public). It was also used to discover whether the themes that emerged from the discussion forum were responding to the goals set out by the transparency initiative, which helped to determine whether the public believes that the transparency initiative is achieving the goals described by the CPSO. Discourse analysis acknowledges the subjectivity of interpretations, and the claims that it generates are interpretive and descriptive. It describes similarities and patterns across texts to construct interpretations of what is being discussed, and

these interpretations are supported by examples found during the analysis (Merrigan, Huston & Johnston, 2012).

## CHAPTER 4: ANALYSIS

### 4.1 Levels of Analysis

#### 4.1.1 Authors of Responses

Authors of the 226 responses on the discussion forum were able to identify as one of four categories: physician, member of the public, organization, or anonymous. Of the 226 responses, 97 (43%) were posted by a physician, 39 (17%) by a member of the public, 5 (2%) by an organization, and 85 (38%) by anonymous. It is important to note that these categories do not differentiate a physician from a patient; only the “physician” category distinguishes someone as a physician. There were some responses posted by a “member of the public” or “anonymous” in which the poster hinted in some way that they were a physician or other health professional, meaning that these categories could include physicians as well. However, for the purpose of the analysis, authors will be identified according to the category they chose. This may complicate the interpretation of the findings in some ways, as the opinion of a patient could be expressed under the category of anonymous and the opinion of a physician could be expressed under the category of member of the public; however, the themes of discussion within the responses may provide further clarity on which opinions are from patients and which are from physicians.

#### 4.1.2 Transparency Proposals

Most responses addressed one or more of the proposed amendments to the transparency principles, rather than addressing them all as a whole. The majority of responses (118, or 52%) discussed the publication of cautions, with the second most common topic of discussion being criminal charges (49, or 22%), and the third most common being SCERPs (33, or 15%). Unsurprisingly, many responses addressed cautions and SCERPs simultaneously (30, or 13%), as both cautions and SCERPs are a result of investigations into the problematic conduct of a

physician. 15 responses (7%) discussed cautions and criminal charges, 13 responses (6%) discussed SCERPs and criminal charges, and 12 responses (5%) discussed all three simultaneously.

Proposal	Responses related to code (N=226)		Author of response							
			Physician		Member of the public		Organization		Anonymous	
	n	%	n	%	n	%	n	%	n	%
Cautions	118	52.21	44	19.47	24	10.62	4	1.77	46	20.35
Criminal charges	49	21.68	27	11.95	3	1.33	4	1.77	15	6.64
SCERPs	33	14.60	14	6.19	4	1.77	5	2.21	10	4.42
Discipline findings in other jurisdictions	12	5.31	5	2.21	1	0.44	4	1.77	2	0.88
Licences in other jurisdictions	12	5.31	5	2.21	1	0.44	3	1.33	3	1.33
All / transparency in general	69	30.53	30	13.27	13	5.75	0	0.00	26	11.50

**Table 1. Proposals covered by forums as a function of author of response**

#### **4.1.3 Nature of Agreement/Disagreement with Proposals**

To classifying responses as being either in agreement or not in agreement with the proposed transparency amendments, they were classified according to their views on the specific amendment they were responding to rather than according their views on transparency as a whole. For example, some responses voiced support for other amendments or for transparency in general, but focused their response on a specific amendment they did not support, and these responses were classified as not being in agreement. Those classified as having “mixed

agreement” were responses that supported the amendment they were commenting on but recommended certain stipulations or caveats, i.e. that publishing cautions or SCERPs was a good idea for the most serious cases and less useful for the rest. An example of a mixed agreement response would be as follows:

I theoretically agree that there should be more transparency and that more information should be made available to the public. However, the current process whereby decisions are made for oral caution and disciplinary action is not rigorous enough. (...) Because of all of these problems in the current process, I would NOT be in favour of having this information made public. Once there is more standardization as to when a physician should have an oral caution or receive disciplinary action (...) I think the issue of releasing these sorts of information to the public should be reconsidered (Physician, March 27, 2015, 9:00 am).

54 responses (24%) were classified as being “in agreement” of the amendments they were responding to, 166 responses (73%) were classified as “not in agreement,” and 6 responses (3%) were classified as “mixed agreement.”

Nature of agreement	Responses related to code (N=226)		Author of response							
			Physician		Member of the public		Organization		Anonymous	
	n	%	n	%	n	%	n	%	n	%
In agreement	54	23.89	6	2.65	19	8.41	2	0.88	27	11.95
Not in agreement	166	73.45	87	38.50	20	8.85	2	0.88	57	25.22
Mixed agreement	6	2.65	4	1.77	0	0.00	1	0.44	1	0.44

**Table 2. Support expressed in forums as a function of author of response**

**Nature of Agreement with Individual Proposals.** These varying degrees of agreement were further broken down by the proposed amendment they were responding to. Because individual responses often commented on more than one proposal, the data for each of the proposed amendments exceeds the total number (226) of responses classified as either in agreement, not in agreement, or mixed agreement. However, the trend shown above remained the same for each of the proposals individually: the majority of responses were not in agreement with the proposed amendments.

Level of support	Responses related to code (N=226)		Proposed amendment											
			Cautions		Criminal charges		SCERPs		Discipline findings in other jurisdictions		Licences in other jurisdictions		All / transparency in general	
	n	%	n	%	n	%	n	%	n	%	n	%	n	%
In agreement	54	23.89	35	15.49	8	3.54	6	2.65	4	1.77	3	1.33	16	7.10
Not in agreement	166	73.45	78	34.51	40	17.70	25	11.06	6	2.65	7	3.10	52	23.01
Mixed agreement	6	2.65	5	2.21	2	0.88	2	0.88	2	0.88	2	0.88	1	0.44

**Table 3. Support expressed in forums as a function of proposed amendment**

Of the 118 responses on cautions, 35 (30%) were in agreement, 78 (66%) were not in agreement, and 5 (4%) had mixed agreement. Of the 49 responses on criminal charges, 7 (14%) were in agreement, 40 (82%) were not in agreement, and 2 (4%) had mixed agreement. Of the 33

responses on SCERPs, 6 (18%) were in agreement, 25 (76%) were not in agreement, and 2 (6%) had mixed agreement. Of the 12 responses on discipline findings in other jurisdictions, 4 (33%) were in agreement, 6 (50%) were not in agreement, and 2 (17%) had mixed agreement. Of the 12 responses to licenses in other jurisdictions, 3 (25%) were in agreement, 7 (58%) were not in agreement, and 2 (17%) had mixed agreement. And of the 69 responses that either responded to all of the amendments or transparency in general, 16 (23%) were in agreement, 52 (75%) were not in agreement, and 1 (1%) had mixed agreement. Shown in the table above are the percentages out of the total number of responses.

#### **4.2 First Cycle of Analysis**

During the first cycle of analysis, 12 descriptive codes were identified. The first cycle of coding is intended to be simple and direct; the codes identified allow for more thorough and analytical second cycle coding (Saldaña, 2015). Descriptive coding (also called topic coding) was applied to a careful reading of all 226 responses on the discussion forum. This type of coding “summarizes in a word or short phrase—most often as a noun—the basic topic of a passage of qualitative data” (Saldaña, 2015, p. 70). Because the data being analyzed were short discussion forum responses, this type of coding is useful to identify the main point being addressed in the response. Many responses covered more than one topic; however, all responses seemed to address a common range of 11 topics. The 11 topics identified in this first cycle of coding, and a description of the basic ideas contained within these topics, are:

Code	Responses related to code (N=226)		Author of response							
			Physician		Member of the public		Organization		Anonymous	
	n	%	n	%	n	%	n	%	n	%
Public reprimand	24	10.62	14	6.19	4	1.77	1	0.44	5	2.21
Due process	39	17.26	21	9.29	5	2.21	2	0.88	11	4.87
Fairness to physicians	85	37.61	45	19.91	6	2.65	2	0.88	32	14.16
Public trust	24	10.62	7	3.10	10	4.24	2	0.88	5	2.21
Public perception	46	20.35	21	9.29	8	3.54	1	0.44	16	7.08
Patient safety	43	19.03	5	2.21	11	4.87	3	1.33	24	10.62
Secretiveness	17	7.52	3	1.33	5	2.21	1	0.44	8	3.54
Media	25	11.06	9	3.98	5	2.21	0	0.00	11	4.87
Improving patient care	29	12.83	17	7.52	4	1.77	2	0.88	6	2.65
Patient choice	20	8.85	8	3.54	6	2.65	1	0.44	5	1.77
Organizational flaws	56	24.78	21	9.29	10	4.24	0	0.00	24	10.62

**Table 4. Topics covered by forums as a function of author of response**

#### 4.2.1 Overview

Before detailing the analysis of these codes, it is necessary to define the topics of discussion within the forums. The elements of the transparency initiative that the discussion forums are responding to include criminal charges, cautions, Specified Continuing Education or Remediation Programs (SCERPs), discipline findings in other jurisdictions, and licenses in other jurisdictions. These items would be published on the register, which is a database of public

information about Ontario doctors. This database previously included only items such as the physician's specialty, practice location, education, languages spoken, gender, terms and conditions of practice, postgraduate training and registration history.

**Criminal charges.** In this context, this includes all *Criminal Code* and *Health Insurance Act* charges against the physician that are known by the CPSO. The information to be published on the website would include the fact and content of the charge against the physician as well as the place and date of the charge if that information is available. Once the charge is no longer outstanding, it would be removed from the public register.

**Cautions.** Cautions are issued by the CPSO's Inquiries, Complaints and Reports Committee (ICRC) when a patient complaint results in significant concern about a physician's conduct or practice and the direct impact it could have on patient care, safety or the public interest if left unaddressed. As a result of the transparency initiative, a summary of all cautions investigated on or after January 1, 2015 will be posted on the public register. Cautions may be appealed and, if the decision is overturned, the caution will be removed from the public register.

**Specified Continuing Education or Remediation Program (SCERP) orders.** SCERP orders are another possible outcome of patient complaints investigated by the ICRC. If the ICRC determines that the physician requires education or remediation as the result of their investigation of a patient complaint, the physician may be required to take a SCERP. A SCERP might include educational courses or one-on-one instruction by another physician, and there may be a reassessment component to ensure the success of the SCERP. As a result of the transparency initiative, this information will be posted to the public register for all investigations that began on or after January 1, 2015.

**Discipline findings in other jurisdictions.** Disciplines are the most severe result of a patient complaint. They are issued when the complaint results in serious concern about the physician's conduct or practice and the impact it may have on the public. Previously, only disciplines issued in Ontario were posted on the CPSO public register. As a result of the transparency initiative, discipline findings in other jurisdictions that became known to the college on or after January 1, 2015 will be posted on the public register. Information posted will include the fact of the finding against the physician, the date of the finding and the jurisdiction in which the finding was made.

**Licences in other jurisdictions.** This refers to medical licenses held in other jurisdictions—meaning any non-Ontario licence, for example, a licence from the College of Physicians and Surgeons of British Columbia (CPSBC)—of which the CPSO is aware. Medical licences are issued by the province or territory of practice within Canada.

