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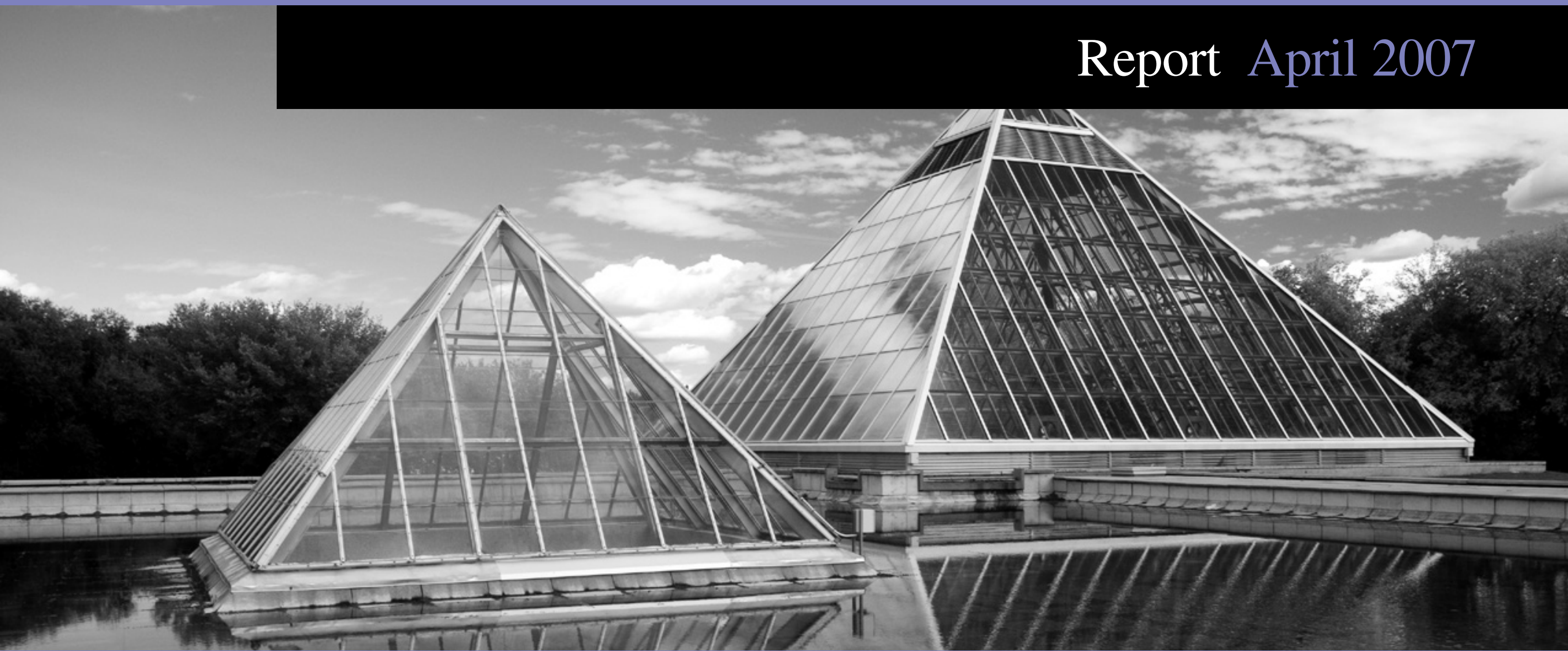

Achieving Public Protection Through Collaborative Self-Regulation Reflections for a New Paradigm

HEALTH, HEALTH CARE AND WELLNESS

The Conference Board of Canada
Insights You Can Count On

Achieving Public Protection Through Collaborative Self-Regulation—Reflections for a New Paradigm
by *The Conference Board of Canada*

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Preface

This report examines the regulatory barriers and facilitators to collaborative patient-centred practice. It does this by reviewing the provincial/territorial and national legislation and regulation related to health professionals in Canada and identifying international regulatory trends. The content builds on information gathered during a two-day workshop that brought together regulators from different jurisdictions and professions with the objectives of identifying key issues in regulation and inviting their views on the future of health professional regulation in this country.

The purpose of this report is to provide advice to regulators and policy-makers as to the future role that legislation and regulation could play in enhancing collaborative practice and improving health human resource management. The report builds on a previous report authored by Lahey and Currie, "Regulatory and Medico-Legal Barriers to Interdisciplinary Practice." Both this and the Lahey/Currie report were funded by Health Canada's Interprofessional Education for Collaborative Patient-Centred Practice Pan-Canadian Health Human Resource Strategy.

In keeping with The Conference Board of Canada's guidelines for financed research, however, the design and content of this report, as well as the method of research for it, were determined solely by the Conference Board.

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EXECUTIVE SUMMARY

Achieving Public Protection Through Collaborative Self-Regulation

Reflections for a New Paradigm

At a Glance

- Current legislation and regulation do not prohibit collaborative practice, but neither do they encourage or require it.
- Legislation and regulations should be updated and amended to expressly support collaboration.
- Regulators have an important role to play in supporting collaborative practice through the development of partnerships between regulators (and other standard-developing organizations), educators, governments and the public.
- Encouraging regulators to work together in the areas of quality assurance, complaints and discipline would signal to health professionals the importance of collaboration.
- Regulators can act now, wait for the demographically driven sustainability challenge to hit the health-care system, or deal with the potential crisis of regulation, which could arise from a lack of focus in the areas of recertification, regulatory accreditation or standards. This report outlines the eight steps we could take to stay ahead of the curve, not behind it.

Health-care stakeholders have been focusing on interdisciplinary collaboration to achieve greater flexibilities and efficiencies in health human resources planning and management. This report is intended to shed light on the legislative and regulatory environment, and how it acts as a barrier—or as a facilitator—to interdisciplinary collaboration. Experts agree that the legislative and regulatory environment is critical to reform. It is where Roy Romanow, Commissioner of the Future of Health Care in Canada, and Senator Michael Kirby have said we need to begin the transformation of our health-care systems. They have declared that changing scopes and patterns of practice is the first step we must take.

This report is intended to shed light on the legislative and regulatory environment, and how it acts as a barrier—or as a facilitator—to interdisciplinary collaboration.

The purpose of this report is to provide advice to regulators and policy-makers as to the role that legislation and regulation could play in enhancing collaborative practice and improving health human resources management. This report builds on a previous report authored by Lahey and Currie, "Regulatory and Medico-Legal Barriers to Interdisciplinary Practice." The current report examines

legislative and regulatory barriers and facilitators to collaboration of health professionals in this country by:

- reviewing the provincial/territorial and national legislation and regulation related to health professionals in Canada;
- identifying international regulatory trends; and
- building on a two-day workshop with regulators.

There is very little known about health professional regulation—which in this country mostly means self-regulation—even among those who are regulated. When health professionals receive mail from their regulatory body, they hope that the envelope contains a bill, which is preferable to the alternative: a disconcerting notice naming them in a formal complaint or asking them to participate in a peer review or remediation program. This is the world of self-regulation. It is a complex area marked by inconsistency and lack of clarity. This report attempts to simplify a very complex area by using a framework to view the regulatory environment across Canada. The framework describes the principles that lie at the foundation of regulation. From these principles, legislators develop legislation aimed primarily at protecting the public. This legislation then forms the basis on which regulators create standards, which members must then meet in order to provide high-quality health care.

There is very little known about health professional regulation—which in this country mostly means self-regulation—even among those who are regulated.

Our analysis begins with a discussion of the fundamental principles underlying self-regulation. It identifies existing principles and provides thoughts on potential principles worth including. Two key concepts are presented: orders and modes of regulation. Orders of regulation describe *who* regulates, and modes of regulation describe *how* we regulate health professionals. We then use the orders and modes to assess the consistency across jurisdictions and professions on a series of key regulatory instruments. Six principles of interdisciplinary collaboration—patient/client engagement; population health approach; best possible care and services; access; trust and respect; and effective communication—serve as an assessment tool to determine which regulatory instruments should be analyzed in this report. Based on this assessment, we review scope of practice, delegation, codes of ethics and consent to release information in order to determine the regulatory environment's state of readiness to support interdisciplinary collaboration.

From this analysis, it is clear that regulation is a complex area that becomes increasingly complex across professions and jurisdictions. It is easy to appreciate why a lack of understanding of regulation exists across the country. Quite simply, it is a difficult subject.

Two key concepts are presented—orders of regulation describe *who* regulates, and modes of regulation describe *how* we regulate health professionals.

That said, based on our analysis, regulation and legislation do not appear to be substantial barriers to collaboration, but nor do they significantly facilitate or enable it. Therein lies the rub. Legislatures and regulators have not traditionally made collaborative care one of their main or leading objectives among competing priorities. There has been no apparent need for them to do so. Shifts in demographics, however, are necessitating a change.

Our analysis found inconsistency and lack of clarity in legislation and regulation with respect to collaboration across the country. When these types of flaws exist in legislation or regulation, regulators, health professionals (and indeed most individuals) will traditionally err on the side of caution. What are the implications of this for collaboration? Health professionals might be hesitant to work in teams or to delegate duties. Legislators and regulators must be clear and consistent in emphasizing the importance of collaboration.

It is inevitable that trade-offs must be made by regulators when principles or priorities conflict, such as the requirement to promote collaboration versus the need for efficiency in delivering simple health-care procedures. These trade-offs require greater research, focus and understanding. In addition, further analysis is needed on regulatory instruments for incorporation and record keeping.

A review of licensure and certification standards may reveal additional insights on barriers to collaboration. Finally, a better understanding is needed of how regulation and standards set by employers interface with standards developed by regulators.

The report emphasizes the importance of appropriate measurement and evaluation tools, which, when properly applied, could lead to the improved management of regulators, health professionals and the health-care system as a whole. On this subject, a wealth of information is at our fingertips, just waiting to be used and applied.

Regulators have indicated overwhelmingly that they recognize that change is imperative and that they are willing to be part of the change process. The changes required to support collaboration are straightforward, and this report lays out the eight steps to bring them about, as well as outlining five recommendations, listed below. Regulators have an important part to play in supporting collaboration because they have unique skills and talents that enable them to fulfill leadership roles in their respective jurisdictions and professions.

Governments need to update the various items of health profession legislation to allow the various health professionals and their regulators to work together.

The five key recommendations that arise from this report are as follows:

1. **End the legislative silence or neutrality.** The law should do more than simply "not prohibit" collaborative practice; it must encourage it. Governments need to update the various items of health profession legislation to allow the various health professionals and their regulators to work together. Without a clear legislative mandate to undertake a specific program, regulators are reluctant to spend time and resources—which are, after all, limited—on something that is not *legally* required of them. Alternatively, the development of clear government policy indicating support for collaboration and directed towards regulators would reinforce its importance.
2. **Amend ancillary legislation.** Other health-care legislation similarly needs to be examined and amended to allow for and support collaborative practice. Most of the legislation was created before the emergence of collaborative, team-based care, so many pieces of legislation do not reflect the current roles of both individuals and teams. For example, updating the public hospitals acts and privacy and consent to treatment legislation to better reflect the emergence of collaborative care would reinforce the importance and need for greater access to a collaborative team of providers.
3. **Provide financial incentives to regulators to develop instruments (such as standards for delegation, consent and codes of ethics)** to support collaborative care. Provincial/territorial regulators and governments will need to work together to ensure that appropriate resources are available to make this happen. Regulators will need to encourage, support and respect professional cultural differences and facilitate consensus.
4. **Encourage regulators to work together in the area of quality assurance, complaints and discipline.** There are interesting examples in Canada and abroad whereby regulators have collectively joined forces to deal with various issues of self-regulation. Quebec and the United Kingdom serve as examples of better practices to emulate. Regulators have an important role to play in supporting collaborative practice. Leadership and infrastructure support on the part of regulators and governments will ensure that public safety issues around collaborative care are dealt with most effectively and efficiently.
5. **Federally fund an arm's-length organization dedicated to creating and sharing information among regulators.** This organization would be an independent forum of professions, provincial/territorial regulators and ministries of health with a clear mandate to research, educate and disseminate best practices across the country. Organizations such as the American Council on Licensure, Enforcement and Regulation (CLEAR) and the Canadian Network of National Association of Regulators (CNNAR) could serve as archetypes on which to build. The new organization should begin with three key functions:
   - Develop templates for various regulatory instruments that could be adopted or adapted by regulators. In Ontario, for example, the Federation of

Health Regulatory Colleges recently developed templates for delegation. This could be done for various regulatory instruments at the pan-Canadian level much more cost-effectively.
- Create and maintain a data warehouse to track regulatory indicators, such as the level and nature of quality assurance activities, complaints and disciplinary actions, and the cost of regulation.
- Facilitate a continuing scoping review among stakeholders with the mandate to develop and support a pan-Canadian principle-based framework for self-regulation. It should allow for provincial/territorial flexibility and adaptability, while reinforcing the principle of portability in the *Canada Health Act*.