#### **4.2.2 Public Reprimand**

This code was given to responses that addressed the idea that providing more information about physicians online is a punitive action, with the intention of publically shaming the physician. The idea is that information such as cautions received by physicians, and SCERPs that physicians are ordered to take, are educational in nature if they take place without public knowledge. Once they become public knowledge, the educational procedure transforms into a disciplinary one that is ultimately able to impact the physician in a negative way. 24 out of 226 responses received this code, with the majority of these responses posted by physicians (58%).

A common argument against the publication of information such as cautions can be found in this response posted by a physician:

[Physicians] would be much more likely to improve if deficiencies were pointed out in a non-threatening manner rather than punishing them with a public reprimand. To make an analogy, if your contractor installed a toilet and it leaked do you think it would be more effective to give the contractor a chance to remedy the issue before reporting them to the Better Business Bureau and publishing their mistake on the Internet? (Physician, January 29, 2015, 4:26 am).

From the responses posted by physicians under this code, it is clear that physicians find the idea of the details of errors they have made in their practice being published on the Internet for anyone to read to be threatening and punitive. One physician went so far as to say that “a public disclosure is entirely punitive in the extreme. I personally could think of no worse punishment other than licence suspension” (Physician, February 10, 2015, 9:28 am).

Contrastingly, others feel that patients have a right to know these details: one member of the public wrote that “if the investigations committee determines a caution is warranted it is because the doctor has engaged in some conduct that needs correcting. The public has a right to know if a person in a position of public trust has made such errors” (Member of the Public, January 9, 2015, 11:11 am).

Prior to publishing the outcome of cautions or the ordering of SCERPs on their website, the CPSO’s process was to issue written decisions of the Inquiries, Complaints and Reports Committee (ICRC) in response to patient complaints to the patient who filed the complaint and the physician the complaint was filed against. These decisions can be appealed by the patient or the doctor. With the new process implemented by the transparency initiative, written decisions that result in a cautions or a SCERP are now published online; the physician still has the ability to appeal this decision, and if the decision is overturned, it is removed from the public register.

There are still other possible outcomes of ICRC decisions that are not made available online: if advice or recommendations are issued by the ICRC for the doctor to improve their practice following a patient complaint, but the doctor's conduct was not deemed problematic enough to warrant an oral caution or a SCERP, this information still remains private.

#### **4.2.3 Due Process**

Many of the discussion forum responses used the phrase “due process” directly, while others referred to the concept of “innocent until proven guilty,” and others simply referenced malpractice and litigation, with the aim of demonstrating the fairness or unfairness of providing certain types of information from the public. Some of these responses argued that the information the College proposed to make publicly available is fair and does not bypass due process, while others argued that it is unfair and violates the rights of the physician as an individual. Of the 226 responses, 39 received this code, with the majority posted by physicians (55%).

While some responses went as far as to claim that the publication of cautions and SCERPs bypass due process, ICRC decisions are not a legal proceeding, nor are they permissible to be used in Court. However, the majority of responses within this code referred to the proposal to publish criminal charges against physicians as bypassing due process. While the CPSO did not post criminal charges against physicians prior to the second phase of the transparency initiative, this phase introduced the publication of all *Criminal Code* and *Health Insurance Act* charges on the public register. These charges are removed from the public register once the charge is no longer outstanding.

Of all of the transparency proposals, the publication of criminal charges had the highest volume of responses that voiced disagreement (81.63% of all responses about criminal charges).

This is likely because, as one physician's response states, "I cannot believe that the CPSO is even considering publishing criminal charges. As has been mentioned, a charge is not a conviction. Our entire society operates on the premise of presumed innocence, not presumed guilt" (Physician, March 21, 2015, 5:20 pm). The opposition to posting criminal charges expressed in the responses is that, particularly in cases where individuals accessing the information might not understand the difference between a criminal charge and a criminal conviction, and because by posting the information on the public register the CPSO is deeming the information relevant for patients to know, patients may interpret the information to mean that their physician is guilty of a criminal offence and this will damage the physician's reputation.

Additionally, some responses voiced concern that unhappy patients could use this as a means of intentionally damaging their physician's reputation. One anonymous response states that "making charges public allows the potential for vexatious and unscrupulous individuals to make untrue allegations that can cause irreparable harm to a physician's reputation without due process" (Anonymous, January 5, 2015, 9:27 pm). While other responses expressed similar opinions or agreed that the publication of criminal charges gives vexatious individuals the opportunity to unduly damage the reputations of their physicians, what the responses neglect to mention is that it is law enforcement and not the patients themselves who may press charges, and that a charge is only laid when a police officer has reasonable and probable grounds to suspect that a crime has been committed (Canadian Judicial Council, 2007).

Nonetheless, the argument that those who do not understand that an individual with a criminal charge against them is presumed innocent might interpret the information on the public register to mean their physician is guilty of a criminal offence is a plausible one, and this is demonstrated by how few responses were in agreement with the publication of criminal charges.

An example of a response in agreement with the publication of criminal charges, posted by a member of the public, is as follows:

Regarding criminal charges, the presumption of innocence does not imply that charges must be secret. In fact, they are not. Every day the news includes items about people who have been arrested and charged with crimes but who have not yet had their day in court. This should be no different for physicians, and if the news reports that a physician was charged with a crime yet the CPSO is silent, there is an appearance of a lack of transparency (Member of the Public, December 17, 2014, 3:55 pm).

Interestingly, this response uses the reporting of criminal charges in the news media as justification for their inclusion in the public register, and Canada's judicial system struggles with balancing freedom of the press with the potential for news media reporting on legal proceedings to influence perceptions of guilt or innocence before an official decision has been reached (Canadian Judicial Council, 2007).

#### **4.2.4 Fairness to Physicians**

Responses that received this code addressed, at a basic level, whether or not the proposed amendments were fair to physicians. There was significant overlap between this code and the others, which addressed in more specific ways the fairness of the amendments by referencing concepts such as due process, public reprimand, and public perception. However, what is distinct about the responses that received this code is that they centred on the idea that a physician is a human being and that the proposed amendments treat them differently than others in society can expect to be treated. These responses propose that physicians as individuals could be harmed—either psychologically, or by way of their career and reputation—by the proposed amendments in

a way that is unjust. Many of these responses directly used the word “unfair.” 85 responses received this code, with the majority posted by physicians (53%).

A response from an anonymous poster argues: “At present, just 2 or 3% of all complaints by patients are referred to the Disciplinary Committee. So, 98% of complaints result in NO meaningful sanction against a doctor [...] even when a patient is harmed by a doctor’s negligence. It amazes me to see so many physicians on this feedback page moaning about how the present system is unfair to THEM!” (Anonymous, March 15, 2015, 12:34 am). This sentiment was echoed by others who felt that physicians who were more concerned about how the publication of cautions, SCERPs and criminal charges could damage a physician’s reputation than they were about the risks that some physicians’ errors in practice posed to the life and safety of their patients. Many members of the public and anonymous posters in the discussion forum felt that they had the right to know when a physician had made errors in their practice. However, what is implied by this “right to know” is the right to avoid physicians who have been cautioned for deficiencies in their practice in the past, and many physicians on the discussion forum expressed that a physician having made a mistake in the past does not warrant being avoided by current and future patients, particularly when their intention is to correct that mistake and to prevent it from occurring in the future.

One physician detailed the psychological consequences that can result from such sanctions: “I have to state that the caution caused severe psychological distress for me. Documentation seems to be the only thing that mattered. I was very close to suicide during the process. I don’t see how posting this would have helped me to be a better physician” (Physician, January 29, 2015, 11:50 am). Others focused more on reputational consequences, as well as potential consequences to patient care that could stem from posting cautions line: “publishing

cautions will forever ruin the reputation of many doctors, and will make medicine more about pleasing the patient to avoid a complaint, than about good medicine” (Member of the Public, January 10, 2015, 6:37 pm). In this scenario, not only would the physician’s reputation be harmed, but they would change their practice in such a way that avoiding damage to their reputation became of higher importance than sound medical care.

A point of contention raised in many of the responses is that, were the tables reversed, and a physician had a right to refuse care for patients based on criminal charges laid against them or based on their history of filing complaints against other physicians, this would be seen as discrimination; that it is not seen as discrimination when applied to physicians presents a double standard. One physician summarizes: “I appreciate the sentiment that patients should have information about their present or soon to be doctors but I feel the proposals are prejudicial and unfair. The flip side is a physician who refuses to take a patient on the basis of their criminal record. This would be discriminatory” (Physician, January 23, 2015, 2:23 pm).

However, the difference here outlines the positioning of the patient as a consumer, as another physician explicitly states: “just as you the consumer want as much information about a doctor before making your choice, don’t you think it would be fair then for the doctor to request information about your past too, especially as it relates to your criminality?” (Physician, January 29, 2015, 4:26 am). In the relationship between a patient and physician, the patient may be seen as the consumer while the physician is viewed as a service provider; the information provided to patients is intended to inform their choice in services, while the physician, as a provider, has fewer rights in choosing to withhold services from a potential client.

#### 4.2.5 Public Trust

Responses that received this code responded to the basic premise of the transparency initiative, which is to enable public trust in the self-regulatory nature of the CPSO and its physicians. Many referred to trust in the practices of self-regulation more broadly, while others referred to the ability of patients to trust the physician(s) responsible for their care. 24 responses received this code, with the majority posted by a member of the public (42%).

One response by a member of the public addresses the lack of trust in self-regulation: “CPSO self-regulation has equated to little or no protection for the public and in the end, the public has learned to distrust the profession as whole [...] CPSO themselves are responsible for the loss of trust of patients in Ontario” (Member of the Public, April 1, 2015, 5:05 pm). While this comment does not specifically address the source of the loss of trust, others reveal that it is rooted in fear created by specific doctors: as one anonymous response states, “There are some doctors that the public needs to be afraid of” (Anonymous, March 5, 2015, 9:27 am). Still other responses refer to the unique vulnerability of the physician-patient relationship, as one member of the public describes: “As a patient who is entrusting my doctor with my wellbeing, and granting them a level of access to my person and to my personal information that goes well beyond what I share with most other people in my life, I feel that any relevant information should be available” (Member of the Public, December 17, 2014, 3:55 pm).

In this case, absence of negative information on the public register would indicate a trustworthy physician, while the presence of negative information would deem a physician untrustworthy, which is exactly why some oppose posting more information to the public register. As one physician writes: “While I believe that it is important that the public look to the College as a body to ensure that physicians and surgeons in the Province of Ontario are

practicing safely, I'm not sure that this form of transparency achieves that goal. I worry that it could create mistrust and sabotage the physician-patient relationship by creating stigma” (Physician, March 21, 2015, 9:10 am). Having a caution, SCERP, or criminal charge posted on a physician's public register is an indication to the patient that the physician has committed an error; this will diminish trust in that particular physician, but can also create a broader lack of trust in the profession as a whole if individuals generalize their experience with one physician to their perception of others.

However, what these responses address is patients' trust in individual physicians; what the CPSO's transparency initiative seeks to accomplish is to strengthen public trust in their organization and its ability to regulate physicians. The act of making the information available is seen as being able to positively influence trust for some, while withholding the information can create a perception that the organization is hiding the mistakes of their members from the public. Thus, the goal in providing this information isn't necessarily to enable trust in physicians individually, but to create an image of trustworthiness for the organization that regulates their practice.

#### **4.2.6 Public Perception**

This is another broad code that addresses, in general, the public's perception of the CPSO and of physicians and how this perception can be influenced by the transparency initiative and its proposals. Many of the responses that received this code more specifically addressed the ability of the public to interpret and understand the information that would be available to them as a result of the transparency initiative. The responses expressed concern that the general public would misinterpret the information found on the CPSO website, leading to a loss of trust or avoidance of a particular physician for the wrong reasons. Essentially, these responses referred to

the gap between the perception and understanding of the general public and the organizational information that would be provided—in organizational language—by the transparency initiative. 46 responses received this code, with the majority posted by a physician (46%). For example, the Ontario Medical Association (OMA) wrote within their response that:

The OMA maintains the position that information is only useful to the patient in making informed decisions about their care if the information is contextual, relevant and easily understood by the patient. The potential lack of context when it comes to cautions-in-person and SCERPs is troubling. Expecting a patient to make judgments about his or her physician without fully understanding the context of a reference on the register only serves to undermine the patient-physician relationship (Organization – Ontario Medical Association, March 27, 2015, 11:05 am).

This same concern has been echoed in the literature on the volume of health information made available on the Internet, as well as the literature on making patients' electronic health records and lab results available to them and their guardians: most members of the public are not licenced health professionals, and without a licenced health professional to guide their interpretation of the information they are receiving, there is a potential for misunderstandings that could harm the patient and create problems in their relationship with their physician (Wald, Dube & Anthony, 2007; Cline & Haynes, 2001; Earnest, Ross, Wittevrongel, Moore & Lin, 2004; Winkelman, Leonard & Rossos, 2005; Urowitz et al., 2008). Beyond the issue of whether individuals can understand the health information provided to them on the Internet is the issue that not every individual understands how to use, or has access to, the Internet or a computer (Eng et al, 1998). A member of the public illustrates this problem in their response:

This ‘buyer beware’ type of policing does not help me or any other consumers who are not doctors or nurse to understand medical lingo and risk. How are consumers to decide if this doctor is safe or not? I thought that was the job of the College. The College should be deciding who is safe to practice medicine, not me. And what about people who are not internet savvy, or don’t have computers? I guess the College is gonna say too bad that you got botched, because we told you so on the website and it’s your fault for not checking... (Anonymous, December 18, 2014, 10:37 am).

A response posted by a member of the public asserts that patients judge their physicians on likability rather than evaluation of their professional skills, and that making cautions public will not lend itself to accurate interpretation: “Members of the public lack the knowledge and context to properly assess the significance of a caution. This is because the ordinary member of the public is unable to determine the professional abilities of a physician. They, the public, judge physicians as they do everyone else: Do they like the person?” (Member of the Public, March 3, 2015, 12:58 pm). The member of the public goes on to compare this with RateMDs, stating that doctor ratings may be an accurate measure of a doctor’s likability, but that likability is not necessarily correlated to medical skill and knowledge.

#### **4.2.7 Patient Safety**

This code was given to responses that addressed the idea of patient safety, defined as “the reduction and mitigation of unsafe acts within the health-care system as well as through the use of best practices shown to lead to optimal patient outcomes” (Davies, Hebert & Hoffman, 2003, p. 12). Many responses referred to incidents where patients were harmed, or the potential that patients might learn how to avoid harm owing to the information provided to them by the

transparency initiative. 43 responses received this code, with the majority posted by anonymous (56%).

Patient safety was commonly used as a defensive remark against responses that stated that posting information about complaints, SCERPs or criminal charges could encourage dissatisfied patients could use these processes against physicians who had not given them what they wanted, as can be observed in this anonymous response:

I am very concerned that you appear to see the majority of complaints to the College as vexatious in nature. Why are you unable to acknowledge that, in fact, many complaints occur because there has been serious concern on the part of the complainant that a preventable medical error has indeed occurred, and that it has had a serious effect on their life and health? If a complaint involves 'waiting 15 min too long in the waiting room' or 'not getting happy pills to sell on the street,' it certainly will not be taken seriously by anyone, so what are you so concerned about? (Anonymous, March 24, 2015, 7:28 pm).

From this response it is clear that while physicians may feel that the errors that warrant cautions or SCERPs do not entail an inherent risk to patient safety, patients do. As Gallagher and Mazor (2015) point out, from a patient safety perspective, patient complaints are not usually perceived as adverse events and thus not taken as seriously as critical incidents such as wrong-site surgeries. However, diminishing patient complaints in this manner prevents meaningful health care improvements that can result from acknowledging that patients file complaints because they *believe* that they have been harmed, and this belief in itself results in a loss of trust as well as potential distress and life disruption that can constitute harm to a patient, regardless of whether what occurred is defined as harm by the health care provider or organization.

Other responses argued that publishing this information could inadvertently lead to a greater risk to patient safety by discouraging physicians from being transparent with their patients and with health care organizations when they have made a mistake. Ideally, physicians are ethically expected to disclose to their patients and/or the patient's family when a mistake has been made (Mazor, Simon & Gurwitz, 2004). One anonymous response speculates: "the transparency which makes cautions and SCERPs public knowledge will lead to a lack of transparency when a mistake occurs, and that is an unsafe act" (Anonymous, April 1, 2015, 5:13 pm). The suspicion is that if physicians know that this information will become public and could deter patients from seeking their care, they will become less transparent when a mistake has been made for fear that it will result in a caution, SCERP or criminal charge.

A similar suspicion has often been noted about error disclosure in the United States, where malpractice litigation is much more common than it is in Canada: it is believed that the fear of being sued is an obstacle in encouraging physicians to disclose errors to patients. However, Gallagher et al. (2006) found that when surveyed, physicians in both the United States and Canada demonstrated that the probability of being sued did not affect their belief in whether or not medical errors should be disclosed to patients, and that the majority (66%) felt that disclosing serious errors made lawsuits *less* likely.

Notably, there may be many medical errors that occur but do not result in any of these sanctions because the patient does not file a complaint with the CPSO. Patients may not file complaints despite being negatively affected by a physician's conduct or errors in practice for many reasons: they may not be aware of the complaints process; they may feel that the process of filing a complaint is too much work or that it invades their privacy, since it necessitates the collection of their medical records; they may feel that it will not achieve the result they desire;

or, in some cases, they may decide not to based on their interactions with the physician who made the error. It has been demonstrated that patients feel less inclined to take legal action or to report their physician when their physician explains and apologizes for their error (Witman, Park & Hardin, 1996; Mazor, Simon & Gurwitz, 2004). The same logic may follow for filing complaints, meaning that the absence of a caution, SCERP or other form of discipline on the physician's record does not indicate that that physician has never made an error, but that no patient has filed a complaint against them as a result of an error.

While disclosing an error to the patient directly affected by that error may be viewed positively and advance patient safety, it is unclear what impact disclosing physicians' errors to all patients, including those they have not (yet) treated, will have for patient safety. The discussion forum responses reveal that patients believe that having access to the information provided on the CPSO's public register makes them feel safer, and that they feel safer because it enables them to avoid physicians with a history of error(s) resulting in CPSO sanctions. Other responses on the discussion forum indicated that physicians do not feel that the additions to the public register have anything to do with patient safety and should not be public; as one physician explains it:

Every citizen of Canada has a right to privacy, including physicians. If a physician's transgression is adequately serious, then the CPSO should take the appropriate disciplinary actions— if the physician's license is not revoked, then clearly there is no perceived effect on patient care and safety, so there should be no need to publish anything publicly (Physician, January 9, 2015, 2:15 pm).

#### 4.2.8 Secretiveness

Responses that received this code addressed the idea that physicians and/or the CPSO are secretive, and that transparency is more beneficial to patients than having information about physicians and the health care system kept secret. The premise of many of these responses is that secretiveness does not serve the public interest, and that increased transparency will lead to better patient experiences. 17 responses received this code, with the majority posted by anonymous (47%).

These responses also expressed the fear that the CPSO, physicians and health care organizations “hide” information from patients, as was expressed in the following anonymous response:

As a mother who lost her son to gross negligence. The physician medically cleared [my son] when he was NOT medically clear. He knew this and said he was not concerned. This is in the records. Many others in the hospital questioned this yet nobody did anything except the next two doctors tried to cover up his mistake and caused more harm. I did not find out about this until after my son died and I got the records. The college continually protects the bad and incompetent doctors (Anonymous, March 5, 2015, 9:24 am).

The fear that organizations and authorities are secretive is a driving force in the ideal of transparency, and in the idea that a free and democratic society requires information. The demand for transparency arises from a desire for knowledge, accountability and trustworthiness (Christensen & Cheney, 2014). As expressed above, patients and their families, particularly those who have witnessed or been victims of traumatic medical events or who have had negative experiences with the health care system, hold the fear that essential information is being hidden

and that by gaining access to more information, they will be better able to protect themselves and their families.

Costas and Grey (2014) define organizational secrecy as “the ongoing formal and informal social processes of intentional concealment of information from actors by actors in organizations” (p. 1423). Secrecy is neither inherently good nor bad: for example, the authors point out, it is essential that physicians maintain patient confidentiality, but that they do not conceal malpractice. In this way, concerns about secrecy are less about the act of concealing information than they are about the consequences of concealing or disclosing certain types of information. They differentiate between formal secrecy, which is the intentional concealment of information that is governed by rules and regulations, and informal secrecy, which is the intentional concealment of information that takes place in unofficial ways, regulated by social norms rather than formal requirements. Transparency—which is often conceptualized as an antonym to secrecy and imposed as a means of controlling secrecy—may eliminate formal secrecy, but not informal secrecy.

Birchall (2011) explains that the moral discourse that surrounds the ideas of secrecy and of transparency ignores the symbiotic relationship between the two. Calls for transparency create a false choice between secrecy and transparency, positioning the two as opposites, with secrecy bearing mostly negative connotations and transparency representing the ideal. Transparency projects that are dependent on technology—i.e. initiatives in which the information made transparent is provided on the Internet, such as the CPSO’s—create an additional paradox, as much of the information remains unseen due to the sheer volume of information made available, as well as its findability. Nonetheless, transparency is often offered as the solution to all types of social, political, environmental and economic problems (p. 19).

Because transparency is so frequently offered as the only solution to the problems organizational secrecy may create, the responses within this code tended to assert unquestioningly that transparency is positive and secrecy is negative, and more transparency will mitigate the problem of secrecy. This logic carries over into the belief that transparency will enable parents to make better choices, which will in turn improve patient care, and that secrecy thwarts both goals. One member of the public asserts:

The CPSO has a mandate to regulate the profession in the public interest. The public interest is not served by the issuance of secret cautions. By making the cautions public Ontarians will be able to evaluate the quality of health care they are receiving and make decisions about the health care professionals they choose to employ. With this information available we can push for changes to address systemic shortfalls and avoid doctors who should be avoided. That is how making cautions public will improve patient care. Problems with the health care system will not be addressed if they remain secret (Member of the Public, January 9, 2015, 11:03 am).

This logic also assumes a considerable amount of agency on the part of the public, in that more transparency and less secrecy will empower them not only to make better choices for themselves but to push for systemic changes in Ontario's health care system as a whole. Etzioni (2010) points out that transparency "reflects the idea that people are autonomous rational choosers who can govern themselves" (p.403), yet there is a lack of evidence to support the idea that more information leads people to make different choices, and that even a well-informed individual may have limited agency in a scenario where choices are few.