One of this report's key messages is that more important barriers to collaboration exist than legislation and regulation. For example, the impact of funding models on how, and from whom, the patient/client receives care needs careful attention, as funding overwhelmingly influences the behaviour of health professionals. As well, the importance of professional and organizational culture as a barrier to collaborative care cannot be overstated.

Finally, the report describes the burning platform for change and calls for leadership. Regulators voiced consistent concerns about the sustainability of the self-regulatory environment in many jurisdictions and professions. Leaders have a choice: they can act now, wait for the sustainability challenge associated with looming demographics changes, or wait for a crisis of regulation, which has already occurred in the United Kingdom. The prudent choice would be to act now and take advantage of the experiences of others and avert a similar crisis that exposes the lack of recertification/revalidation, accreditation of regulatory bodies, and regulatory instruments. Partnerships are the way forward. They can bridge silos, create efficiencies, and build trust and respect among stakeholders. In short, they are essential to foster collaboration.

Two heads are usually better than one.

For a glossary of terms used throughout this report, please see Appendix A.

CHAPTER 1

Introduction

Chapter Summary

- By 2025, the proportion of Canadians over the age of 65 is expected to double from its 1980 level.
- At that time, we will have older patients with multiple chronic diseases who will require support from collaborative teams.
- This report reviews provincial/territorial and national legislation and regulation, identifies international trends, and builds on a consultation with Canadian regulators.

THE HEALTH HUMAN RESOURCES CHALLENGE

At the outset of the new millennium, the Canadian health-care system stands at a crossroads. It is becoming more and more difficult to provide all Canadians with affordable and accessible health care and to meet their changing and evolving health-care needs in a cost-effective and efficient manner. A system that is already strained faces the additional challenges of an aging population and the increasing burden of care that comes with it, due primarily to the higher prevalence of chronic diseases. The proportion of Canadians over age 65 is estimated to be 20.4 per cent by the year 2025—double the share in 1980.[1] Currently, chronic diseases account for approximately 67 per cent of all health-care costs,[2] and this share is likely to rise as Canadians age. At the same time, health professionals are getting older and closer to retirement. Undoubtedly, Canadians will need to take a more active role in managing their own health, but significant patient-centred support from a range of health professionals trained to support patients/clients with chronic diseases will most certainly be required.

The First Ministers agreed to provide access to an appropriate health-care provider 24 hours a day, 7 days a week.

The First Ministers acknowledged the present and looming human resources challenge. Their 2003 Accord outlines plans for health-care renewal, with a particular focus on health human resources (HHR) and planning. The First Ministers agreed to provide access to an appropriate health-care provider 24 hours a day, 7 days a week, and committed to ensuring that 50 per cent of residents have access to this type of service by 2011. Governments consider collaborative care to be part of the HHR solution, as it

1 The Conference Board of Canada, *Performance and Potential 2005–06. The World and Canada: Trends Reshaping Our Future.* (Ottawa: The Conference Board of Canada, 2005), p 132.

2 The Conference Board of Canada. *Understanding Health Care Cost Drivers and Escalators* (Ottawa: The Conference Board of Canada, 2004), p. 31.

is one way to optimize the use of HHR and improve the delivery of care.[3] A full $90 million was to be devoted in 2003 to Health Canada's Pan-Canadian Health Human Resource Strategy, with $20 million in annual funding thereafter. The pan-Canadian strategy has three components: Pan-Canadian HHR Planning, Interprofessional Education for Collaborative Patient-Centred Practice (IECPCP), and Recruitment and Retention.

As part of the Pan-Canadian Health Human Resource Strategy, the IECPCP[4] seeks to facilitate and support collaborative practice education across all health-care sectors. It also provides an excellent opportunity to effect cultural change within professions with respect to collaborative practice by changing the educational ethos in which health-care professionals are trained.

The overuse or misuse of collaboration may be as detrimental to the system as underusing it.

The First Ministers Agreement of 2004 provided further support through a commitment to accelerate and expand the assessment and integration of internationally educated health-care professionals. Federal Budget 2005 provided $75 million over five years to support the integration of internationally educated health-care professionals.[5] The 2004 First Ministers Agreement outlined a 10-year plan to strengthen HHR.

For more than a decade, different levels of government, and health-care professionals and their associations have been involved in discussions aimed at meeting the growing challenges in health care, including perceived HHR shortages. Whether or not collaboration is the solution to future HHR shortages is open to debate or conjecture. As with any type of innovation, the overuse or misuse of collaboration may be as detrimental to the system as under-using it.

Adopting a team approach to chronic disease management—particularly for patients with complex co-morbidities—is a wise use of resources. It would not be wise, however, to use the same approach to treat a sick child with a simple ear infection. Two heads are not always better than one.

Many believe that the way to deal with HHR shortages is to redefine scope of practice or "job description" as defined in legislation, regulation, policies and procedures. In his 2002 report, Commissioner Romanow identified changing the scope and patterns of practice of health providers as the first step in the transformation process.[6] Senator Kirby has stated that there is a "need for a thorough independent review of the scope of practice rules for the various health professions."[7] As well, regulators have indicated that clarifying scope of practice is a key issue requiring attention.[8]

But how does scope of practice relate to collaborative care, or more to the point, how do legislation and regulation support collaborative patient-centred practice? This report provides an answer.

DEFINING COLLABORATION AND SELF-REGULATION

To begin, one must first understand a few key definitions. *Collaboration* has been defined by Way and Jones as "an interprofessional process of communication and decision-making that enables the separate and shared knowledge and skills of health care providers to synergistically influence the client/patient care provided."[9] Health Canada states that *collaborative patient-centred practice*

3 Health Canada, "2003 First Ministers' Accord on Health Care Renewal" [online]. (Ottawa: Health Canada, 2003), [cited March 6, 2007]. www.hc-sc.gc.ca/hcs-sss/delivery-prestation/fptcollab/2003accord/index_e.html.

4 www.hc-sc.gc.ca/hcs-sss/hhr-rhs/strateg/interprof/index_e.html.

5 www.hc-sc.gc.ca/hcs-sss/pubs/care-soins/2006-wait-attente/hhr-rhs/index_e.html.

6 Roy Romanow, Q.C. (Commissioner), *Building on Values: The Future of Health Care in Canada—Final Report* (Ottawa: Commission on the Future of Health Care in Canada, 2002), p. 91.

7 The Honourable Michael J.L. Kirby (Chair), *The Health of Canadians—The Federal Role: Volume Six: Recommendations for Reform, Final Report on the State of the Health Care System in Canada* (The Standing Senate Committee on Social Affairs, Science and Technology, October 2002), p. 198.

8 Enhancing Interdisciplinary Collaboration in Primary Health Care, *Barriers and Enabling Factors Task Groups Report* (Ottawa: The Conference Board of Canada, 2005), p. 16.

9 Daniel Way, Linda Jones and Nick Busing, "Collaboration in Primary Care–Family Doctors & Nurse Practitioners Delivering Shared Care" [online]. Discussion paper written for The Ontario College of Family Physicians. (May 18, 2000), (cited February 16, 2007). www.familymedicine.uottawa.ca/eng/implementation_strategies.aspx, p. 3.

"is designed to promote the active participation of each discipline in patient/client care. It enhances patient- and family-centred goals and values, provides mechanisms for continuous communication among caregivers, optimizes staff participation in clinical decision-making within and across disciplines and fosters respect for disciplinary contributions of all professionals."[10] For ease of communication, we will use the terms "collaboration" and "collaborative patient-centred practice" interchangeably throughout the report.

Regulation is defined by Webster's dictionary as a "rule or order having the force of law issued by an executing authority of a government."[11] In health care generally, regulation relates to an executing authority of a government setting certain standards for health care. The present health-care system is governed by a multitude of interrelated and interdependent federal and provincial/territorial rules and regulations. They affect everything from funding to pharmaceuticals, profession-specific regulations (which differ in each jurisdiction within Canada), political and labour intrigues (within each province/territory and between them and the federal government) and, most importantly, the differing demographic, geographic and economic requirements of Canada's population as well as the complexity and acuity of patients/clients' health-care needs. While no one solution provides all the answers, First Ministers believe that moving towards a system of interprofessional collaborative care will significantly help to provide greater responsiveness, accountability and flexibility in the health-care system. In this report, we focus on self-regulation of health professionals—in other words, how governments transfer to health professions their authority to protect the public and govern their respective professions.

LEGISLATIVE AND REGULATORY BARRIERS TO COLLABORATION

The health-care system's requirements are complex, evolving, and challenging to meet. In searching for solutions, one has to examine HHR and the regulation of health professionals. Self-regulation in Canada is not uniform across the country. There is irregularity in terms of which professions are regulated, how they are regulated in each province/territory, under which legislative structure, and by means of which regulatory mode. Even within a given profession there are significant differences across the country in a variety of categories.

The provinces and territories, in collaboration with health professions and their regulatory bodies, have enjoyed the benefits of their autonomy and have created structures and practices to reflect their specific needs. However, while these may have respected the autonomy of many of the groups involved, the system's needs—current as well as projected—are placing demands on resources that are becoming increasingly scarce. The cumulative picture, when seen through the lens of a pan-Canadian health-care system, is one of partial solutions for partial problems. It is time to move towards more comprehensive and efficient options. In this report, we will discuss such an option—interdisciplinary collaborative care—and in particular how legislation and regulation can act as either a barrier or a facilitator to it.

In searching for solutions, one has to examine health human resources and the regulation of health professionals.

Chapter 2 gives an overview of how legislation and regulation are undertaken in the current health-care system. It discusses self-regulation in the context of legislative structures and how it relates to collaborative care. It ends by presenting a vision of legislation and regulation in which many of the current structures can be maintained, guided by overarching principles favourable to interdisciplinary collaborative care.

Chapters 3 and 4 elaborate on the many aspects of regulation that are directly or indirectly influenced by legislation and regulation. We will look at what is working and what is not working, and point to better practices in Canada and abroad. Chapter 5 offers a summary of conclusions regarding the issues and solutions, along with a short list of key recommendations for adjusting the regulatory environment.

10 Ivy Oandasan et al., "Executive Summary—Interprofessional Education for Collaborative Patient-Centred Practice: An Evolving Framework" [online]. Prepared and submitted to Health Canada. (2003), (cited February 16, 2007). www.hc-sc.gc.ca/hcs-sss/hhr-rhs/strateg/interprof/summ-somm_e.html, p. 2.

11 *Webster's Ninth New Collegiate Dictionary* (United States: 1983), p. 992.

CONTEXT AND METHODOLOGY OF REPORT

As part of the Pan-Canadian Health Human Resource Strategy and IECPCP, Health Canada commissioned research on various components of interprofessional care. The main message of one key report, known as the Lahey and Currie report,[12] is that liability issues and regulatory legislation can either be barriers or facilitators to collaborative care. However, Health Canada needed to know more, and in 2005 it awarded The Conference Board of Canada two contracts to research liability and legislation/regulation barriers to collaborative care.[13]

It is the purpose of this report to provide a vision of health professional regulation that facilitates interdisciplinary collaboration across Canada to ensure the delivery of safe and effective health care. It also provides recommendations to achieve that vision. In focusing on legislation and regulation, the research included: an analysis of provincial/territorial and national legislation and regulation in Canada; a review of international trends; and consultations with Canadian regulators. While any number of regulated health-care professions would find this report relevant, it has been written primarily for the following professions: physicians and surgeons; nurses;[14] psychologists; dietitians; pharmacists; physiotherapists; occupational therapists; speech-language pathologists; audiologists and social workers.

REVIEW OF PROVINCIAL/TERRITORIAL AND NATIONAL LEGISLATION AND REGULATION

The research started with an in-depth review of each jurisdiction's legislation and regulations governing the health professions at issue. This was conducted for the most part online. Next, all of the professional regulators' websites and professional associations' websites were reviewed for all of the jurisdictions to examine any codes of ethics, guidelines and policies affecting interdisciplinary collaboration. Privacy and hospital insurance legislation was also reviewed where it existed.

REVIEW OF INTERNATIONAL TRENDS

We reviewed the legislative and regulatory environment in eight jurisdictions using the Internet as the primary data source. The jurisdictions included: Australia, the European Union, France, Germany, New Zealand, Sweden, the United Kingdom and the United States. We identified trends and best practices in each jurisdiction as they relate to interprofessional collaborative care.

CONSULTATION WITH CANADIAN REGULATORS

Shortly after the initial phase of the above research, Canadian regulators were brought together for a meeting on March 30–31, 2006. The purpose was to gather feedback on their perception of the state of readiness of legislation and regulation to support collaborative care. Forty-eight health profession regulators were randomly selected using a stratified, random sample. Of those selected, 44 attended the two-day workshop. The meeting's objectives were threefold:

- to assist in building a comprehensive research agenda;
- to identify the key issues in regulation for health-care professionals working collaboratively; and
- to discuss the future of regulation in Canada.