#### 4.2.9 The Media

Many responses referred to media reporting about physicians, the CPSO or the health care system more generally. In particular, responses referenced newspapers (with 6 references to the *Toronto Star*, and 2 to the *National Post*), online patient groups, and doctor rating websites such as RateMDs (3 references). Some responses indicated that the transparency initiative is catering to the demands of the media, and that it is a political move by the CPSO in reaction to negative attention they have received from the media. 25 responses received this code, with the majority posted by anonymous (44%).

**RateMDs.** All of the responses that referenced the doctor rating website RateMDs made comparisons between the website, which allows patients to rate their doctors on a five-point scale and provide feedback about their experience, and the formal complaints process that can result in cautions. A member of the public commented: “Regrettably, there already exists a public rating system for physicians. Publicizing cautions is superfluous. The system is called RateMDs” (Member of the Public, March 3, 2015, 12:58 pm).

The comparison between the publication of cautions and comments left by patients on RateMDs is an inaccurate one: on RateMDs, anyone can post any comment about any physician. There is no verification process to ensure that the poster was actually treated by the physician they are rating, nor is there any investigation into whether the content of the comment is true. Someone cannot rate the same doctor more than once from the same IP address, and problematic comments can be “flagged” by the physician or other readers and may be taken down by RateMDs at the discretion of their moderators, but it is otherwise not subject to a careful review process. This opens the way for many misleading reviews and ratings, whether positive or negative: false negative reviews may be posted in an attempt to damage the reputation of a

physician or lower their rating, while false positive reviews may be posted in attempt to boost the doctor's rating and attract more patients. It has been demonstrated that reviews posted on these websites do in fact affect the public's perception of certain doctors, as well as their willingness to see those doctors (Trehan & Daluiski, 2016).

The CPSO's complaints process, on the other hand, is much more formalized. Not all patient complaints result in an investigation by the Inquiries, Complaints and Reports Committee (ICRC), and of those that do result in an investigation, and of those that do, all are subject to thorough examination before they result in a cautions or ordering of an SCERP as a result. The motivation in filing a complaint also differs from the motivation in posting a review: for many patients, the point of filing a complaint is to restore their sense of personal justice and to prevent the same negative event from reoccurring (Bouwman, Bomhoff, Robben & Friele, 2015), while the use of online rating websites is rooted in consumerism and the desire to share positive or negative experience in order to encourage or deter others in seeking the same service from the same individual.

**News Media.** The CPSO attracts attention from Canada's national and provincial news media companies. In particular, it is frequently a topic of discussion in the *Toronto Star*, as many responses highlight. One physician posted a response in the discussion forums stating that "the College should not bow down to the pressure of the *Toronto Star*," (Physician, March 20, 2015, 11:25 am) while another physician comments that "a couple malpractice lawyers that are directly quoted in all the stories, have been feeding a couple of *Star* reporters for some years now. It's getting ridiculous that the College keeps entertaining this bunch with policy changes" (Physician, March 10, 2015, 1:16 am). What these physicians are referring to are the *Toronto Star*'s publication of negative events involving Ontario physicians that were either unaddressed by the

CPSO, or, in the opinion of the journalists, inadequately addressed or made transparent to the public. Interestingly, the *Toronto Star* frequently quotes the information made available by the CPSO's transparency initiative in its articles, using direct quotes from the results of disciplinary hearings or cautions.

**Online Patient Support Groups.** One member of the public referred to using online patient groups as a means of learning more about their physician. Online patient groups have been studied for their ability to “empower” patients, particularly by becoming better informed and enhancing their social well-being (Van Unden-Kraan, Drossaert, Taal, Seydel & Van de Laar, 2009). Patients use these groups for support as well as for information seeking, and their use for information seeking can affect health care encounters, as many intend to ask their physician about the information they find or to present their physician with information they have found; some use the information to request new or different treatments or tests, or even to request referral to another physician (Hu, Bell, Kravitz & Orrange, 2012).

#### **4.2.10 Improving Patient Care**

Responses that received this code responded to the ability of the transparency initiative to influence patient care in a positive way. Many argued that posting the details of cautions or SCERPs online for the general public to see undermines their educational purpose and does not improve patient care, as cautions and SCERPs are intended to do. Others argued that greater transparency would lead to greater accountability, which would improve patient outcomes. 29 responses received this code, with the majority posted by a physician (59%).

Within these responses, members of the public expressed the belief that the transparency initiative could lead to an opportunity for physicians to improve their practice and patient care more broadly: “Physicians should not view Phase 2 of the Transparency Project negatively as a

personal attack against them or their profession. It should be embraced as an opportunity to recognize, self-reflect, learn and correct deficiencies in their practice to improve patient care” (Member of the Public, December 15, 2014, 4:16 pm). Another member of the public elaborates that the transparency initiative represents a “watchdog” role, which could lead to improvements in patient care:

I am writing to encourage a larger number of doctors to learn of how they can improve their practice. The process of complaining enables the physician to learn a broader number of skills. It stops them from making unsafe decisions and validates the concerns of the client. Physicians have very little opportunity to improve their practice, who is their watchdog? (Member of the Public, March 4, 2015, 2:21 pm).

In this individual’s opinion, patient complaints are necessary in helping physicians to improve, and keeping the result of these complaints between the physician and patient in question does not go far enough. This individual go on to state that this information should be made available to the public because “Ontario tax-paying citizens are funding the Ontario College of Physicians and Surgeons to be our watchdog.” This mirrors ideals of the media as a watchdog and guardian of the public interest (McQuail, 1997). While the individuals who posted these responses do maintain that the transparency initiative will improve patient care, the mechanism by which it will lead to improvements is by creating an additional level of surveillance and accountability, and securing public confidence in the CPSO as a health care “watchdog.”

The belief that greater accountability and transparency will lead physicians to improve their practice is based on the assumption “that when health care practitioners are confronted with negative information regarding their performance relative to that of their peers and these results

are presented openly for everyone to see, the behaviour of the practitioners will change” (Grol, 2001, p. 2581). However, Grol points out that this is difficult to systematically study and measure and thus not possible to guarantee.

One physician commented that the transparency initiative is not interested in improving patient care, but in bettering the organizational image of the CPSO:

This new transparency legislation represents a complete failure of the CPSO in doing its job of regulating our profession. [...] it will release more misinformation and incomplete information to the public which will only confuse and in no way improve patient care. It is no longer acting in the public’s interest but its own bureaucratic interests. The CPSO would love to have the public to think it’s doing its job by posting everything, but in reality it’s skirting its responsibilities as a regulator and pushing the decisions process back into the public’s lap, in the hope that the lay person will figure it out what all of this new information means (Physician, January 29, 2015, 3:53 pm).

In this view, providing more information to the public does not guarantee that the public will understand and use the information to make better decisions, and allowing patients to decide what to do with the information does not directly generate improvements in patient care. Shaw (2001) states that efforts to ensure transparency, accountability, self-regulation and quality improvement have not been demonstrated, with reliable evidence, to bring improvements for staff and patients—it is not impossible that it could, but little is known about whether it does.

#### **4.2.11 Patient Choice**

These responses referenced patient choice and decision-making, in particular the public’s ability to choose a physician or make decisions on their health care based on information provided by the transparency initiative. Many of the responses directly referred to the language

used in the transparency initiative describing its goal in helping the public to make informed choices. 20 responses received this code, with the majority posted by a physician (40%).

Fischer (2015) defines patient choice as “the transfer of consumer denominations and characteristics to the group of healthcare recipients, particularly involving the individual freedom to select time, location and type of healthcare treatments as well as the service provider performing it” (p. 174). It necessitates the positioning of the patient as a health care consumer. Patient choice operates as the central goal in patient empowerment. Saltman (1994) explains that patient choice can be viewed from two perspectives: that patient choice is an exercise in commercial rights and a product of consumerism, or that patient choice is an exercise in democratic rights particularly in publicly funded and operated health care systems, allowing patients more influence over what happens to them and thus more control over their living conditions (p. 207).

While patient empowerment encompasses patient choice, it is a more complex concept than informed decision-making, and it is supported in its ability to both enhance patients’ wellbeing and increase efficiency in the health care system. However, equity is an issue in patient empowerment and there is a need to focus on the determinants of health care inequalities more specifically—such as socioeconomic status, lifestyle behaviours and living conditions, as well as the link between stress and powerlessness—rather than just access to, and choice between, services and service providers (Segal, 1998).

An element of the demand for patient empowerment is the inevitable power imbalance in the physician-patient relationship (Aujoulat, d’Hoore, & Deccache, 2007). This was highlighted in the discussion forums, as an anonymous poster explains: “I support making all of this information publicly available as proposed. Given the power imbalance that is in the physician-

patient relationship, this information is very important” (Anonymous, February 3, 2015, 9:54 am). This response was met with the rebuttal of another anonymous response:

A patient in most cases has many choices, and can without notice terminate the relationship with a provider and go to another one. A doctor cannot terminate a patient unless going through several difficult steps and risking a complaint. A patient can file a complaint with the College free of charge and for any reason, thus tying up the physician in paperwork and lots of anxiety for many months. Where can a physician complain about an abusive patient? Any complaint has the potential of becoming professional misconduct which can end the physician’s livelihood. If anything, the power balance seems skewed against the physician, not the patient (Anonymous, February 4, 2015, 3:12 pm).

This conversation reveals two different notions of the word “power” in the physician-patient relationship, and a misunderstanding between the two. For the patient, their physician is perceived to have absolute control over their health, their bodies and by extension their lives, placing them in an exceptionally vulnerable state in which their only choice is to see one physician over another, or choose one treatment offered to them over another, or attend one health care facility over another. For the physician, the patient has some control over their physician’s obligations to them, which allows the patient to choose whether or not to maintain the physician-patient relationship, to file complaints, to make demands, to allege mistreatment and to exercise a few other mechanisms of choice when they are dissatisfied with the care they are receiving, which could potentially impact the physician’s career and reputation.

Regarding how the specific types of information provided to the public as a result of the transparency initiative may influence patient choice, one physician points out: “I would suggest

that the information in the Register more often contributes to a decision AGAINST seeing a physician, than TOWARD that physician” (Physician, March 19, 2015, 2:56 pm). Because the additions to the public register added during the second phase of the transparency initiative are mostly negative information—particularly cautions, SCERPs, criminal charges and discipline findings in other jurisdictions—physicians view the information as unfair and prejudicial as the only choice it seems capable of influencing is the choice to avoid physicians who have this information attached to their name.

The ability to choose not to seek the services of a particular physician, although it is a choice, does not align with descriptions of what patient empowerment is supposed to achieve. Patient empowerment is conceptualized as something that goes on in the relationship *between* a physician and a patient, such as physicians offering individualised information and advice to support patients in making choices that best fit with their personal goals and priorities (Aujoulat, d’Hoore, Deccache, 2007). It does, however, align with the consumerist view of patient choice, allowing patients the freedom to select one service provider over another, based on information about that provider’s history with other patients.

#### **4.2.12 Organizational Flaws**

These responses referred to flaws in the CPSO as an organization. In particular, they referred to the way in which the college protects physicians and/or its own self-interests. Others criticized self-regulation, and others criticized processes such as filing complaints against physicians, Independent Medical Examinations (IMEs), OHIP billings, the Inquiries, Complaints and Reports Committee (ICRC) and the Health Professions Appeal and Review Board (HPARB). 56 responses received this code, with the majority posted by anonymous (43%) followed closely by physicians (38%).