The review of provincial/territorial and national legislation and regulation and of international trends, plus the consultation with Canadian regulators, served as the basis for this report.

It is important to emphasize that this report does not significantly review the evidence that supports collaboration, nor does it assess whether self-regulation in and of itself is a barrier to collaboration. Others have addressed the first point, and for the most part, the second point remains outstanding.

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12 William Lahey and Robert Currie, "Regulatory and Medico-Legal Barriers to Interdisciplinary Practice," *Journal of Interprofessional Care* Supplement 1 (May 2005), pp. 197–223.

13 For more information on this topic, see Gabriela Prada et al., *Liability Risks in Interdisciplinary Care: Thinking Outside the Box* (Ottawa: The Conference Board of Canada, Unpublished at time of printing).

14 Note that the term "nurse" in this report refers to registered nurses (RNs) unless otherwise stated. Also, licensed practical nurses (LPNs) are referred to as registered practical nurses (RPNs) in Ontario.

CHAPTER 2

Current Regulatory Framework

Chapter Summary

- This chapter offers a jurisdictional overview of health-care professional legislation and regulation in Canada.
- It devotes special attention to current regulatory principles and modes and orders of regulation.
- Finally, it describes the regulatory context and defines basic terminology.

While conducting this research, it became apparent that there is a general lack of understanding about the legislative and regulatory process and structures in health care.[1, 2, 3, 4] We therefore developed a simple exhibit to describe the key elements of legislation and self-regulation. (See Exhibit 1.)

The framework describes the principles that lie at the base of self-regulation. To ensure that these principles are respected, the public, through its elected officials, creates legislation based on these principles. This legislation is the structure or the basis of self-regulation. The legislation ultimately dictates how regulators govern health professionals in the public interest. Regulators then provide public protection through the development of licensure/certification, regulation, standards of practice, policies and guidelines.

The challenge has been and will always be to answer this question: What level of enforceability is required to protect the public with each health-care intervention?

These legislative and regulatory instruments are ultimately created to protect the public, and more specifically to ensure that the individual relationship between patients/clients and providers ultimately results in the delivery of safe, high-quality care in which patient rights and confidentiality are respected. As one moves from legislation to regulation, and eventually to patient/client care, the pace of change, or the ability to make changes, increases. At the same time, however, the ability to enforce the various levels and elements becomes harder as one moves from legislation to regulation and patient/client care. The challenge has been and will always be to answer this question: What level of enforceability is required to protect the public with each health-care intervention?

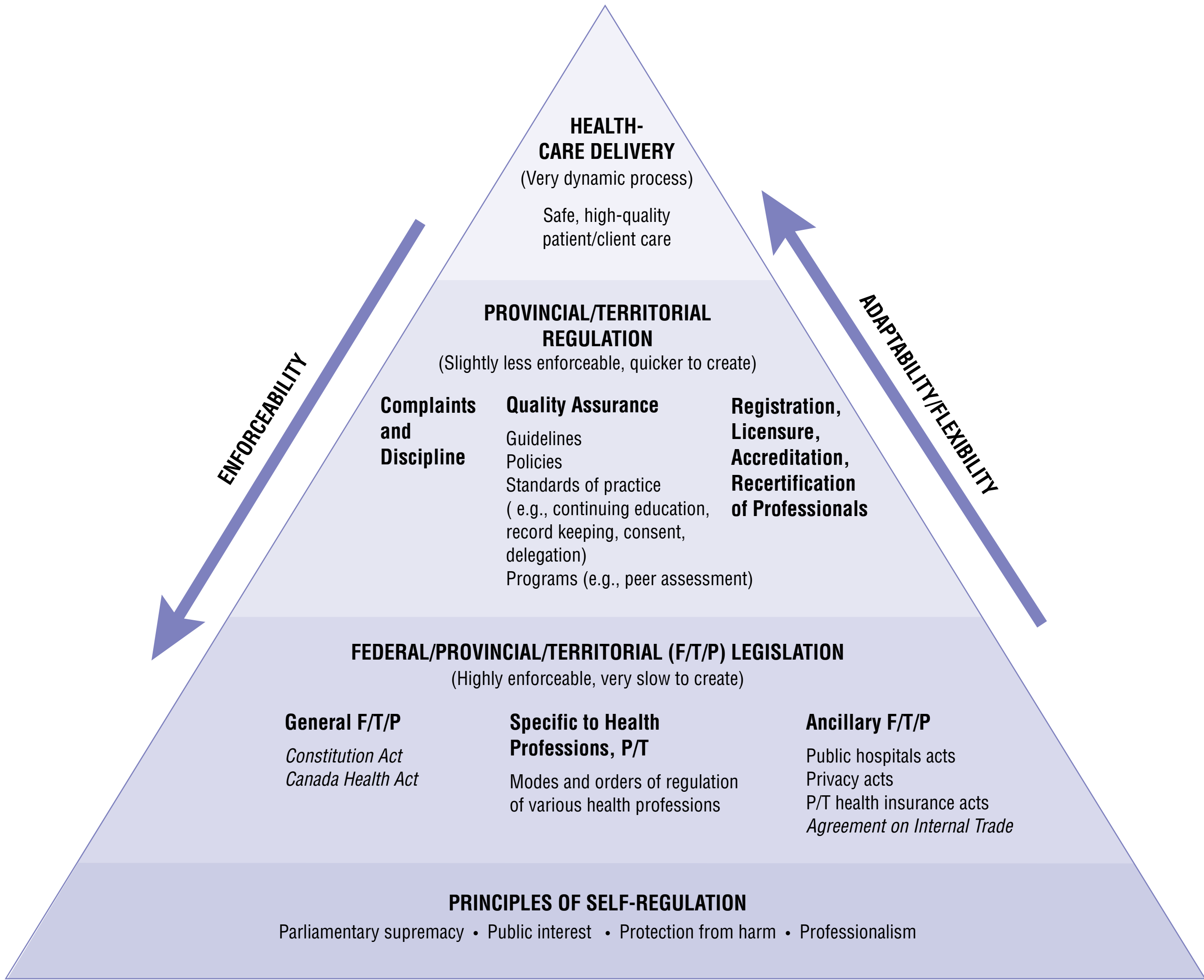
1 Enhancing Interdisciplinary Collaboration in Primary Health Care, *Provider Workbook Analysis Report* (Ottawa: The Conference Board of Canada, 2005), p. 6.

2 Enhancing Interdisciplinary Collaboration in Primary Health Care, *Regulatory Factors Task Group Snapshot* (Ottawa: The Conference Board of Canada, 2005), p. 1.

3 The Health Professions Regulatory Advisory Council, *Regulation of Health Professions in Ontario: New Directions* (Toronto: HPRAC, 2006), p. 3.

4 Health Professions Council, *SAFE Choices: A New Model for Regulating Health Professions in British Columbia, Part II: Legislative Review* (British Columbia: Ministry of Health, 2005), p. 26.

Exhibit 1
Regulation and Canada's Health-Care Systems



Source: The Conference Board of Canada, 2007.

This framework is not exhaustive. It does not intend to describe in detail the differences in legislation and regulation of disciplines across the country. Nor does it describe all of the elements of regulation at each level. It is intended only to provide a simple way to describe self-regulation in Canada. We use this framework as the basis for this report.

PRINCIPLES OF SELF-REGULATION

There are four central factors behind self-regulation (or regulating professions):

1. The nature of the service involved and its technical sophistication does not lend itself well to traditional regulation.
2. Regulation by normal competitive markets is virtually impossible in health care.

3. There is an essential trust and inevitable imbalance in the patient-health professional relationship.
4. There is a need to determine the quality of care given and outcomes.[5]

In Canada, health professionals have been given the responsibility to self-regulate. In this way, governments for the most part have in fact delegated their authority to regulate health professionals to members of the profession who then act in the public interest. A tradition exists in our country of strong patient representation within the governance structure and decision-making of regulators or colleges.

The legal context of regulation in Canada is based on four broad principles of health professional regulation present in every jurisdiction in Canada despite their variety and differing complexities. Specifically, the following four principles that underlie regulation in Canada may prove to be the most germane to the issue of collaborative interdisciplinary practice:

- parliamentary supremacy
- public interest
- protection from harm
- professionalism

Articulating and developing these regulatory principles, which are evident in the legislation, is one way to address the reality of Canada's health professional regulation across the country. These regulatory principles exist in the legal and cultural ethos of the regulatory institutions found within all jurisdictions in Canada. There is no need to invent them. Once these principles are recognized as a common set of regulatory and legal norms, they provide an excellent opportunity to shape the discussion of how universal and portable principles can be applied to the provincial level to better protect the public and guide the regulation of all health professions engaged in collaborative interdisciplinary practice or other forms of practice. There may very well be additional principles (or fewer) that should be clearly articulated and defined, but as yet no mechanism is in place to ensure any consistency across jurisdictions. We offer the following descriptions for debate.

5 Bruce Doern and Mark MacDonald, *Free Trade Federalism* (Toronto: University of Toronto Press, 1999), pp. 160–164.

PARLIAMENTARY SUPREMACY

Legislators are supreme, but this supremacy is subject to other important existing Canadian legislation such as the *Constitution*, the *Charter of Rights and Freedoms*, and in Quebec, the *Quebec Charter of Rights and Freedoms*. As a matter of practice, this means that legislatures are fully responsible to enact the required regulatory legislation to institutionalize collaborative interdisciplinary practice among health-care professions. Whether that legislative competency will be realized is largely a question of the political will of the various stakeholders involved in health-care profession regulation.

Canada is a federal constitutional monarchy. Under this constitutional framework, legislative authority over regulation of health professions is vested in provincial governments by virtue of section 92(13) of the *Constitution Act, 1867*,[6] and in the case of the territories, in the federal government by virtue of section 4 of *The British North America Act, 1871*.[7] Thus, while the state is the ultimate regulator, it is the provincial legislatures that carry the majority of the regulatory burden, in collaboration with the professions and public stakeholders.

Legislatures are fully responsible to enact the required regulatory legislation to institutionalize collaborative interdisciplinary practice among health-care professions.

As a result of the constitutional division of powers, the regulatory landscape of health professions is one of multijurisdictional authority involving 13 different legislative actors (provincial and territorial) and dozens of regulated professions. In addition to government and regulator stakeholders, there are an equal number of professional associations—at both the national and provincial/territorial levels—as well as other stakeholders, such as employers, unions, hospitals, long-term care facilities, community groups and the general public. All these stakeholders have an impact upon the regulation of health-care professions to varying degrees. At the outset, self-regulation is a system by which the powers of protecting the public are passed along to the various regulators.

6 30 & 31 Victoria, c. 3 (UK).

7 34 & 35 Victoria, c. 28 (UK).

PUBLIC INTEREST

Health-care professionals are regulated on the premise that it is in the public interest to do so. This principle is recognized across Canada regardless of whether the profession is regulated through a "public act,"[8] as in Ontario, or a "private act,"[9] as in New Brunswick. It is also a principle well recognized in other jurisdictions, from the United Kingdom to the United States.

As an organizing principle, protection from harm provides a common frame of reference for regulators across Canada regardless of how a profession is actually regulated.

While there may exist a broad consensus that regulation of health-care professions is justified only in terms of defending the public interest, there is often no clear consensus as to what exactly is the public interest. Lack of consensus on the meaning of this term is not problematic but rather indicative of public policy formulation within a democratic polity such as Canada, which is subject to open debate as to how to define the public interest and how to promote it.

PROTECTION FROM HARM

The fundamental legislative principle within every Canadian jurisdiction with respect to health-care profession regulation is the protection of the public from harm in the delivery of health care. One could argue that, in fact, protection from harm is a subset of public interest. However, protection from harm is so fundamental to our understanding of regulatory existence that perhaps it is sometimes taken for granted or simply underlies discussions of regulatory propriety without being recognized for the organizing principle that it is.

As an organizing principle, protection from harm provides a common frame of reference for regulators across Canada regardless of how a profession is actually regulated. In doing so, it presents an opportunity for a common appreciation for collaborative interdisciplinary practice and the steps that need to be taken to ensure that such practice is safe. Moreover, such regulatory functions as quality assurance, discipline, registration and continuing education/recertification requirements are all ways in which regulatory authorities protect the public from harm and provide a ready matrix in which to address collaborative interdisciplinary issues.

Professional self-regulation is a privilege, not a right.[10] It continues to be a privilege only as long as professionals continue to be vigilant in their responsibility to protect the public.

PROFESSIONALISM

Regulation of those involved in the delivery of health care is not simply a matter of regulating individuals, but rather of regulating the professions to which individuals belong. This, however, begs the question, What is a profession? One answer is that the term *profession* refers to a group pursuing a learned art as a common calling in the spirit of public service—no less a public service because it may incidentally be a means of livelihood.[11]

Professional self-regulation . . . continues to be a privilege only as long as professionals continue to be vigilant in their responsibility to protect the public.

While this definition acknowledges the potential for conflict between public and private interest, it nevertheless clearly articulates the essential relationship between a profession and the "spirit of public service." This relationship is most unmistakably present in those professions associated with the healing arts. While undoubtedly there are many motives for becoming a health-care professional, it would be foolish to ignore the fact that professional

8 A "public act" is legislation that is of general applicability and broad significance and is enacted in furtherance of government policy.

9 A "private act" is for the benefit of a specific applicant, which can be an individual, corporation or municipality, and relates only to the interests of the applicant.

10 Health Professions Council, *SAFE Choices: A New Model for Regulating Health Professions in British Columbia*, Part II: Legislative Review (British Columbia: Ministry of Health, 2005), p. 3.

11 Roscoe Pound, *The Lawyer From Antiquity to Modern Times* (St. Paul: West, 1953), p. 5.

life is a "calling." It makes demands upon those who pursue a common calling, in terms of education, commitment and discipline to a profession's ethic and expectations.

When examining health professional regulation, it is important to remember that a specifically human endeavour is being regulated. Professions are not perfect; they reflect the qualities of those who make up the profession—both good and bad. Yet, a spirit of public service allows health professionals, and their regulators, to benefit and support the public interest.

The principles of parliamentary supremacy, public interest, protection from harm and professionalism are basic to the legislative ethos of all jurisdictions in Canada.

At the same time, it is important to recognize and acknowledge that regardless of the degree to which professions follow a "spirit of public service," there also exist fundamental differences in the cultures of different professions. These are partly reflected in regulatory attitudes and norms. A profession that has a rule-based culture will differ markedly from a profession that has an experience/evidence-based culture, even though both seek the common good of the patient/client in terms of health, welfare and interests. Professionals from both cultures can work collaboratively, but it is imperative that the cultural differences be recognized and reconciled through open dialogue and consensus.[12]

These basic regulatory principles—parliamentary supremacy, public interest, protection from harm and professionalism—are also capable of reflecting other principles. For example, in 1995, the Pew Health Professions Commission's Taskforce on Health Care Workforce Regulation[13] articulated a set of five principles for the regulation of health-care professionals that would, in its view, best serve the public interest. They are:

- promoting effective health outcomes and protecting the public from harm;
- holding regulatory bodies accountable to the public;
- respecting consumers' rights to choose their health-care provider from a range of safe options;
- encouraging a flexible, rational and cost-effective health-care system that allows effective working relationships among health-care providers; and
- facilitating professional and geographic mobility of competent providers.[14]

One can deduce from this list that promoting health outcomes, enforcing accountability, ensuring sustainability and allowing geographic mobility are added responsibilities that regulators would assume under such a principle-based system. However, regulators today may already be dealing with them through appropriate risk assessment and managing priority trade-offs.

The principles of parliamentary supremacy, public interest, protection from harm and professionalism are basic and endemic to the legislative ethos of all jurisdictions in Canada and provide a common starting point for further discussion on the possible addition of principles, such as collaboration. If collaboration is in fact in the public interest, then it logically follows that regulatory support for collaboration must also be in the public interest.

Principles are the foundation on which systems are designed. The current focus on collaborative care creates an opportunity to discuss and rethink how the current regulatory system could be better designed to support collaborative care and public protection. Beginning with principles is the first step.

THE LEGISLATIVE CONTEXT

This section will provide a jurisdictional/legislative overview of health-care profession regulation in Canada, with special attention being paid to:

- the legal context of health-care profession regulation; and
- definitions of basic terminology (e.g., licensure, scope of practice).

12 Examples of such reconciliation can be found when professions collaborate to establish complementary policies with respect to delegation.

13 Taskforce on Health Care Workforce Regulation, *Reforming Health Care Workforce Regulation: Policy Considerations for the 21st Century* (San Francisco: Pew Health Professions Commission, 1995).

14 Ibid., p. vii.

As noted, it is primarily Canada's provinces and territories that deliver health care. Because of this legislative prerogative, provincial legislatures bear the brunt of the regulatory burden for health care. It must also be recognized that regulatory responsibilities are shared responsibilities among state, professional and public stakeholders.

In addition to governments and regulators, an equal number of professional associations and stakeholders all have an impact upon the regulation of health-care professions.

As a result of the constitutional divisions of power, the regulatory landscape of health professions is one of multi-jurisdictional authority involving 13 different provincial-territorial (P/T) legislative actors and dozens of regulated professions. In addition to governments and regulators, an equal number of professional associations—at both national and P/T levels—and stakeholders (such as employers, unions, hospitals, long-term care facilities, community groups and the general public) all have an impact upon the regulation of health-care professions.

CATEGORIES OF SELF-REGULATORY LEGISLATION

One of the implications of the legal context described above is that each legislative body is free to regulate in the manner it chooses. As a result, there is no uniform or standard model of health professional regulation in Canada; details of regulation vary and reflect the historical, political, economic and cultural differences in each province and among the different health-care professions, which arose as those professions grew and developed in their respective provinces.

The basic legislative and profession differences have given rise to divergence in basic terminology describing how a profession is regulated. Despite these regulatory differences, a number of key concepts are common to every jurisdiction and can be characterized as belonging to two legislative categories: the orders or modes of regulation.[15]

15 The Modes and Orders analysis of regulation was first articulated by D. Alderson in *Regulating, De-Regulating and Changing Scope of Practice in the Health Professions: A Jurisdictional Review* (Toronto: Health Professions Regulatory Advisory Council, 2003).

Orders of Regulation

Orders of regulation concern the "who" aspect of regulation. In considering the institutions, structures and laws that actually govern a profession, it is important to recognize that regulation is carried out by a combination of relevant stakeholders who share the duties and obligations that regulation entails.

The subject of orders of regulation raises a fundamental question: What does self-regulation mean? Within the Canadian context, it is almost universally accepted that health-care professions are self-regulating. However, does that nomenclature accurately describe the reality? Depending upon who is asked, "self-regulation" can mean any number of things. For example, the ability to discipline members through peer review, or the ability to set standards of practice or entry to practice requirements is regarded by many as the hallmark of self-regulation. For others, professional self-regulation is synonymous with the regulator having a governance body, a majority of which is composed of members of the profession itself.

It is important to recognize that regulation is carried out by a combination of relevant stakeholders who share the duties and obligations that regulation entails.

In the context of the orders of regulation, however, the fundamental issue is one of *imperium*—who has ultimate authority, and the extent of that authority, over health-care profession regulation. The orders of health professional regulation are best understood as being a regulatory continuum of complete autonomous self-regulation at one end, self-administration in the middle, and direct government control at the other end. In Canada, all three orders of regulation exist.

Autonomous Self-Regulation

In this order, professions are truly autonomous in their regulation and are characterized by a complete lack, or almost complete lack except for their enabling legislation, of government control or need for legislative action in

order to fulfill their regulatory mandates. For example, in New Brunswick, the professions of medicine, nursing and dentistry are all governed by regulatory bodies that are relatively autonomous.

Self-Administration

In this order, the regulatory bodies are dependent upon the legislature not only for their enabling legislation but also for continued government support in drafting regulations to support regulators as well as the ministers of health or lieutenants governor-in-council. They control what the regulators do, and have the power to require something to be done when necessary.

Ontario's *Regulated Health Professions Act* regime is an example of this order. Professions are self-governing and self-disciplining, but the Minister of Health and Long-Term Care retains significant powers over regulatory affairs.

Direct Government Regulation

Under this order, a government department directly regulates a profession. In Canada, only the territories have this kind of regulatory regime, and it applies only to a limited number of professions (pharmacists in the Yukon; physicians, pharmacists and psychologists in the Northwest Territories and Nunavut).

These different orders underscore the fact that some professions are more self-regulating, in the sense of being more autonomous from government, than others. However, all are dependent upon legislation for the power to regulate. This dependency reflects the fundamental political nature of health-care profession regulation and the important role of legislatures in ensuring that regulators have the necessary tools and authority to implement government policies with respect to the health-care system.

These different orders underscore the fact that some professions are more self-regulating, in the sense of being more autonomous from government, than others.

When a body or college is set up expressly for the purpose of regulating, the mandate is clear. In the case of health professionals, this body may be a college (order in Quebec), an association or a government body

Exhibit 2
Orders of Regulation

Source: The Conference Board of Canada, 2007.

(e.g., department of health). When it is the professional association that takes on the added role of regulation, confusion may arise in the minds of the members.[16]

Modes of Regulation

Modes of regulation describe *how* health professionals are regulated. In Canada, two basic legislative structures effect the regulation of health-care professions. The first structure, commonly described as a "controlled acts model," comprises omnibus legislation that applies to all professions with accompanying profession-specific legislation relating to the unique nature of the profession itself. The second legislative structure, commonly referred to as a "licensure model," is stand-alone, self-contained legislation that applies to a specific profession. In some instances, the legislation has been developed publicly (Nova Scotia) while in others it has been produced privately (New Brunswick). In each structure, professions are also governed by ancillary legislation, such as the *Public Hospitals Act*.

The controlled acts mode seeks to regulate those activities that are deemed to be harmful and allows for regulatory flexibility for those activities not deemed harmful.

Regardless of the legislative structure, all legislation in Canada aimed at regulating health-care professions does so by regulating their scopes of practice. Scopes of practice are regulated by two basic modes:

Controlled Acts Mode

This mode is characterized by the articulation of controlled or restricted acts that are authorized to a specific profession. Only those who are duly registered may perform these controlled acts when acting within their scope of practice. The controlled acts mode does not do away with scope of practice; rather, it seeks to define what is done within a given scope of practice by reference to certain specific activities that are deemed to be harmful if not performed by a qualified individual. This mode characterizes regulation in Ontario, British Columbia and Alberta and is relatively new in its approach to self-regulation. The controlled acts mode seeks to regulate those activities that are deemed to be harmful and allows for regulatory flexibility for those activities not deemed harmful. These activities then remain within the public domain and are not guided through legislative regulations.

In Quebec, the reserved activity model, similar to the controlled acts mode, is flexible and amenable to teamwork because reserved activities may be assigned to more than one profession.

Licensure Mode

This mode of regulation is the traditional model of regulation. There is one general scope of practice statement that offers a general definition and statement that restricts the

16 Health Professions Council, *SAFE Choices: A New Model for Regulating Health Professions in British Columbia*, p. 7.

Evolution of Self-Regulation in Canada

Regulatory systems in Canada have been revamped over the last 25 years. This is especially true of Ontario but is also the case in Quebec, British Columbia and Alberta. Regulation is "morphing." For example, Ontario's system is large, with 24 regulated professions, and is continuing to expand. New and old professions such as traditional Chinese medicine and kinesiology are moving towards regulation, as are some assistive personnel, such as pharmacy technicians.[1, 2] As well, provisions in Ontario have been introduced before the House to add four new college objectives: promote and enhance relations; promote inter-professional collaboration; enhance the ability of members to respond to change; and pursue any other object related to health care that councils consider desirable.[2]

The Quebec Interprofessional Council, which falls under the province's Professional Code, creates opportunities for the exchange of ideas and information among the orders, intervenes as the collective voice on issues of common interest to the orders, and provides information to the public. The Council also serves as an advisory body to the government.

1 Health Professions Regulatory Advisory Council, *Regulation of Health Professions in Ontario: New Directions*, pp. 147, 192.

2 Government of Ontario, *The Health System Improvements Act*, 2006, Schedule M, s. 18(2).

Source: The Conference Board of Canada.

practice of the profession to those who are duly licensed. What underlies this mode is the belief that in order to practice a health profession, one must be licensed to do so. The licence is indicative of a restrictive scope of practice. In other words, only those who are licensed may perform the "scope of practice." This mode is characteristic of regulation found in Saskatchewan, Manitoba, the Maritime provinces and the territories. The licensure mode of regulation is generally believed to be less flexible in that it regulates much of what might traditionally be considered in the public domain by the controlled acts mode.

At its most basic, "scope of practice" identifies what a profession does and how it does it. It is the range of activities that a qualified practitioner may practise.

At its most basic, "scope of practice" identifies what a profession does and how it does it. It is the range of activities that a qualified practitioner may practise. It establishes the boundaries of a profession in relation to other professions that may perform similar activities. A scope of practice may be established through legislation or through internal regulations adopted by a regulatory body. It also acts as an important identifier as to what consumers of health care can expect from a provider of health-care services. A profession's scope of practice also reflects its culture, regulatory and educational traditions. It is not surprising therefore that scope of practice issues between professions often centre on definitions, boundary and autonomy.