One perception held by the members of the public and anonymous respondents on the discussion forum was that the CPSO protects the mistakes and secrets of “bad” or “incompetent” physicians, as discussed under “secretiveness,” and that this protection ensures that physicians do not face the same consequences for their actions as others do, making them “above the law.”

This perception is summarized by the following anonymous response:

Members of the public are far more intelligent than you give them credit. We can and continue to see just how often harm is covered up by the College. You speak about the harm to the doctors but say nothing about the horrific pain and suffering they cause many patients and families that have been affected by their harm. At present there is no accountability and doctors are above the law (Anonymous, March 4, 2015, 11:22 pm).

It can be deduced through careful reading of the language of the CPSO’s transparency initiative that this is one of the perceptions they seek to address with policy such as this one. In an issue of *Dialogue* published in 2013, when the first phase of the transparency initiative was beginning, the CPSO explained that the transparency initiative arises in response to a changing culture:

The public perception of institutions has changed. Citizens no longer have blind a faith acceptance that organizations with a public interest mandate will do the right thing on their behalf. As a result, many would argue that demonstrating accountability has become paramount to the credibility of organizations charged with protecting the public. The College is launching a conversation with the public and the profession to determine whether we can become more transparent with our decisions and processes (College of Physicians and Surgeons of Ontario, 2013, p. 9).

As explored in the responses that referenced news media, some responses voiced the idea that the transparency initiative is a public relations strategy in response to media pressure. In examining what might generate the perception that the CPSO “covers up” for their physicians, it is plausible that the news media contributes. In 2015, the *National Post* published an article titled “Inside Canada’s secret world of medical error: ‘There is a lot of lying, there’s a lot of cover-up,’” which described some medical errors endured by Canadian patients and claimed that the absence of a public record of these errors, lack of error reporting institutionally, and lack of meaningful outcomes when patients complain is indication of a breakdown in Canada’s health care system (Blackwell, 2015). In 2015, the *Toronto Star* published an article titled “‘Backroom deals’ keep problem MDs out of the public eye” claiming that high risk doctors, such as those accused of botching surgeries, sexually abusing patients, abusing and improperly prescribing narcotics, harming infants and their mothers during childbirth, among other serious offences, are offered “undertakings” from the CPSO which allow them to quietly resign or restrict their practices in exchange for having investigations or plans for prosecution dropped (Boyle, 2015). In 2016, *CBC News* published a news article stating that complaints filed against Canadian physicians almost never result in formal discipline from the provincial regulatory colleges (Moore, 2016). These, and numerous other examples of negative attention received by the CPSO as well as the Royal College and all of its provincial organizations more generally, create a worrying image of dangerous, unethical, incompetent physicians and untrustworthy, dishonest organizations willing to make every effort to conceal their mistakes.

In addition to patients, many physicians within the discussion forum expressed negative opinions about the CPSO as well, in particular its control over them and the ways that it is controlled by external forces such as legislation, the government and the media. In addition, the

notion of “self-regulation” was refuted and physicians expressed that they felt disempowered by the CPSO, as can be seen in the following anonymous response:

The government already regulates physicians, ‘self-regulation’ is an illusion. The government passes the laws that govern the CPSO, the ‘self-regulation’ facade enables them to justify robbing doctors of their constitutional rights and freedoms not to mention their wealth. After all, it gives the illusion doctors are doing this to themselves, how can the government be to blame? Similar strategy is in place with the current Minister of Health and the current ‘contract’ imposed on doctors. It’s time for Ontario doctors to take the veils off their eyes and wake up to the reality that they are currently enslaved by the government (Anonymous, January 18, 2015, 12:09 pm).

This response refers to negotiations between the Ontario government and the Ontario Medical Association (OMA) regarding the Physician Services Agreement (PSA), a contract which details how much physicians can bill for services as well as where health care funding should be invested and where it should be cut back in order to support government priorities. Beginning in 2015, a contract was proposed which would include a 2.65% decrease to physician fees, amongst other shifts in financing, which was met with disapproval from the OMA and Ontario physicians (Harrison & Guo, 2015). Health Minister Eric Hoskins maintained that Ontario physicians “can’t just bill more and more and more. At some point they’ll have to accept that they can do roughly the same amount of work as last year for roughly the same pay” (The Canadian Press, 2015).

Physicians in the discussion forums expressed frustration with government control and extended this frustration to the government’s regulation of the CPSO, claiming that this invalidates “self-regulation”: “The physicians of Ontario do not have any type of self-regulation

in sense of the meaning. All rules, regulations, criteria, standards and anything else has been predetermined by extensive legislation and bylaws already. Furthermore, if the government does not like in any way something that the CPSO is doing, then they simply pass new legislation or rules to make the CPSO do whatever they want them to do” (Physician, January 11, 2015, 6:00 pm). In the same response, this physician invites readers to recall “the debacle of the Medical Review Committee and its blatant abuses,” referring to the former CPSO-administered Medical Review Committee (MRC) which was tasked with the audit of physicians’ OHIP billing practices. The MRC was replaced by the Physician Payment Review Board in 2006 after a 2005 review by Supreme Court Justice Peter Cory found that the MRC’s audits took too much time to complete, had unfair methods of assessment and collection, and its hearing process “left doctors feeling they were presumed guilty from the start” (Kondro, 2007, p. 334).

Beyond critiques of the CPSO, its current and past practices, and government regulation, some expressed the opinion that the policy consultation process itself is insincere and doesn’t impact policy outcomes. One anonymous response asks: “The comments posted on the consultation for Phase 1 of the project were overwhelmingly and almost entirely against the proposal, yet the Counsel appears to have approved it unchanged. The question is what is the value of the consultation process then?” (Anonymous, January 6, 2015, 12:46 am).

#### **4.2.13 Further Analysis**

Because most responses received in this phase of analysis received more than one code, there were some codes that frequently appeared in combination with each other. For example, the codes “public reprimand” and “fairness to physicians” were both given to the same response 12 times. The codes “public reprimand” and “due process” were both given to the same response 7 times. All 3 of these codes were given to the same response 5 times. Of the 5 responses that

received all 3 codes, the main argument can be found summarized in this response, posted by a member of the public:

Regarding cautions-in-person to be made public, what this policy does is to essentially make such oral cautions by the ICRC into reprimands that are issued by the disciplinary committee [...] the public will view it as a judgment against the physician. In other words, such a publication would bypass due process, investigations and hearings to achieve the same results as a reprimand. This proposal may be viewed by physicians as very unfair (Member of the Public, December 11, 2014, 9:38am).

Looking at the ways in which these codes share a common opinion or argument will help to inform the second phase of analysis and the development of the second cycle codes. Other codes which overlapped more than 5 times were: organizational flaws and fairness to physicians (16 occurrences), secretiveness and patient safety (11 occurrences), media and fairness to physicians (9 occurrences), media and organizational flaws (8 occurrences), patient choice and fairness to physicians (8 occurrences), and public reprimand and improving patient care (7 occurrences).

Many of the opinions expressed within responses sharing common codes are evident in the discussion of the individual codes, for example: those that addressed organizational flaws and fairness to physicians tended to express the belief that the CPSO and the government more broadly are unfair to physicians; those that addressed secretiveness and patient safety explored the ways that withholding information from the public can compromise patient safety or cause patient safety incidents to be inadequately addressed by those responsible; and those that addressed public reprimands and improving patient care questioned how making physician

reprimands public would lead to improvements in patient care. Through analysis of what these arguments share in common, the second cycle of coding can be narrowed and more specific.

### **4.3 Second Cycle of Analysis**

The second cycle of coding builds on the first cycle by developing a clearer “categorical, thematic, conceptual, and/or theoretical organization” (Saldaña, 2015, p. 149) of the data. The list of codes becomes smaller, but also broader, beginning to identify the larger themes in the data. The second cycle coding method selected for this data is pattern coding, which groups codes from the first cycle of analysis together based on what they have in common.

From the first cycle of codes, it became clear that many overlapped. For example, responses about fairness to physicians also often referenced public reprimands or due process; responses about secretiveness often addressed patient safety. The codes that overlapped frequently were not always related concepts; while public reprimands and improving patient care are two distinctly different conversations, they overlapped through the question of *how* they might relate to and influence one another. Looking at what the codes had in common thematically (such as improving patient care and patient safety being about preventing adverse outcomes and encouraging positive outcomes), as well as how the codes together helped form a common argument (such as organizational flaws and fairness to physicians leading to the question of whether the CPSO and government regulations are fair to physicians), helped to develop the second cycle of codes.

Within the second cycle of coding, care was taken to ensure that each response received only one code, unlike in the first cycle when responses received more than one. This helped to confirm that the second cycle of analysis appropriately grouped the first cycle’s codes into

categories that adequately described the data. This time, only four codes were developed, and the number of responses within each code was much more evenly dispersed.

Code	Responses related to code (N=226)		Author of response							
			Physician		Member of the public		Organization		Anonymous	
	n	%	n	%	n	%	n	%	n	%
Transparency can damage to the physician-patient relationship.	59	26.11	32	14.16	4	1.77	1	0.44	22	9.73
Transparency can improve patient experience and engagement.	59	26.11	14	6.19	19	8.41	1	0.44	25	11.06
Transparency can lead to misunderstandings and misperceptions.	53	23.45	27	11.95	5	2.21	2	0.88	19	8.41
Problems within regulatory organizations complicate transparency.	55	24.34	24	10.62	11	4.87	1	0.44	19	8.41

**Table 5. Topics covered by forums as a function of author of response**

As a second level of analysis, each code was compared with the level of agreement to the transparency proposals (as seen in Table 2) expressed by the responses within the code. The responses that fell under codes representing negative opinions, such as “transparency can damage the physician-patient relationship,” were overwhelmingly not in agreement with the transparency proposals they were responding to, while the majority of the responses falling under codes representing positive opinions, such as “transparency can improve patient experience and engagement,” were in agreement with the transparency proposals they were responding to.

Level of agreement	Responses according to level of agreement (N=226)		Code							
			Transparency can damage to the physician-patient relationship (N=59)		Transparency can improve patient experience and engagement (N=59)		Transparency can lead to misunderstandings and misperceptions (N=53)		Problems within regulatory organizations complicate transparency (N=55)	
	n	%	n	%	n	%	n	%	n	%
In agreement	54	23.89	0	0.00	46	20.35	4	1.77	4	1.77
Not in agreement	166	73.45	59	26.11	10	4.42	48	21.24	49	21.68
Mixed agreement	6	2.65	0	0.00	3	1.33	1	0.44	2	0.88

**Table 6. Topics covered by forums as a function of agreement**

#### 4.3.1 Transparency Can Damage the Physician-Patient Relationship

These responses voiced the idea that transparency can be damaging to physicians, their rights and the physician-patient relationship more broadly. From the first cycle of analysis, the codes “fairness to physicians,” “due process,” and “public reprimand” helped form this category, as the sentiment expressed within those codes was that the proposed transparency changes are unfair to physicians because they bypass their rights as professionals and as citizens, and that reprimanding a physician in such a way that patients are able to witness the reprimand both damages the physician as well as their relationships with their patients. 100% of the responses under this code were not in agreement with the transparency proposals they were responding to.