While the controlled acts mode is conducive to overlapping scopes of practice, it is not in and of itself a guarantee of collaborative practice, as interdisciplinary cooperation can and does take place under either licensure or controlled acts regimes. Some have argued[17] that the controlled acts mode is more conducive to collaborative care. Others have found evidence of strong collaboration in both modes of regulation.[18] It is hard to reach a definite conclusion about the best mode or order of regulation without an appropriate tool to measure collaboration. Such a tool is currently being used in Saskatchewan, and it, or one like it, would have to be used consistently across jurisdictions to make any direct comparisons of the effect of these modes or orders on collaboration. The Canadian Institute for Health Information indicator project—particularly its indicators that relate to collaboration—may become a proxy for this type of measurement tool.

LEGISLATIVE LANDMARKS AND MILESTONES

In the overall history of regulatory changes in Canada, the greatest changes have occurred in the last 20 years. During that time, government has assumed greater responsibility for ensuring public safety, or regulation. As well, the Internet has expanded our knowledge base and places extra pressure on professionals to do things right. Patients/clients are more informed and want to know more about what services are delivered.

Numerous acts have been introduced and or modified to strengthen the financing, management and delivery of health services in Canada. (See Appendix C.)

In 1984, the Canadian Parliament passed the *Canada Health Act*. This act, which is the basis of the Canadian health-care systems, is often viewed as representing the moral values of Canadian society. It establishes the criteria and conditions related to insured health-care services that the provinces and territories must meet to receive the full federal cash transfer contribution under the current transfer mechanism, the Canada Health Transfer (CHT). The *Canada Health Act* confirmed the following principles or program criteria:[19]

- Universality—all residents of Canada must be entitled to services.
- Comprehensive—all medically necessary hospital and physician services must be covered.
- Accessibility—services must be provided on uniform terms and conditions, and reasonable access to services must not be impeded.

17 William Lahey and Robert Currie, "Regulatory and Medico-Legal Barriers to Interdisciplinary Practice," pp. 197–223.

18 Enhancing Interdisciplinary Collaboration in Primary Health Care, *Interdisciplinary Primary Health Care: Finding the Answers —A Case Study Report* (Ottawa: The Conference Board of Canada, 2006), p. 36.

19 The Conference Board of Canada, *Understanding Health Care Cost Drivers and Escalators*, p. 83.

- Portability—persons must remain covered while temporarily absent from their province (within Canada).
- Public administration—health plans must be administered by a non-profit public authority.

In 1994, the Agreement on Internal Trade, signed by all First Ministers, provided *inter alia*, an agreement to eliminate barriers to mobility, and it sought to ensure compliance by regulatory authorities that oversee professions in each jurisdiction.[20] Pursuant to Article 707, dealing with the Licensing, Certification and Registration of Workers, regulatory authorities were to rely principally on competencies as the criteria for granting licensure or registration in a profession.

Regulations are the details that support legislation. They exist pursuant to legislation and typically require consultation within various levels of health ministries.

The Canadian Constitution, the *Canada Health Act*, the *Public Hospitals Act,* and various modes and orders of regulation act as the platform from which regulators exercise their responsibility to protect the public.

INSTRUMENTS WITHIN THE REGULATORY CONTEXT

We now turn to the regulatory context to give an overview of the way in which regulators exercise their responsibility through the development of regulatory instruments, such as regulations, standards of practice, policies, guidelines, regulatory programs (complaints and discipline, quality assurance), and registration, accreditation and recertification of health professionals. These instruments were developed to protect the public from health professionals who deliver substandard care. They provide clarity around the scope of work each provider is competent to deliver and set benchmarks for the quality of care expected of a reasonable health professional. (See Exhibit 3.)

Regulations are the details that support legislation. They exist pursuant to legislation and typically require consultation within various levels of health ministries. While in theory they can be enacted and brought into force more quickly than legislation, in practice getting regulations approved can be very slow and in some cases next to impossible. For example, regulations are applied to advertising, registration, quality assurance, professional misconduct, fees, delegation and record keeping.

Standards of practice are developed by the various regulated health professions through regulatory mechanisms reflected in legislation. They are intended to guide a profession in its delivery of health care and ensure the appropriate level of quality within a profession. As well, they may promote continuous learning and improvement. Standards of practice are easier to implement and quicker to change than are legislation and regulations because they require approval by the regulatory body or college only. Most have a mechanism for enforcing standards of practice, because failing to meet a standard of practice is considered an act of professional misconduct. Examples of standards of practice include record keeping, and reporting of diseases and standards for the performance of one's duties. In particular, standards of practice are typically set for those duties described as controlled acts. Standards of practice are slower to develop than regulations but can be created more quickly than policies.

Policies are easier to create than standards of practice but are markedly less enforceable. Policies attempt to help members understand their professional responsibilities and help regulators state their positions on a variety of issues. They aim to describe what is acceptable.

Guidelines, on the other hand, provide recommendations to members of a profession. Guidelines are typically more flexible and easier to implement and can be changed more quickly than standards of practice and policies as they require college approval only and are not reflected in legislation. They are, however, less enforceable because

20 Human Resources and Social Development Canada, "Government of Canada Agreement on Internal Trade—Guidelines for Meeting the Obligations of the Labour Mobility Chapter." www11.hrsdc.gc.ca/en/cs/sp/hrsdc/lmp/mobility/9999-000057/page03.shtml.

courts maintain that a guideline cannot serve as a substitute for a standard or regulation simply because it is easier to pass.[21] Examples of guidelines include codes of ethics, consent and advertising.

If a college feels that a guideline is insufficient to protect the public, it may then create a standard of practice and even a regulation within the same area following the appropriate consultation phase. Thus, a guideline on a code of ethics could become a standard of practice or a regulation if a college deemed it necessary to protect the public.

Regulators have at their disposal the instruments of regulations, standards of practice, policies and guidelines. Regulators attempt to balance the need for public protection with flexibility and or rigidity depending on the level of risk to the public. A renewed assessment of risk may be required under a new paradigm that supports collaborative care.

Regulators of Canada's health-care professions have a tremendous responsibility to ensure that health care is delivered safely and effectively and that their respective professions are governed in the public interest. More often than not, however, the regulators' role in HHR planning and management, in general, and collaborative practice in particular, and their impact upon them, is misunderstood, underestimated and understated.[22]

KEY CONCERNS OF SOME HEALTH PROFESSIONAL REGULATORS

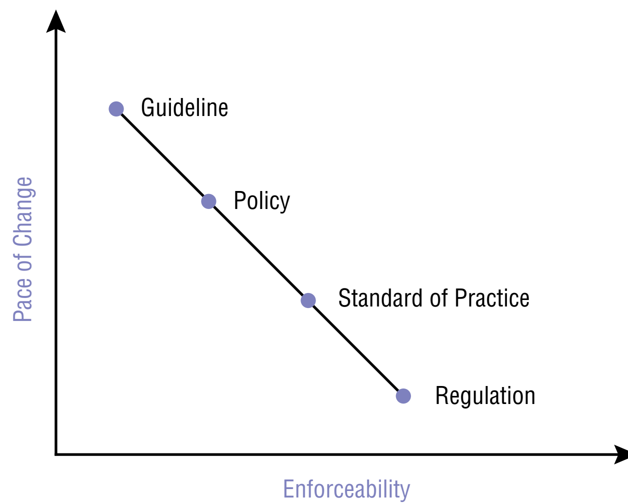
Feedback from the regulators who attended the March consultation revealed the following concerns:

- Different models of health-care delivery will make it difficult for regulators to provide guidance and oversight, and regulators will also face increasing pressures to raise admission standards.
- Boundaries between professions will break down, and in light of that, it will be incumbent upon each profession to broaden its understanding of the others.

21 *Szmuilowicz v. Ontario* (*Minister of Health*) 125 D.L.R. (4th) 688.

22 The Standing Senate Committee on Social Affairs, Science and Technology, *The Health of Canadians—The Federal Role: Final Report* (Ottawa: The Senate, October 2002), p. 199.

Exhibit 3
Comparison of Regulatory and Legislative Instruments



Source: The Conference Board of Canada, 2007.

- Colleges and regulatory boards that remain will find their focus changing from managing discipline to boosting quality improvement and assurance.
- There will be challenges in terms of sorting out team accountability, and dealing with insufficient funds and the erosion of public and members' trust. Funding and reimbursement will drive care practices.

ADJUSTING THE IMAGE: CLARITY WITH LEGISLATION AND REGULATION

The concerns voiced by regulators bring home the fact that making collaborative interdisciplinary practice viable and accountable will require a shift in current regulatory and educational patterns and approaches. While the IECPCP initiative is a good starting point in changing the education culture, the regulatory paradigm must also shift towards a regulatory norm that supports and facilitates collaborative interdisciplinary practice.

Collaborative care calls for a renewed paradigm for regulation—one that recognizes the unique skill-sets of a range of professionals working in teams. Patient-centred care is both the driving force and the common ground

on which to begin building a new framework. The role and status of the patient/client is also important and needs to be articulated.

Regulators must hold high the vision of a regulatory culture, which is, in part, measured by its success in the creation, continuing development and support of collaborative, interdisciplinary, patient-centred health-care team practices. This vision will ensure the delivery of safe and effective health care to the patient/client by the right health-care professional, in the right place and at the right time. The new system will also reflect job descriptions and HHR functions, which are becoming increasingly important facts in establishing the best mix of health-care providers. It will involve much more of a partnership between patients/clients, regulators, educators and government ministries overseeing the health-care systems.

Success indicators for regulatory reform that would better support collaborative care would include the following:

- greater interdisciplinary cooperation in the development of collaborative regulatory instruments;
- changes to legislation and ancillary legislation with clear language that supports collaboration;
- greater interdisciplinary collaboration of regulators in the area of quality assurance, complaints and discipline;
- inclusion of education and training in effective collaboration and team function as part of regulatory standards for licensure; and
- quality assurance and continuing quality improvement programs, rather than discipline, driving matters of profession and regulatory accountability.

There are other, more far-reaching indicators that may or may not be directly attributable to regulatory reforms. Although a direct correlation may be hard to establish, regulators play an important role in improving indicator scores, whether they fully recognize it or not. The indicators include:

- overall improvement in population health/patient care, characterized by better access and improved patient/client outcomes;
- improved recruitment and retention of health-care providers;
- team-based practice that provides high patient/client safety and fosters communication among health-care providers;
- efficient and effective employment of health human resources throughout the health-care system; and
- greater satisfaction among patients/clients and health-care providers.

Principles for Interdisciplinary Collaboration

The principles that underpin interdisciplinary collaboration in primary health care in Canada reflect shared values and create a foundation for professional and system-wide approaches to primary health-care policies, programs and services. The six principles are:

- patient/client engagement;
- population health approach;
- best possible care and services;
- access;
- trust and respect; and
- effective communication.

Source: Enhancing Interdisciplinary Collaboration in Primary Health Care, *The Principles and Framework for Interdisciplinary Collaboration in Primary Health Care* (Ottawa: EICP, March 10, 2006).

How can all this be achieved? The following chapter reviews current Canadian trends regarding legislation and regulation in the context of collaborative care. It discusses how some features and practices tend to hinder collaborative care while others support it. A presentation of better practices, from both the Canadian and international contexts, points to viable solutions that would support collaborative care, some quite strongly and positively.

It should also be acknowledged that there are other barriers (e.g., fee structures, funding models, liability issues) to collaborative care. To paraphrase one regulator, “We do not own all of the problems.” While these barriers are also germane to collaborative practice, they are beyond the scope of this report. Liability issues will be addressed in The Conference Board of Canada report *Liability Risks in Interdisciplinary Care: Thinking Outside the Box*. Other supportive activities, such as education and funding models, will also need to be addressed.

CHAPTER 3

Legislative and Regulatory Support for Collaborative Care

Chapter Summary

- This chapter examines the various legislative and regulatory components of Canada's health-care system that are relevant to collaborative interdisciplinary practice.
- For each component, the chapter cites key differences among the provinces and territories and identifies current barriers/facilitators to collaborative care.

Using the principles of collaboration identified in the previous chapter's text box "Principles for Interdisciplinary Collaboration," it is evident that a key element of collaboration is effective communication among members of the team, including the patient. We will now assess the various regulatory instruments across the country as a basis for evaluating the state of regulatory readiness to support collaboration. In this comparative analysis we will look at scope of practice and three specific regulatory instruments (delegation, code of ethics and consent to share health information), which all relate directly to effective communication.

ANALYSIS OF LEGISLATIVE INSTRUMENTS

SCOPE OF PRACTICE

We will use a broad definition of scope of practice in this analysis and compare the various modes and orders of regulations across the country. (See Table 1). The table is not exhaustive. Although its purpose is to present the consistencies and generalities within each province across the nine disciplines, it must be emphasized that there are many inconsistencies across provinces and disciplines. Table 1 brings home a number of salient points, but for brevity, we present the following:

- The term *scope of practice* means many things depending upon the context in which it is used. It can define what a health professional can or cannot do. It can describe a specific mode of regulation or describe the modes of regulation more generally. One must be sensitive to the context when using the word until a consensus can be reached on the specific definition required to cross boundaries and professions.
- Regulation is a complex arena to navigate. There are complexities within professions, and they become more so across professions and jurisdictions. It is easy to appreciate why there is a lack of understanding of regulation across this country. Increasing knowledge in this area will not come easily given the area's complexity and the lack of focus and general inertia surrounding it. A focused, dedicated and concerted effort in this area would be required.