This tension between the rights and powers of the physician and the rights and powers of the patient is an ongoing one that is constantly shifting. In their research on the physician-patient relationship, Emanuel and Emanuel (1992) write that “during the last two decades or so, there

has been a struggle over the patient's role in medical decision making that is often characterized as a conflict between autonomy and health, between the values of the patient and the values of the physician" (p. 2221). It is this struggle that responses under this code represent: patients, and the organizations charged with considering and representing patients' interests, value transparency and the freedom to make their own decisions and draw their own conclusions about their health and health care providers. Physicians value medical expertise, and as physicians are by profession the experts in patient care, they defend their own credentials and knowledge against demands that the public should be provided specialized information and permitted to decide for themselves what is best for their health care needs.

**The Internet as a source for health information.** The impact that the growing amount of health information made available on the Internet may have on the physician-patient relationship has increasingly become a topic of interest for health researchers. Some theorize that because patients conduct research using the Internet before consulting their physicians, the positive effects of patients feeling empowered with information may be offset by a loss of trust in the authority of the physician, leading to difficulties for physicians who are accustomed to taking a more authoritarian or paternalistic role with their patients. It may lead to conflict even with physicians who are supportive of a more collaborative physician-patient relationship, as patients may not fully understand the information they find and may make inappropriate requests or assertions of their physician based on misunderstandings (Wald, Dube & Anthony, 2007). Some physicians may even acquiesce inappropriate requests for fear that refusal would damage their relationship with their patient (Murray et al., 2003).

In researching the effects of patients bringing information found on the Internet to their consultations with their physicians on the physician-patient relationship, Murray et al. (2003)

found that while many physicians thought it could have a beneficial effect on the physician-patient relationship, some of the ways in which it is associated with worsening the physician-patient relationship include feeling that the patient is challenging the authority of the physician, and the physician believing that the patient's request as a result of the information was not appropriate for their health. In addition, 38% of physicians felt that patients bringing information to their consultations was harmful to time efficiency in the encounters, and most physicians believed the information had no impact on quality of care or health outcomes.

When patients were surveyed on how they believed health information might impact the physician-patient relationship, respondents felt that whether it improved or damaged the relationship depended on the physician's reactions and communication skills: patients who expressed that the information made them feel more in control during their consultation felt that it had a positive impact, while patients who perceived that their physician felt "challenged" by the information, who felt hurried during their consultations or who perceived their physician as having inadequate communication skills felt that it worsened their interactions with their physician (Murray et al., 2003).

**Effects on physicians' practice.** With regards to the transparency initiative, the ways in which physicians on the discussion forum felt that it might impact the physician-patient relationship did go beyond the patients' abilities to understand the information provided to them and act accordingly based on that information: some physicians also reflected on the impact that having that information about physicians in reach of the general public might have on the way that they practice medicine. One physician reflected on how this type of transparency might influence their willingness to see more "difficult" patients:

I think it makes sense for the CPSO to be more transparent. That being said, I wonder whether oral cautions should follow physicians around for our whole careers or whether, if they do end up being reported to the public, they could be taken off the record after a period of time without further incidents? I actually think the College should place stricter restrictions on physicians who make the most serious errors in judgment (e.g. those who are involved in serious boundary violations) before considering increasing transparency for other complaints. Everyone makes mistakes in every profession and of course physicians need to be held to high standards, but there has to be a limit. I know the fear of medicolegal repercussions affects the way I practice, and possibly not always for the best. I certainly don't believe that patient complaints should be publicly available. Most psychiatrists receive complaints at some point in our careers, usually more than once. I know I received a ridiculous one last year that is basically guaranteed to be thrown out. If those complaints were to be public record I would be reluctant to see some of the more difficult patients, even though they are the ones who often need us the most (Physician, December 18, 2014, 10:34 am).

From this response it is evident that physicians must weigh their value in their relationship with their patient against their value in their career: the physician wants to provide the best care possible for their patient, but if the best care possible means that the patient might be frustrated with their physician (as might happen, for example, if a physician refuses to prescribe a medication that a patient feels they need but which the physician feels would not benefit them), and that their frustration might drive them to file complaints against their physician which could become public knowledge and adversely impact the physician's career, reputation, or ability to attract new patients, the physician must consider their career as a whole

over their duty to one patient. This would undeniably impact the physician-patient relationship as the values of the physician and the values of the patient would be at odds. Another physician's response summarizes this tension in values, while pointing out that it may not only impact the physician-patient relationship, but also impact physicians' motivations toward their profession more broadly:

Physicians have a sincere desire to be of service to society and they are generally conscientious and caring individuals. The effect of a caution is powerful enough to affect meaningful change in an MD's behaviour. The added humiliation will simply drive MDs from the profession altogether and discourage others from pursuing it at all (Physician, March 27, 2015, 2:59 pm).

**Defensive medicine.** The way that repercussions, whether they come in the form of patient complaints or medicolegal litigation or other public sanctions, affect the practice of medicine has been termed "defensive medicine." This occurs "when practice is governed by the fear of medicolegal actions rather than sound medical judgement" (Nash et al., 2009), and evidence of defensive medicine has been observed by studies in the United States, United Kingdom, Australia and in Canada. It has been shown to affect a wide range of physician attitudes and practice patterns, including: causing physicians to consider early retirement, leave the profession or reduce their working hours; increased ordering of tests and specialist referrals resulting in increased costs to the health care system and/or patients; unnecessary prescriptions and avoidance of performing more high-risk or invasive procedures (Nash et al., 2009; Nash et al., 2010). Not all observed effects of defensive medicine are negative: it has also been shown to increase the amount of time physicians spend communicating risks and benefits to patients; to increase disclosure of uncertainty; and to improve physicians' documentation of their procedures

and interactions with patients (Woodward & Rosser, 1989; Nash et al., 2009; Nash et al., 2010). There are effects on physicians' perceptions of what is expected of them: physicians surveyed believe that while all physicians make mistakes, the law expects them to make perfect decisions (Nash et al., 2009) and that patients have unrealistically high expectations of modern medicine (Woodward & Rosser, 1989).

Defensive medicine has also been shown to cause physicians to avoid certain patients, such as those perceived to be high-risk, including clinically complex patients and patients with certain personality characteristics or personal circumstances that might increase their propensity for litigation (Studdert et al., 2005). Across a variety of surveys, an overwhelming majority of physicians admit to having engaged in some form of defensive medicine to reduce the probability of patient complaints or litigation, for example: Studdert et al. (2005)'s survey of high-risk practitioners in Pennsylvania (including emergency medicine physicians, general surgeons, obstetrics and gynecologists, orthopedic surgeons and radiologists), 93% of respondents reported engaging in one or more defensive behaviours; in a random sample of physicians from all specialty groups in the United States, Bishop, Federman and Keyhani (2010) found that 91% of physicians believed that unnecessary tests and procedures were ordered to protect against malpractice suits; in a survey of 300 general practitioners in the United Kingdom, 98% reported practice changes as a result of the possibility of patient complaints (Summerton, 1995). Because these practice changes have been shown to affect physicians' attitudes about their profession more generally (Nash et al., 2009; Nash et al., 2010), the widespread perception that the threat of patient complaints or malpractice litigation can impact physicians' patient care practices is significant in considering the effect that making more information about remedial

actions such as cautions or SCERPs may have on physicians' practice and the physician-patient relationship more broadly.

#### **4.3.2 Transparency Can Improve Patient Experience and Engagement**

These responses were generally positive about transparency and the proposed amendments, outlining that the goal of transparency is to improve patient experience of, and engagement with, the health care system. From the first cycle of analysis, the codes "improving patient care," "patient safety," and "patient choice" correspond to this category, which is about how transparency benefits patients rather than how it harms physicians. 77.97% of responses under this code were in agreement with the transparency proposals they were responding to, 16.95% were not in agreement, and 5.08% had mixed agreement.

Responses from members of the public within the discussion forums demonstrate that patients believe transparency improves patient experience by helping them to make informed choices about which health care providers they can trust and which they should avoid. This belief is rooted in the idea that there are problems inherent in the health care system and that by making these problems transparent rather than keeping them secret, the public can trust that the health care profession is reliable and that physicians are working to minimize and eliminate the problems patients have encountered in the past. One member of the public's response summarizes this idea:

The purpose of making cautions public is for the public to make informed choices.

Informed choices about the doctor we want to visit and informed choices about the kind of health care system we want. If cautions are made public Ontarians will be in a position to better evaluate the profession and the health care you provide. Before a problem can be fixed you have to know the problem exists. Making cautions public will help our

communities address systemic problems. Keeping them secret allows these problems to persist. A doctor will not lose new patients as a consequence of a minor misstep such as an advertising infraction or a billing error. However, if you are cautioned for a medical error or for lying to a patient about the consequence of a medical error you deserve to lose patients and your conduct deserves public condemnation. If such conduct remains secret the entire profession loses the public trust rather than the relatively few doctors who deserve it (Member of the Public, January 9, 2015, 11:32 am).

**Informed choice in health care.** Informed choice in health care is often discussed in terms of treatment selection by the patient or shared decision-making between the patient and the physician. The information provided by the transparency initiative, however, promotes the selection for or against specific physicians. Research has suggested that despite growing demand for transparency and public reporting of quality data in health care, there is little evidence that patients are using the information (Fanjiang, von Glahn, Chang, Rogers & Safran, 2007). Public reporting of health care information operates on the assumptions that there is a competitive market with multiple providers and free choice, and that consumers desire and will use the information when selecting a health care provider; however, there is limited evidence to demonstrate that information about the quality of health care providers and the health care system more broadly has an effect on consumer choices (Faber, Bosch, Wollersheim, Leatherman & Grol, 2009).

In response to this, a 2007 study invited patients seeking a new primary care physician (PCP) to view web-based physician-level information to assist them in making a decision. The information included credentials such as number of years in practice or medical school attended, as well as personal characteristics such as age and ethnicity, and patient experience scores from

the Short-Form Ambulatory Care Experiences Survey (ACES) which is administered in California and asks patients to rate their physicians based on quality of interpersonal interactions, access to appointments, coordination of care, health promotion and willingness to recommend that physician to other patients. Results showed that out of 2,225 patients seeking new PCPs invited to consult the web-based information about their physicians, only 17% visited the website. For those that visited the website, patient experience scores were cited by the majority of patients as the most important factor in informing their choice in PCP. The information was shown to help them make choices that were well-aligned with their personal priorities (Fanjiang, von Glahn, Chang, Rogers & Safran, 2007).

Beyond the hope that transparency of physician-specific information will support informed choices, other members of the public expressed the desire for greater equality between patients and physicians and felt that making information such as cautions against physicians as a result of patient complaints public would provide another form of justice for dissatisfied patients:

I think the point being made is that, with the lack of transparency at the College, patients who are dissatisfied with the results of their College complaint have nowhere else to go. The CMPA does prevent most patients from suing, even when they have a reasonable case against the physician, due to the massive imbalance in power between the self-funded patient and the taxpayer-funded physician. [...] More transparency at the College, and a better understanding amongst the public as to how difficult it is for patients to sue their practitioners for malpractice in Ontario and why, will hopefully result in a more balanced playing field for patients who have legitimate complaints and have suffered injury as the result of physician negligence (Member of the Public, March 24, 2015, 6:48 pm).

**Patient satisfaction.** It has been demonstrated that patient satisfaction ratings are associated with patient complaints and malpractice risk. Stelfox, Gandhi, Orav and Gustafson (2005) found that a relatively small number of physicians generate a high number of complaints, that complaints more often relate to communication issues rather than patient care issues, and that physicians with low patient satisfaction ratings were more likely to have had complaints and malpractice lawsuits against them than those with high ratings. In this way, some patients may view increased transparency of the outcomes of patient complaints such as cautions or SCERPs as an indication of other patients' level of satisfaction with that physician. They may also view the complaints process, and the possibility that other patients may be able to view the outcome of their own complaint against a physician, as an alternative form of justice for negative experiences with physicians.

#### **4.3.3 Transparency Can Lead to Misunderstandings and Misperceptions**

These responses are concerned with how transparency may impact the way that the public views physicians (and vice-versa) and can lead to misunderstandings. It is linked to the first cycle codes "public trust," "public perception," "secretiveness," and "media" as it deals primarily with perceptions and interpretations of information. 90.57% were not in agreement with the transparency proposals they were responding to, 7.55% were in agreement, and 1.89% had mixed agreement. This response from a physician addresses the types of misunderstandings and misinterpretations that might result from the transparency initiative's proposals:

Is there a reason that physicians are not also innocent until proved guilty? No matter what the CPSO says, by noting a charge on a physician record, they are implying that it is relevant for the public to know about it, i.e. relevant to patient care. I understand there is great public pressure for increased transparency. I do not think that it will improve patient

care (nor is there any evidence that this will be the case). I think that it will increase, rather than decrease, public fear and mistrust. Regarding publishing cautions and SCERPs, I think these may be misunderstood by the public. I think there will be some patients who interpret ‘caution’ to mean ‘use caution when seeing this doctor.’ [...] Even 20 years later a patient may choose to avoid a physician who had a caution or SCERP, fulfilled the requirements set out by the CPSO, and then practiced impeccable medicine ever since. Is this fair? It seems to me that it is certainly not fair to the physician, who has already been disciplined, publicly shamed, and remediated; and if the patient uses the information to avoid a doctor who is now practicing standard-of-care medicine, it isn’t even fair to the patient (Physician, March 21, 2015, 5:20 pm).

An argument highlighted in the above response that was not addressed in other responses is the potential for the public’s misunderstanding or misinterpretation of the information provided by the transparency initiative to not only negatively impact the physician, but also the patient. It has been speculated that the quantity of general health information available on the Internet may cause harm to individuals who use the information inappropriately due to inadequate understanding—for example, reading and applying erroneous information about medication dosages or other treatments (Crocco, Villasis-Keever & Jadad, 2002). If a patient sees a caution or SCERP on a physician’s file and assumes this means the physician is unsafe and should be avoided, they may inconvenience themselves by restricting their ability to receive timely care by a qualified physician.

The most common concern cited about patients’ abilities to understand the information provided on the public register is that patients will automatically assume the worst. One physician states: “Unquestionably, in the eyes of the public, an oral caution will be viewed just

like what is now a public reprimand. The public and the media will never know or want to know the difference” (Physician, March 24, 2015, 1:08 pm). Another describes the same concern about the posting of criminal charges: “The public will just see charges, and therefore assume guilt. This is a common response. Once thought to be guilty, a doctor would never get rid of the effect” (Physician, February 23, 2015, 8:30 am). The way that this information is presented on the public register seems to support this view: if physicians have received a caution, for example, it is listed under the heading “Concerns” on the physician’s page, and is marked beside their name in search results. The CPSO is indicating that having received a caution or a criminal charge denotes a concern about that physician’s ability to provide patient care. While physicians on the discussion forum seem to disagree that having received a caution or a criminal charge should be a concern to patients, it is possible that the CPSO as well as patients feel that it is a legitimate concern.

#### **4.3.4 Problems within Regulatory Organizations Complicate Transparency**

These responses addressed the idea that the organizations that regulate physicians, and/or their processes, are inherently flawed and that these flaws complicate questions of organizational transparency by default. 89.09% of responses under this code were not in agreement with the transparency proposals they were responding to, 7.27% were in agreement, and 3.64% had mixed agreement. The basic sentiment in the majority of these responses is that it is the organizational flaws of regulatory bodies and of the government that negatively impact medical care and that transparency could lead to further negative consequences. This physician’s response illustrates, in more extreme language, this opinion:

The witch-hunt on Ontario physicians by an inept government, a sadistic media, a voyeuristic public and a self-serving college continues unabated on many fronts. No

worries... I will give the public what it wants... what Dr. Google tells it to demand of me. I will give in to every demand for x rays. I will give in to demands for MRI's. I will give into demand from patients who come with a long ridiculous list of lab tests that their naturopath wants them to have. I will give in to demands for that 6th opinion from yet another specialist. I will give them antibiotics I know that they do not need. I will respond to the many threats that I get every single day and give the patients what they want. I will not be giving them what they need. I will be costing taxpayers a mint at a time when I am being told to tighten my belt. I will not be practising good medicine. I will cease to be an actual doctor—just doling out what is wanted. But... I will avoid a college complaint. I will avoid a public 'caution.' And I will be out of this god forsaken profession in less than 10 years. Just providing some examples of where this could go and what the unintended consequences could be (Physician, January 29, 2015, 11:32 pm).

This response not only illustrates a negative view of the government, regulatory organizations and the media, but a negative view of patients and the sense that these organizations are enabling patients to make unreasonable demands of their physicians and a means for patients to retaliate if these demands are not met. Notably, it references patient use of health information found on the Internet to request interventions or services that their physicians don't feel the patient requires. It again demonstrates the tensions addressed under the code "Transparency can damage the physician-patient relationship": physicians feel that their authority as medical experts is challenged by patients who, desiring autonomy, use information they obtain from the Internet to decide what is best for them rather than allowing medical experts to decide what is best for them. The situation the physician describes above is defensive medicine: in order to avoid the negative consequences associated with patient complaints,

physicians may acquiesce requests they view as unnecessary, and this may result in increased costs to the health care system (Nash et al., 2009; Nash et al., 2010). This response also describes the way that dissatisfaction with organizational regulations can lead to physicians' dissatisfaction with their profession in general, a feeling which is echoed in another physician's response:

Due to political pressure, this proposal is already decided upon even though the College probably knows it is unjust and unfair. The College would never risk its status and power to stand up to the [government] for physicians. [...] This is getting to be a sad, sadistic, and risky profession to practice in. Going to work is like going to walk in a minefield. Despite one's best efforts and diligence, you never know when which patient, other party (anyone can file a complaint) will set off a mine as you walk on, and tangle you up in a complaint for months to come. There is no penalty to file a complaint and despite the outcome, a complaint is a sentence itself. 10 years into this profession, but honestly if someone had sat me down to discuss with me the College and what it can do to one's psyche, I would have never chosen this one (Physician, January 26, 2015, 9:11 pm).

It is clear that some physicians feel not only at odds with patients, but with the College they belong to as well, creating general animosity toward a transparency initiative that is seen to service both at the expense of their own careers and well-being. From this point of view, having a patient file a complaint is already a stressful event, and to make the outcome of those complaints available on a public register is unfair because it heightens that stress and further impedes physicians' ability to influence the way that their patients view them.

**Career satisfaction.** Many factors are known to influence physicians' career satisfaction, and physician career dissatisfaction has been demonstrated to significantly increase likelihood that physicians will leave the medical profession or reduce their practice hours (Landon,

Reschovsky, Pham & Blumenthal, 2006; Pathman et al., 2002). There is a strong correlation between patient satisfaction, quality of care and physicians' career satisfaction. Physicians with greater career satisfaction tend to have higher patient satisfaction scores (Haas et al., 2000; Warren, Weitz & Kulis, 1998) and physicians' perceptions of their ability to provide high quality care lead to greater career satisfaction (Friedburg et al., 2014).

Some factors shown to lead to career dissatisfaction among physicians are stresses associated with malpractice litigation and practicing defensive medicine, feeling that patients have unrealistic demands or expectations, lack of autonomy and control over their work, and concerns over externally imposed regulation and rules (Friedburg et al., 2014; Zuger, 2004; Landon, Reschovsky, Pham & Blumenthal, 2006). Warren, Weitz and Kulis (1998) suggest that patient rights movements may inadvertently lead to greater career dissatisfaction for physicians because "public knowledge of and involvement in medical matters has increased while public trust in physicians has decreased. As a result of these challenges to professional authority, physicians are becoming only expert consultants whose advice may be taken or left, rather than members of a profession" (p. 358). The authors' findings demonstrate that physicians who feel that patients lack confidence in them are almost three times more likely to be dissatisfied with their profession than those who do not feel that their patients lack confidence in physicians. Lack of patient trust and the existence of imposed regulations then decrease physicians' career satisfaction because they threaten the physician's role as a professional and may lead physicians to believe they are providing a lower quality of care to their patients by practicing defensive medicine and giving in to demands they feel are unrealistic.

#### 4.4 Summary

Within the first cycle of analysis, 11 main topics of discussion within the forums were identified. These topics were assigned short codes that summarized the premise of the topic: public reprimand, due process, fairness to physicians, public trust, public perception, patient safety, secretiveness, media, improving patient care, patient choice and organizational flaws. The topics most frequently discussed by physicians were fairness to physicians, due process, public perception, organizational flaws and improving patient care. For members of the public, the most common topics of discussion were patient safety, public trust, organizational flaws and public perception. For organizations, patient safety was the most commonly discussed topic, and for anonymous respondents, fairness to physicians, patient safety, organizational flaws and public perception generated the most responses. Overall, the most discussed topics were fairness to physicians, organizational flaws, public perception and patient safety. Fairness to physicians was a code given to responses that questioned or debated how fair the transparency proposals were to physicians. Responses under the code organizational flaws expressed concern about the organizations that regulate physicians as well as the factors that influence their decision making, such as government or the media. Public perception was a code concerned with the public's ability to understand the information being provided to them, as well as the way that the public perceives health care and health care professionals in general. Responses assigned the code of patient safety dealt with a variety of patient safety-related concerns such as medical errors, incidents of harm to patients, or avenues of justice for patients who have been harmed in the health care system.

The most common topics of discussion within the first cycle of analysis allowed for a narrower, more descriptive range of codes within the second cycle of analysis. Four codes were

developed: 1) transparency can damage the physician-patient relationship, 2) transparency can improve patient experience and engagement, 3) transparency can lead to misunderstandings and misperceptions, and 4) problems within regulatory organizations complicate transparency. These second cycle codes roughly align with the four most common first cycle codes of fairness to physicians, patient safety, public perception and organizational flaws, respectively. For physicians, “transparency can damage the physician-patient relationship” was the most frequent topic of discussion, while “transparency can improve patient experience and engagement” was the most frequent for members of the public. This highlights a trend in the opposing points of view or issues of contention between physicians and members of the public, as physicians were concerned about how transparency could negatively impact their relationship with their patients through various means such as undermining patient trust or eroding physician career satisfaction, while members of the public were optimistic that increased transparency might reduce patient safety incidents and enable patients to take a more active role in their health care. These findings help to draw a conclusion about the two main themes within the discussion forum, to be explained in the next chapter.