Table 1
Regulation Models and Scopes of Practice, by Province and Territory

Province/Territory	Model and Mechanism	Notes on Scope of Practice
Yukon	**Model:** Scope of practice **Regulation Authority:** ◆ Regulation of physicians is a hybrid between government and self-regulation. ◆ Governments regulate pharmacists. ◆ Nurses are self-regulated by the Yukon Registered Nurses Association. ◆ Others practise without a licence.	Physicians have exclusive scope of practice;[1] however, nurses, pharmacists, occupational therapists, physiotherapists and others are exempt from the prohibition while practising their professions.[2] Unregulated professions practise without a licence; thus, anyone can practise these professions. Given the absence of much legislation and regulation, this model is very flexible.
Northwest Territories and Nunavut	**Model:** Scope of practice **Regulation Authority:** ◆ Governments regulate physicians, pharmacists and psychologists. ◆ Nurses and licensed practical nurses are self-regulated. ◆ Others practise without a licence.	Physicians have exclusive scope of practice; however, pharmacists, psychologists and nurses are exempt from this prohibition provided they are practising in accordance with the laws of the territories.[3] Pharmacists[4] have exclusive scope of practice; however, physicians and nurse practitioners are exempt, provided they are practising in accordance with the legislation and regulations governing them. Legislation governing physicians and psychologists does require input from professional associations. Nurses and psychologists have no exclusive scope of practice. Non-regulated professions practise without being licensed. Given the absence of much legislation and regulation, this model is very flexible.
British Columbia	**Model:** Mixture of controlled acts and scopes of practice **Regulation Authority:** ◆ Most professionals are self-regulated. ◆ Audiology and speech-language pathology are not regulated.	Regulation (licensing) has been in transition for the past 10 years. *Health Professions Act* (HPA) was enacted in 1996.[5] Some disciplines such as social workers enjoy title protection only. Medical profession bylaws have not yet been enacted. As well, sections of the HPA respecting medicine have not been proclaimed. Pharmacists in British Columbia are not yet regulated under the HPA. The hybrid and evolving nature of this model will be worth watching.

1 *Medical Profession Act*, R.S.Y. 2002, c. 149, s. 40.

2 *Medical Profession Act*, R.S.Y. 2002, c. 149, s. 40(3).

3 *Medical Profession Act*, R.S.N.W.T. 1988, c. M-9, s. 46.

4 R.S.N.W.T. 1988, c. P-6.

5 Government of British Columbia, *Health Professions Act,* R.S.B.C. 1996, c. 83.

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Table 1 ***(cont'd)***
Regulation Models and Scopes of Practice, by Province and Territory

Province/Territory	Model and Mechanism	Notes on Scope of Practice
Alberta	**Model:** Controlled acts with profession-specific statements **Regulation Authority:** ◆ All nine[2] are self-regulated. ◆ The Health Professions Advisory Board plays a key role.	Each profession-specific statement lists any restricted activity that the profession is permitted to perform as well as any additional training or education necessary for the person to perform that restricted activity. Alberta has a flexible and open system. The practices of health professionals are defined in the HPA but are not exclusive to a profession. Restricted activities can also be performed by more than one health profession provided they have the required training and skills. Only psychologists, dietitians, registered nurses, social workers, speech-language pathologists and audiologists have their regulations enacted.
Saskatchewan	**Model:** Scope of practice **Regulation Authority:** ◆ Each of the nine professions has their own act and is self-regulating. ◆ No profession-specific regulations. Each profession has its own bylaws, which are regulatory in nature. They require the minister's approval.	Physicians have an exclusive scope of practice. None of the exemptions to the act exclusively permit another health professional to perform acts within the scope of practice of medicine, even though nurse practitioners may do things considered the practice of medicine, dentistry and pharmacy. They apply to doctors from other jurisdictions, first aid situations, family situations and religious ceremonies. Registered nurses have exclusive scopes of practice. Psychologists have an exclusive "authorized practice," which involves communicating the identification of a diagnosis. All non-members are prohibited from performing this authorized practice with the exception of physicians. Pharmacists have a prohibition against anyone other than a member practising pharmacy, with a list of exceptions. Dietitians, occupational therapists, physical therapists, social workers, speech-language pathologists and audiologists have no prohibition against non-members performing acts within their areas of practice. The only prohibition is against non-members using their titles.
Manitoba	**Model:** Scope of practice **Regulation Authority:** ◆ All but social workers are self-regulated. ◆ Social workers are not regulated. ◆ Each of the self-regulated professions has its own act.	Even though each regulated profession in Manitoba has its own statute, this legislative framework is surprisingly conducive to teamwork. The main reason for this is that out of all of the professions being considered in this paper, only doctors and pharmacists have the exclusive right to practise their professions.[6] The rest of the professions have no exclusive right to practise their professions. They have only the right to use their respective titles, and non-members are prohibited from holding themselves out as members.[7] This means that all the members of a health-care team can practise dietetics, nursing, occupational therapy, physiotherapy, psychology, social work, speech pathology and audiology as long as they do not represent themselves as being licensed or registered to do so. This gives a health-care team an enormous amount of flexibility in treating patients/clients, because many members

6 *Medical Act*, C.C.S.M., c. M-90, s. 5(1) and *Pharmaceutical Act* C.C.S.M. c. P-60, s. 2(1).

7 See for example subsections 3(1) and 3(2) of *The Physiotherapists Act* C.C.S.M. c. P65.

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Table 1 ***(cont'd)***
Regulation Models and Scopes of Practice, by Province and Territory

Province/Territory	Model and Mechanism	Notes on Scope of Practice
Manitoba *(cont'd)*		of the team can theoretically perform many different types of treatment. They would be limited, however, by their competencies and ability to be compensated. Social workers have the option of being registered. If they choose it, they are then permitted to use the title "registered social worker."
Ontario	**Model:** Controlled act **Regulation Authority:** ◆ Each profession has its own profession-specific act under which there are profession-specific regulations. ◆ Each act includes omnibus and procedural code legislation. ◆ Social workers are regulated under a separate act: *The Social Work and Social Service Work Act,* S.O. 1998, c. 31.	Professions have broad scope of practice statements, which describe what each profession does ordinarily. These statements are for general guidance. There is also a general prohibition on treatment or advice in relation to health care by any person other than a member of a regulated profession acting within his/her scope of practice where the act may be dangerous.[8]
Quebec	**Model:** Reserved activities (similar to controlled act) **Regulation Authority:** ◆ All are self-regulated by the orders (under the Professional Code[9]).	Quebec has the most elaborate system in Canada for regulating its professions. The *Professional Code* accords different rights and privileges to the 50 professions to which it applies. The professions discussed in this report fall into three different categories. Psychologists and social workers have exclusive use of title only (although soon to be proposed amendments define these professions' scopes of practice and reserved activities). Physiotherapists (PTs), occupational therapists (OTs), dietitians, speech-language pathologists and audiologists have exclusive use of title and the right to perform reserved activities defined in the *Professional Code*. (Although they have the right to perform these activities, they can be performed by other professions if permitted under the *Professional Code.*[10, 11]) Physicians, pharmacists and nurses have exclusive use of title and the exclusive right to perform the reserved activities. (However, these professions may also have the right to perform reserved activities which are not exclusive. For example, physicians and nurses share with OTs and PTs the reserved activity of applying a restraint to a patient.[12, 13, 14, 15])

8 *Regulated Health Professions Act*, S.O. 1991, c. 18, s. 30(1). No person, other than a member treating or advising within the scope of practice of his or her profession, shall treat or advise a person with respect to his or her health in circumstances in which it is reasonably foreseeable that serious physical harm may result from the treatment or advice or from an omission from them.

9 R.S.Q. c. C-26.

10 R.S.Q. c. C-26.

11 *Professional Code*, R.S.Q. c. C-26, s. 37.1.

12 Ibid.

13 *Medical Act*, R.S.Q. c. M-9.

14 *Nurses Act*, R.S.Q. c. I-8.

15 *Pharmacy Act*, R.S.Q. c. P-10.

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Table 1 ***(cont'd)***
Regulation Models and Scopes of Practice, by Province and Territory

Province/Territory	Model and Mechanism	Notes on Scope of Practice
New Brunswick	**Model:** Scope of practice **Regulation Authority:** ◆ All are individual private acts, neither consolidated nor published by the province. They also include private subsidiary regulations. ◆ All are self-regulated.	Many of the acts contain specific exemptions from the scope of practice protections in favour of other members of the health-care team and other providers of health-care goods and services to patients/clients. Because New Brunswick's legislation for self-regulation is private, it is sometimes hard to obtain detailed information about the provisions. Regulators have generally shown they are supportive of collaboration.
Prince Edward Island	**Model:** Scope of practice **Regulation Authority:** ◆ Eight professions are self-regulated, each under separate professional acts. ◆ Audiologists and speech-language pathologists are not regulated.	A relatively small number of members for most professions emphasize the message heard at the regulators' meeting: sustaining self-regulatory systems is a big issue, and this is particularly true for smaller professions and jurisdictions. Many "scope of practice" sections contain explicit exemptions for members of other health professions.
Nova Scotia	**Model:** Scope of practice **Regulation Authority:** ◆ Eight professions are self-regulated. ◆ Audiologists and speech-language pathologists are not regulated.	Exclusive scopes of practice are assigned by individual professional legislation. The *Medical Act* explicitly exempts from its operation and prohibitions all other regulated health professions in the practice of their profession.[16] Limited scope of practice protection is provided to social workers.
Newfoundland and Labrador	**Model:** Scope of practice **Regulation Authority:** ◆ Eight professions are self-regulated. ◆ Audiologists and speech-language pathologists are not regulated, but hearing aid practitioners are.	Exclusive scope of practice and title are protection provided in this model. Governing statutes often incorporate both the professional association and the self-governing board or college. The registered nurses statute has an explicit exclusion for a broad category of assistants, midwives and other health professionals.[17]

16 College of Physicians & Surgeons of Nova Scotia, *Chapter 10 of the Acts of 1995–96: An Act Respecting the Practice of Medicine*. Available at www.cpsns.ns.ca/publications/med.html.

17 R.S.N.L. 1990 c. R-9 ss. 22. www.cpsns.ns.ca/publications/med.html.

Source: The Conference Board of Canada.

- There is not one mode of regulation across the country; there are at minimum two (scope of practice versus legislated acts) and as many as 13 (provinces and territories). One could argue that, in fact, there is a different mode of regulation for each discipline and jurisdiction, further complicating the issue. As well, there are various orders of regulation likely along the same number or range. There does not appear to be any right or wrong order or mode of regulations. They all seem to have their own unique qualities, which can support or deter collaboration. It has been argued that the legislated acts mode (Ontario, British Columbia, Alberta and Quebec) is more conducive to collaboration, and this may be true. Yet the "scope of practice" mode of regulation can certainly support collaboration if its language is clear and if it includes prohibition statements in some instances.
- There are inconsistencies across the country as to who is regulated. This raises an important question: Are patients/clients safer in jurisdictions where a profession is regulated? Put another way, are we protecting the public better in some jurisdictions than in others? Each jurisdiction has its own unique demographic, geographical and health human resource challenges and needs. Each jurisdiction requires the regulatory flexibility to ensure access to the appropriate health professionals. But all of this raises another, bigger question: Are we over-regulating or under-regulating health professionals? Blurring scopes of practice may enhance collaborative care but may also increase the risk of liability (although this is debatable, given the fact that collaboration appears to improve the quality of care).

  It is necessary to answer these questions in order to determine the right direction for collaborative self-regulation in Canada. However, without a consistent way to measure the effectiveness of regulation and the extent of collaboration across jurisdictions, the answers will likely be speculative at best.

- Self-regulation is evolving across the country, and there is an opportunity to shape its future to promote collaborative care through partnerships across professions, jurisdictions and possibly sectors.

The table as well raises some interesting questions. Does private legislation have any other additional benefits or costs? Are there innovative ways to promote the sustainability of regulators by crossing boundaries or disciplines? Furthermore, one might ask whether it is a conflict of interest to have a regulator and its related association closely linked. And finally, how can Canada continue to be considered a leader internationally in its self-regulation of health professionals?[1]

ANALYSIS OF REGULATORY INSTRUMENTS

We now turn to the various regulatory instruments of delegation, code of ethics and consent.

DELEGATION

Delegation is defined as transferring the responsibility of performing an activity to another while retaining accountability for the outcome.[2] Table 2 provides a comparative analysis of the regulatory instrument of delegation across professions and provinces/territories.

It brings home a number of important points:

- There appear to be inconsistencies in delegation across the country regardless of the mode or order of legislation. The addition of a harm clause reinforces the need for regulated and non-regulated professionals to include an instrument for delegation.
- The type of instrument used (legislation, regulation, standard, policy or guideline) is inconsistent. Whether or not a more flexible or enforceable instrument is required is unclear. The Alberta experience with delegation is worth noting and watching. Alberta's *Government Organization Act*, which deliberately includes delegation of authority into the *Health Professions Act* stands in stark contrast to the *Regulated Health Professions Act* in Ontario, where delegation

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1 The Health Professions Regulatory Council, *The Regulation of Psychotherapy and Psychotherapists in Ontario* (London, Ontario: October 2005). www.hprac.org/downloads/nov05/Psychotherapy/Psychotherapy_subm_individual21pdf.pdf, p. 5.

2 National Association of School Nurses, *Clarification on the Process of Delegating in the School Setting: Ensuring Safe and Effective Care for Students* (Maryland: National Association of School Nurses, 2005), p. 1.

Table 2
Delegation Authority, by Province and Territory

Province/Territory	Notes on Delegation Instrument
Yukon	◆ Nurses can delegate acts within their scope of practice to other members of the health-care team. (The mechanism is their standards of practice.)[1] ◆ Doctors and pharmacists cannot delegate acts within their scopes of practice.
Northwest Territories and Nunavut	◆ Unregulated professions and nursing and psychology can delegate. ◆ Physicians and pharmacists cannot delegate.
British Columbia	◆ No provision seems to forbid delegation of controlled acts for nurses. Members can delegate only if ordered by another authorized professional. Nurses have an extensive and cautious policy for delegation, with a detailed formal process for doing so. ◆ Pharmacists can delegate to other health-care and support persons. (The college has strict requirements.) A bylaw sets out what can and cannot be delegated. ◆ Occupational therapists—The college's policies contain quasi-formal requirements for assigning occupational therapy functions to unregulated persons, which might affect team collaboration. There are no reserved acts and no provisions regarding acceptance of delegation. ◆ For medical doctors, practising in association with an unregistered person is a specified professional offence, which carries the penalty of mandatory revocation of licence. Misconduct is determined in relation to the *Canadian Medical Association Code*, which does not mention delegation. A policy, however, states that delegation of medical acts may be permitted in some circumstances and provides some guidelines. ◆ The remaining five disciplines do not appear to have a regulation, standard, policy or guideline with respect to delegation.
Alberta	◆ As a result of the *Government Organization Act,* all professions can theoretically (or arguably, really) delegate their authorized acts to any other person, including those who are unregulated health professionals, with some restrictions (including consent, competency and supervision).[2] ◆ These provisions create three categories of individuals who can perform restricted activities: people who are authorized by statute or regulation to do so, people to whom the act is delegated, and people who do so under emergency circumstances without compensation.
Saskatchewan	◆ RNs can delegate to auxiliaries and homecare workers, under the supervision of nurses or physicians. Nurse practitioners can perform duties that are considered to be under the practice of medicine.[3] ◆ That said, the *Medical Profession Act,* 1981, S.S. 1980–81, c. M-10.1, prohibits any other health professional from practising acts considered to be the practice of medicine unless bylaws exist creating exceptions. ◆ Physicians have the right to pass bylaws to delegate; however, no bylaw has been passed. ◆ The remaining seven disciplines do not appear to have a regulation, standard, policy or guideline with respect to delegation.
Manitoba	◆ Delegation is relevant only for physicians and pharmacists because none of the other professions have an exclusive right to practise and therefore anyone is able to perform an act normally considered to be the practice of one of those professions. ◆ Physicians can delegate to non-physicians, under special circumstances (physicians accept the responsibility and supervisory role). Similarly, there are exceptions permitting nurses and physicians to perform acts within the scope of practice of pharmacists.

1 Section 5 of the *Standards for Registered Nursing Practice in the Yukon*. www.yrna.ca/publications/publications.html.

2 *Government Organization Act*, R.S.A. 2000, c. G-10. www.canlii.org/ab/laws/sta/g-10/20061113/whole.html.

3 The *Registered Nurses Act*, bylaws, code of ethics and other health regulations have been amended to permit nurse practitioners to do things considered the practice of medicine, as well as dentistry and pharmacy.

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Table 2 *(cont'd)*
Delegation Authority, by Province and Territory

Province/Territory	Notes on Delegation Instrument
Ontario	◆ The *Regulation of Health Professions Act* (RHPA) states that any delegation must be in accordance with any applicable regulation. However, almost no regulations currently exist to govern the granting of delegation.[4] ◆ Physicians have a policy for delegation with extensive instruction on the process. Physicians must ensure that the professional has the regulatory authority to receive the delegation. Permitting or counselling non-members to perform acts that should be performed by a member is considered professional misconduct.[5] ◆ Nursing has a restriction by regulation on acceptance of delegation. Directing a member, student or other health-care team member not adequately trained for or not competent to perform an act is considered professional misconduct for both nurses and licensed practical nurses.[6] This section makes it an act of professional misconduct to delegate in contravention of the RHPA. ◆ The College of Nurses of Ontario (CNO) and the Ontario College of Pharmacists have worked together to develop a policy for delegation. CNO has a comprehensive delegation standard. ◆ Dietitians have no controlled acts. However, it is considered professional misconduct to delegate dietitian functions. The harm clause is likely the reason. ◆ Speech-language pathologists and audiologists have no controlled acts. The college does not prohibit acceptance of delegation by policy statement. ◆ Occupational therapists can receive delegation of a controlled act by policy and draft regulation. Physiotherapists have a standard of practice for accepting delegation of a controlled act and an actual regulation prohibiting the delegation of a controlled act. ◆ For psychology, it is considered professional misconduct to contravene the RHPA.
Quebec	◆ Delegation is not specifically addressed in the *Professional Code*. There are exceptions: s. 94 of the *Professional Code* allows professions to draft regulations that would permit other professions to perform their professional activities. Also, some laws, such as the *Medical Act* and the *Nurses Act*, permit other professions to perform their reserved activities under certain circumstances.[7,8] ◆ Almost all professions permit delegation to students under supervision. ◆ Psychologists and social workers do not have reserved activities and therefore delegation would not apply.
New Brunswick *(cont'd on next page)*	◆ For medical doctors, section 7 of the regulations defines professional misconduct as permitting counselling or assisting a person not licensed to practise medicine except as provided in the Act.[9] ◆ For nurses, a detailed position statement regarding delegation is published. A policy statement on working in under-staffed conditions acknowledges that delegation may be needed. The *Canadian Nurses Association* (CNA) ***Code,*** which has been adopted, is silent on delegation. ◆ There is a policy statement published regarding delegation by occupational therapists to support personnel. ◆ Regulations prohibit delegation of physiotherapy services requiring the skill, knowledge or judgment of physiotherapists to less-qualified persons.

4 It appears that a regulated health-care worker will be able to delegate to an unregulated person with fewer barriers than to a regulated member of another profession, assuming the person to whom the action is being delegated is properly trained.

5 1(1) (29) Ontario Regulation 856/93 Professional Misconduct under the *Medicine Act*. www.e-laws.gov.on.ca/DBLaws/Regs/English/930856_e.htm.

6 1 (3) Ontario Regulation 799/93 Professional Misconduct under the *Nursing Act*. www.e-laws.gov.on.ca/DBLaws/Regs/English/930799_e.htm.

7 *Medical Act*, R.S.Q. c. M-9.

8 *Nurses Act*, R.S.Q. c. I-8.

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Table 2 ***(cont'd)***
Delegation Authority, by Province and Territory

Province/Territory	Notes on Delegation Instrument
New Brunswick *(cont'd)*	• For audiology, delegation to support personnel is provided for and regulated by the rule of professional conduct. • For dietitians, regulations prohibit appointing, allowing or condoning the appointment of a person as a dietitian if that person is not a member. • For pharmacy, there is no prohibition of delegation in the Act or bylaws. • For social workers, there is no reference in the Act or bylaws. The *Canadian Association of Social Workers* (CASW) *Code of Ethics*, which has been adopted, is silent on the issue.
Prince Edward Island	• For medical doctors and nurses, there is no mention of delegation in the Act or in the regulations. • For occupational therapists, assigning or delegating functions where the delegatee is not adequately trained or experienced to do the act is considered professional misconduct. • For physiotherapists, permitting an unauthorized person to do any of the functions of a physiotherapist except as provided under the Act is considered professional misconduct. • For dietitians, assigning a person not properly qualified or experienced to perform a function of the profession is considered professional misconduct. • For pharmacists, permitting an unauthorized person to perform functions of a pharmacist (where it is under the member's control to do so) except as provided for in the Act is considered professional misconduct. Subsection 29 (h) permits delegation to pharmacy students. • For social workers, permitting another person to perform the work of a social worker (where it is under the member's control to do so) where it is not permitted by the Act is considered professional misconduct.
Nova Scotia	• Jointly published by the colleges of nursing and medicine, extensive guidelines for delegation permit the giving and receiving of delegation and medical directives in conformance with the guidelines. • For social workers, dietitians and psychologists, there is no mention of delegation in the Act, regulations or bylaws. • For licensed practical nurses, standards have been issued regarding acceptance of delegation from others. • For occupational therapists and physiotherapists, regulations regarding delegation are authorized in the Act but have apparently not been made.
Newfoundland and Labrador	• For nurses, physiotherapists, dietitians and pharmacists, there is no mention of delegation in the Act. • Rules and standards of the provincial psychology board require that those to whom delegation is made should be credentialed or otherwise qualified.[10] • For medical doctors, there is an exemption from scope for dentists, optometrists, physiotherapists and RNs. Otherwise, there is no other mention of delegation in the Act or regulations and no published policies. • For registered nurses, there is a policy published on receiving delegation from physicians in palliative care and an extensive policy published on delegation by members to others. • For occupational therapists, there is exemption from scope of practice for MDs and first aid providers, but they may not practise except under medical supervision. There is no mention of delegation in the regulations. • The *Social Workers Association Act* states that it is a professional offence to provide an opportunity to a non-social worker to practise or lead others to believe that they are a social worker.[11]

9 College of Physicians and Surgeons of New Brunswick, Professional Misconduct regulation for the *Medicine Act*. www.cpsnb.org/english/Regulations/regulation-9.html.

10 *Psychology Standards* ss. A (10) and K (1) and (2).

11 *Social Workers Association Act*, S.N.L. 1992, c. S-18.1 s. 24. www.canlii.org/nl/laws/sta/s-18.1/index.html.

Source: The Conference Board of Canada.

is mentioned as a possibility as long as delegation regulations are enacted (which they currently are not). This inconsistency has created a dilemma of uncertainty as to whether delegation is permitted without restrictions or is prohibited.

- The clarity of the process for delegation is likely as important as the necessity to have one. An instrument of delegation should include a description of the process for delegation, including what services can be delegated and by whom, when it is allowed, and who can receive the delegation, and clear instructions on the appropriate documentation protocol. The College of Physicians and Surgeons of Ontario (CPSO) has a policy for delegation that emphasizes the importance of the knowledge of the regulatory environment for those professions to whom one might delegate. The CPSO guideline is also reflected in the delegation policies of other regulated health professions in Ontario. The necessity, however, of having to know multiple sets of standards across professions could well make health professionals in Ontario leery of delegation.
- The joint statement in Nova Scotia on delegation, in which two colleges came together to reach a consensus on the specifics of the standard for delegation, stands as an example to others. This is a model of collaboration—of talking the talk and walking the walk. A broader discussion across a greater number of disciplines—although challenging—would likely be worthwhile, particularly for regulated professions.
- In many instances, colleges use the code of ethics as articulated by their related professional association as the basis for many regulatory instruments. The majority of these codes appear to be silent on the issue of delegation.
- It does not appear that differing orders of regulation have any impact on whether or not delegation is used. It seems that the flexibility bestowed by the controlled/reserved act model (including the provision for delegation in Alberta, for example) at least gives the appearance of or opportunity to delegate health services to other team members. Clarity is critical to the execution of appropriate delegation.

CODE OF ETHICS

Code of ethics is defined by the Canadian Psychological Association as the "principles, values and standards to guide members" of the profession.[3] Table 3 provides a comparative analysis of codes of ethics across professions and jurisdictions.

Table 3 suggests that the orders of regulation (*who* regulates) do not have any impact on the use of a code of ethics. In the Yukon, nurses have a code of ethics (and most professions in New Brunswick have one), but they do not appear to have one in the Northwest Territories or Nunavut. Nor does the mode of regulation appear to be a barrier or facilitator to the use of codes of ethics.

In many instances, colleges use the code of ethics as articulated by their related professional association as the basis for many regulatory instruments.