## CHAPTER 5: CONCLUSION

### 5.1 Main Themes

In discussing the four codes from the second cycle of analysis, it is clear that while the arguments may differ, there is a divide between two points of view: one in which the transparency initiative is positive, which predominantly falls under the code “Transparency can improve patient experience and engagement.” The majority (78%) of responses under this code were in agreement with the transparency proposals, while for the remaining three codes the majority of responses were in disagreement. Despite the fact that they disagreed for different reasons (that transparency would negatively impact the physician-patient relationship, that transparency would lead to misunderstandings and misperceptions, or that organizational flaws complicate transparency), a common thread that can be found in all three is that physicians are concerned about the effect that transparency will have on their career, on their psychological health and on the public’s perception of them, and that this concern may lead either to the practice of defensive medicine in order to preserve one’s reputation and favour with patients, or to increased stress and dissatisfaction with their profession. In this way, transparency is seen to *threaten* the physician’s autonomy and authority.

In the positive view of transparency, which was the most common view expressed by members of the public (see Table 5), transparency fosters for patients a sense of independence, safety and justice. Patients believe that transparency will enable them to make better choices for themselves, to be protected from the potential for harm that naturally exists in the vulnerable health care context, and to have a means of seeking amends when these methods of quality control fail to protect them. In this way, transparency is seen to *increase* the patient’s autonomy and authority. What this juxtaposition illustrates is both a type of power struggle between

physicians and patients and a fundamental disagreement about the purpose and outcomes of increased transparency.

This divide can be seen clearly in the discussion of cautions. Cautions were the most frequently discussed item of all of the transparency proposals (see Table 1). The arguments against the publication of cautions can be roughly summarized by the following physician's response:

If you want to avoid doctors in Ontario that have been issued cautions you'd have a really hard time navigating the system. How, for example, would you know if the radiologist reading your x-ray had not been issued a caution. How about the pathologist interpreting your biopsy specimen? There is risk inherent in using the healthcare system and there always will be. Doctors are humans and humans are not perfect. But doctors are highly trained and skilled professionals and by far and large do more good than harm. They should be allowed a fair chance to remedy their deficiencies without public humiliation (Physician, January 29, 2015, 4:26 am).

As this response addresses, there is concern that the outcome of the transparency initiative will not be to protect the public interest and provide patients with the information needed to make informed choices. Rather, the outcome will be to cause patients to avoid physicians with this information attached to their name, in particular to avoid physicians who have been issued a caution. The purpose of a caution is to point out deficiencies in a physician's practice and encourage them to improve. If cautions are made public, the concern is that the effect is no longer education and opportunity for improvement, but public humiliation and a loss of patient trust.

For those with a positive view of transparency, publishing cautions on the public register is necessary because patients feel that they have a right to know whether their physician has made mistakes serious enough to warrant a caution. This opinion can be summarized in the following response from a member of the public:

It is also true that the CPSO could have concerns regarding the physician's knowledge and skill in his area of practice. As a patient I WANT TO KNOW THIS. A physician could be practising on the edge of incompetence and being issued several oral or written cautions. Just because he hasn't killed anyone or made such an egregious error that caused serious harm doesn't mean I want him treating me. I SHOULD HAVE A RIGHT TO KNOW IF THIS PERSON HAS FALLEN BELOW THE ACCEPTED STANDARD OF CARE WHEN TREATING PATIENTS. I want to make an informed decision when choosing my practitioner as I would if I hired a contractor, nanny, etc. (Member of the Public, January 28, 2015, 12:37 pm).

What this response illustrates is that patients do intend to use the information about which physicians have been issued cautions in order to avoid those physicians. It also demonstrates the increasingly consumerist perspective with which people view health care decisions. However, what is also embedded in the discussion of free choice and patients' right to know is the obvious fears that patients have when accessing health care services. Patients seek to increase their level of trust that they will not be harmed by selecting physicians who do not have cautions posted on the public register. In this way, transparency is viewed as positive because it allows patients to choose between a physician they trust and a physician they do not trust.

To demonstrate the breakdown of discussion forum responses that were in favour of the transparency proposals for the reasons discussed above and those that were against, two main

themes were developed and the responses were sorted into one or the other. The criteria for being sorted into either category were whether their opinion was mostly positive or mostly negative about the effects of transparency. For the responses that expressed mixed opinions (Table 3), they were categorized based on whether they spoke more about the detrimental effect transparency could have on physicians or the positive effect it could have for patients.

Theme	Responses related to theme (N=226)		Author of response							
			Physician		Member of the public		Organization		Anonymous	
	n	%	n	%	n	%	n	%	n	%
Transparency is negative because it threatens physicians' autonomy and authority	167	73.89	94	41.59	13	5.75	3	1.33	57	25.22
Transparency is positive because it increases patients' autonomy and authority	59	26.11	3	1.33	26	11.50	2	0.88	28	12.39

**Table 7. Themes covered by forums as a function of author of response**

### **5.1.1 Transparency is negative because it threatens physicians' autonomy and authority**

In response to the research question, which asks how individuals on the discussion forum view the goals, purpose and probable outcomes of increased transparency and whether this aligns with the CPSO's public interest mandate, the responses in this category express the belief that increased transparency does not help the public enough to justify the damage it could do to physicians. 167 responses fell under this category, with the majority (56% of 167 responses) posted by physicians. While not all responses felt that transparency in general was a negative

thing, all responses felt that the type of transparency proposed by the CPSO's initiative could have negative consequences.

The way in which transparency is seen to threaten physicians' autonomy is because it takes away a certain amount of control they might have over the way they are perceived and the outcomes of disciplinary and remedial actions. The struggle for autonomy is not aimed at patients, nor are physicians blaming patients for restrictions on their autonomy; it is physicians seeking autonomy from regulatory and government organizations including the CPSO as well as the influences on those organizations, such as the media and shifting political ideals. As can be seen in the two cycles of analysis, many responses were highly critical of the CPSO and medical regulation in Canada in general, arguing that self-regulation is an illusion and that the transparency initiative is less about improving patient care than it is about appeasing a range of external forces that are placing pressures on the medical profession.

Transparency is viewed as threatening to physicians' authority because it means that patients want to evaluate their physicians based on other factors than their educational and training qualifications and possession of a medical licence. As discussed in the literature review, physician authority within the physician-patient relationship is something that is always being negotiated. The type of physician-patient relationship idealized today is one where physicians and patients share the responsibility for decision-making: the physician provides their knowledge and expertise to the patient, and the patient ultimately decides which treatment modalities fit best with their lifestyles, goals and priorities. Physician authority is further impacted by an increasingly consumerist perspective on health care, even in Canada where health care is universal. Patients feel that as taxpayers, they have a right to evaluate and select physicians in the same way that they would evaluate and select any other service provider, and much emphasis is

placed on client satisfaction which sometimes has more to do with a physician's personality than their skill level and knowledge base. Some responses within the discussion forum expressed the opinion that the transparency initiative would compound this further by providing patients with a means to evaluate their physicians using information that some patients may lack the knowledge necessary to decode and understand.

### **5.1.2 Transparency is positive because it increases patients' autonomy and authority**

Responses under this category suggest that increased transparency will do what the CPSO proposes it will do, which is to help the public make informed choices. 59 responses fell under this category, with the majority (47% of 59 responses) posted by anonymous, followed closely by a member of the public (44% of 59 responses). This point of view generally agrees that the CPSO's transparency initiative is in line with their public interest mandate and will achieve its goals and purpose of helping patients to make informed choices and to feel confident in the health care system and its processes.

Patients feel that increased transparency will increase their autonomy by allowing them to seek information, understand that information on their own terms, and then use that information to make a decision about which physician they want to see. Responses also expressed the opinion that selecting physicians on this basis would enable patients to protect themselves from harm by avoiding physicians who have had concerns about their practice raised in the past. As previously discussed, this is in line with ideals of patient empowerment and patient choice.

Transparency is also seen to provide patients with more authority within the physician-patient relationship. Some responses centred on the idea that physicians have a great deal of control and power over their patients, and that if patients can access more information about their physicians, power and control can come closer to being equalized. Authority in this sense is

derived from the idea that knowledge is power, and the more knowledge patients have of the health care system, the more power they have over their health.

## 5.2 Further Questions

One significant limitation of the analysis is the ability of those posting responses on the discussion forum to self-identify. It is not possible to cleanly differentiate between which opinions come from physicians and which come from patients, especially given the large volume of anonymous responses, but also because physicians are members of the public and therefore free to identify as members of the public. Because of this, it is difficult to illustrate the degree to which physicians and patients disagree about the goals and outcomes of increased transparency. Nonetheless, it is clear looking at the data from “physicians” and “members of the public” alone that the two groups have different priorities and different opinions about transparency. If it was known which anonymous responses were posted by physicians and which were posted by patients, the nature of this difference might become even clearer.

Another important finding that this analysis highlights is that the majority of responses on the discussion forum about the second phase of the CPSO’s transparency initiative were not in agreement with one or more of the proposed amendments or with increased transparency in general. As is evident in Table 2 and Table 7, it was more common to have a negative view about the transparency initiative and its potential for detrimental effects than it was to have a positive one. One possible explanation for this is that while all physicians and health care professionals in Ontario and throughout Canada would be familiar with the CPSO and its mandate, and would likely know how to access the organization’s website and have read about the transparency initiative in other publications such as *Dialogue*, many members of the public may be completely unaware of the CPSO’s mandate, policies, and/or invitation to the public to

provide feedback on these policies. A question that this raises is whether the data would change if a random but equal sample of physicians and members of the public throughout Ontario were asked to provide feedback on the transparency initiative. Another question it raises is the purpose and utility of the policy consultation process and of the discussion forums, and whether other policies under consultation on the discussion forums would show the same trend. The CPSO states that all feedback is considered and helps them to assess and develop their policies. It does not suggest or imply that their policies will not go through if the feedback they receive on these policies is mostly negative.

### **5.3 Final Remarks**

The CPSO's transparency initiative arose out of a concern that the public's trust in health care, health care professionals and the organizations tasked with regulating them is decreasing. As the CPSO's mandate is to protect the public interest, providing more information to the public was proposed as a means of demonstrating to the public that the self-regulatory practices of the medical profession operate in the public's interest, as well as enabling patients to become more informed and engaged decision makers in their health care. The CPSO invited physicians, members of the public and organizations to provide feedback on the proposals of the transparency initiative on their website. This feedback was analyzed using discourse analysis in order to answer the question of how physicians and members of the public feel that the CPSO's transparency initiative fulfills (or does not fulfill) the organization's public interest mandate.

Through the analysis, it became evident that the point of view that the transparency initiative does serve the public interest was derived from a sense that the more information patients had access to about their health care providers, the better equipped patients would be to make informed decisions about which health care providers and institutions they could trust. This

sense of trust would allow patients to feel they were mitigating the risks associated with using the health care system, such as the potential for physical or emotional harm. Unsurprisingly, it was members of the public who most commonly expressed this point of view on the discussion forums. The opinion that the proposals of the transparency initiative are not in the best interest of the public centred on concerns about the public's ability to understand and utilize the information being provided in a way that was both helpful to them and fair to physicians. Within the discussion forum, this opinion was most frequently expressed by physicians, who worried that patients would misunderstand the information being provided to them and that this misunderstanding would cause undue friction within the physician-patient relationship and undermine trust rather than encourage it.

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