Although in some instances it was difficult to find a code of ethics, their use across the country is reasonably consistent. The codes do, however, differ in their content. There does not appear to be any consistency in the code of ethics across jurisdictions or professions on the importance or approval of collaboration, nor is there consistency in the development of a standard for effective communication among the team members (which includes the patient/client). Clearly, opportunities exist to strengthen the various codes of ethics across the country by including standards that promote collaboration and effective communication among all members of the health-care team. The Canadian Medical Association's code of ethics has been adopted by almost all medical regulatory agencies across the country. Given its supportive nature for collaboration, it deserves mention.

3 Canadian Psychological Association, *Canadian Code of Ethics for Psychologists*, *3rd Edition* (Ottawa: Canadian Psychological Association, 2000), p. 1.

Table 3
Code of Ethics, by Province and Territory

Province/Territory	Notes on Codes of Ethics
Yukon	◆ Nurses adopted a code of ethics as a standard of practice. ◆ The Yukon Medical Council website contains the code of ethics from the Canadian Medical Association (CMA), which requires physicians to cooperate with others.[1] However, neither the Act nor the regulations adopt it, and adherence to it is therefore not mandatory.
Northwest Territories and Nunavut	◆ The Registered Nurses Association's bylaws adopted the code of ethics of the Canadian Nurses Association (CNA), which requires nurses to cooperate.[2] ◆ There is no mention of a code of ethics for the other professions.
British Columbia	◆ Registered nurses (RNs), nurse practitioners (NPs), registered psychiatric nurses (RPNs), dietitians, occupational therapists (OTs), physiotherapists (PTs), pharmacists and social workers have a code of ethics. ◆ The code of ethics for RNs, NPs, RPNs and OTs promotes and/or requires collaborative care and cooperation. ◆ RNs and NPs adopted the Canadian Nurses Association's code of ethics, which promotes collaborative care. The College of Registered Psychiatric Nurses adopted a code of ethics that requires members to collaborate and cooperate with other members of the health-care team. ◆ The code of ethics for licensed practical nurses (LPNs) states that members should recognize the skills and perspectives of other health-care providers and demonstrate respect for them. ◆ Dietitians' code of ethics requires that dietitians respect the values and abilities of colleagues and other health-care team members. ◆ OTs' code of ethics requires members to cooperate and maintain communication with other health-care professionals. ◆ Pharmacists' code of ethics states that they are obligated to work with other health-care professionals and colleagues. ◆ Psychologists have a code of conduct.
Alberta *(cont'd on next page)*	◆ The code of ethics is mentioned, but it is not clear whether all 30 self-regulating professionals have one. ◆ Nurses adopted the code of ethics of the Canadian Nurses Association, which contains a duty to collaborate.[3] ◆ Currently, the College of Physician and Surgeons of Alberta supports the CMA Code of Ethics. ◆ OTs have a code of ethics but not an explicit duty to cooperate. They are required to treat other health professionals in an "unbiased" manner. This provision is really an anti-discrimination clause.[4] ◆ PTs have a code of ethics, but it was not available at the time this report was written; thus we could not determine whether or not a duty to cooperate exists. ◆ Dietitians have a code of ethics that requires them to cooperate.[5] ◆ Psychologists have a code of ethics but not a specific duty to cooperate with other health professionals. But they must treat "others"—which includes colleagues—fairly and communicate information to them necessary for the patient's well-being.[6]

1 Canadian Medical Association, "CMA Code of Ethics" [online]. [Cited February 21, 2007]. http://policybase.cma.ca/PolicyPDF/PD04-06.pdf.

2 Registered Nurses Association of the Northwest Territories and Nunavut, "By-laws of the Registered Nurses Association of the Northwest Territories and Nunavut" [online]. [Cited February 16, 2007]. www.rnantnu.ca/myportal/bylaws/tabid/56/default.aspx#bylaws18.

3 College and Association of Registered Nurses of Alberta, "Code of Ethics" [online]. [Cited February 16, 2007]. www.nurses.ab.ca/profconduct/ethics.html.

4 Alberta Association of Registered Occupational Therapists, "Code of Ethics and Interpretive Guide" [online]. [Cited February 16, 2007]. www.acot.ca/files/Code_of_Ethics.pdf.

5 College of Dietitians of Alberta, "Code of Ethics" [online]. [Cited February 16, 2007]. www.collegeofdietitians.ab.ca/pdf/public/code_of_ethics.pdf.

6 Canadian Psychological Association, "Canadian Code of Ethics for Psychologists" [online]. [Cited February 16, 2007]. www.cpa.ca/cpasite/userfiles/Documents/Canadian%20Code%20of%20Ethics%20for%20Psycho.pdf.

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Table 3 ***(cont'd)***
Code of Ethics, by Province and Territory

Province/Territory	Notes on Codes of Ethics
Alberta *(cont'd)*	• Pharmacists have a code of ethics that requires them to cooperate with other health professionals.[7] • The code of ethics for social workers requires them, when necessary, to seek advice from experts in other health professions and collaborate with them.[8] • No code of ethics was found for speech-language pathologists and audiologists.
Saskatchewan	• All 23 self-regulating health professions have codes of ethics. • These codes almost uniformly require members to cooperate and collaborate with other health-care professionals in the care of patients/clients.
Manitoba	• Physicians have a code of conduct that forms part of their bylaws. It does not specify a duty to collaborate, but there are other references to team care that facilitate it. Physicians must respect a patient's right to choose another health professional; *co-therapy* is defined as concurrent treatment by a physician and another health professional; physicians may refer patients to non-physicians; and non-physicians can be the primary health-care provider.[9] • The code of ethics for nurses promotes collaborative care.[10] • The code of ethics for OTs requires them to cooperate and maintain proper communication with all colleagues.[11] • The legislation for PTs allows for the adoption of a code of ethics, but this does not appear to have happened.[12] • Pharmacists have a code of ethics, but no duty to cooperate or collaborate.[13] • Dietitians, speech-language pathologists and audiologists have codes of ethics, but they are currently not available for review.[14] • There is no mention of a code of ethics for the other professions.
Ontario	• Pharmacists, OTs, PTs, social workers, audiologists and speech-language pathologists, psychologists and dietitians have a code of ethics (the last two adopted the Canadian Pharmacists Association (CPhA) and Dietitians of Canada (DC) codes). Nurses do not have a code of ethics but have an extensive standard regarding ethics.[15] For the medical profession, no code of ethics is promulgated or adopted; Ontario's College of Physicians and Surgeons is one of the few in Canada that has not adopted the CMA code. • Pharmacists' code of ethics (an appendix to their bylaws) requires a collaborative approach. • Psychologists adopted the CPA Code of Ethics, which contains no apparent barriers to collaborative practice. • Dietitians adopted the (DC) Code of Ethics, which endorses a collaborative approach to health-care practice. • The code of ethics for OTs requires a collaborative approach to health care practice. • The code of ethics for physiotherapists has a limited requirement for collaboration and some restrictions on it.

7 Alberta College of Pharmacists, "Code of Ethics Bylaw" [online]. [Cited February 16, 2007]. http://pharmacists.ab.ca/college/resource.aspx?id=2329.

8 Alberta College of Social Workers, "Code of Ethics" [online]. [Cited February 16, 2007]. www.acsw.ab.ca/who_we_are/code_of_ethics/view.

9 College of Physicians and Surgeons of Manitoba, "Code of Conduct" (Schedule G to By-law 1) [online]. [Cited February 16, 2007]. www.cpsm.mb.ca/resources/about/bylaws_guidelines/bylaws/bylaw1/By%20Law%201%20Schedule%20G%20Code%20of%20Conduct.pdf.

10 College of Registered Nurses of Manitoba website, www.crnm.mb.ca.

11 College of Occupational Therapists of Manitoba, "Code of Ethics" [online]. [Cited February 16, 2007]. www.cotm.ca/pdf/CodeofEthics.pdf.

12 College of Physiotherapist of Manitoba website, www.manitobaphysio.com/members/code.html.

13 Manitoba Pharmaceutical Association, "Code of Ethics" [online]. [Cited February 16, 2007]. www.napra.org/provinces/manitoba/provincial/legislation.html.

14 Manitoba Speech and Hearing Association website, www.msha.ca; College of Dietitians of Manitoba website, www.manitobadietitians.ca.

15 In Ontario, there is an ethical framework for nurses, which can be found in the online version of the College's Practice Standard at cno.org/docs/prac/41034_Ethics.pdf.

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Table 3 ***(cont'd)***
Code of Ethics, by Province and Territory

Province/Territory	Notes on Codes of Ethics
Quebec	◆ All professions are required to have a code of ethics. ◆ The codes of ethics for dietitians, PTs and nurses indicate a duty for members to cooperate with members of other professions. ◆ Physicians must ensure that their employees or the people with whom physicians are associated in the practice of the profession comply with the physician code.[16] ◆ If a nurse were to associate with a physician, the nurse would have to comply with the code of ethics for both nurses and physicians.
New Brunswick	◆ Physicians, nurses, PTs, dietitians, pharmacists and social workers have codes of ethics. ◆ Physicians and nurses adopted the CMA and CNA codes of ethics, which support and value collaborative practice. PTs and dietitians also have a code of ethics that requires collaboration with other team members. The code of ethics for pharmacists mentions collaboration mostly in respect to other members of the profession. ◆ Social workers adopted the Canadian Association of Social Workers Code, which does not mention collaboration. ◆ No code is published for psychologists.
Prince Edward Island	◆ Physicians, nurses, OTs, PTs, pharmacists, and psychologists adopted the CMA, CNA, Canadian Association of Occupational Therapists (CAOT), CPA and Canadian Pharmacists Association (CPhA) codes of ethics. The first four indicate a requirement for collaborative practice, whereas the latter two do not. ◆ It is not clear whether the other professions have a code of ethics.
Nova Scotia	◆ Physicians, nurses, OTs, pharmacists and PTs adopted the CMA, CNA, CAOT, CPhA and CPA codes of ethics, all of which provide some support and require collaborative practice. The Nova Scotia Dietetic Association (the regulatory body for dietitians in Nova Scotia) has developed its own code of ethics. ◆ The *Code of Ethics for Social Workers* speaks of respect for fellow workers but does not specifically mention collaborative practice. ◆ There is a code for LPNs, but it was not published at the time of writing of this report. ◆ The *Psychologists Act* requires that all psychologists comply with the psychology national code, which promotes collaboration.[17]
Newfoundland and Labrador	◆ Physicians, nurses, LPNs, pharmacists, social workers, dietitians and psychologists have codes of ethics. ◆ Physicians and nurses adopted CMA and CNA codes of ethics, which support and value collaborative practice. ◆ The *Code of Ethics for LPNs* requires members to work collaboratively and cooperatively with all members of the health-care team. ◆ The *Code of Ethics for Pharmacists* encourages collaborative practice. ◆ The *Code of Ethics for Social Workers* does not mention collaborative practice. ◆ The *Code of Ethics for Psychologists* does not make specific reference to collaborative practice.

16 *Code of Ethics of Physicians* R.S.Q. c. C-26, s. 87, 2001 c. 78, s.6.

17 *Psychologists Act 2000*, c. 32, s. 1.

Source: The Conference Board of Canada, 2007.

CONSENT

Health Canada describes *consent* as "an ongoing process that starts with the first contact with the individual and continues until the study (care) is complete or the participant (patient/client) withdraws" [it]. For this analysis we review "consent" in terms of consent to the sharing of health information among collaborative team members, not in terms of consent to treatment. As well, Health Canada defines *confidentiality* as the obligation of an organization or custodian to protect the information entrusted to it and to not misuse or wrongfully disclose it.[4]

Professions have been cautious about taking firm positions with respect to privacy and consent to disclosure within collaborative health-care teams.

Table 4 provides a comparative analysis of regulatory instruments of consent, confidentiality and privacy across professions and jurisdictions. We will describe these instruments collectively as "consent to release information."

The order of regulation does not appear to influence whether or not consent or confidentiality is required.

The language of regulatory instruments regarding consent to share health information among collaborative team members is inconsistent and unclear across jurisdictions and disciplines. What is needed is the collaborative development of regulatory instruments that support the appropriate sharing of health information.

Generally, there seems to be much greater focus on confidentiality/privacy than on consent. This is likely the result of the development of the federal *Personal Information Protection and Electronic Documents Act* (PIPEDA) and/or the use of provincial privacy legislation. A difference of opinion exists, however, between the current and previous privacy commissioners with respect to privacy and consent to disclosure within health teams. As a result, professions have been cautious about taking firm positions with respect to privacy and consent to disclosure within collaborative health-care teams. Changes to PIPEDA are required to rectify this situation.

4 Health Canada, *Requirements: Informed Consent Documents* (Ottawa: Health Canada, 2006). www.hc-sc.gc.ca/sr-sr/advice-avis/reb-cer/consent/index_e.html, p. 1.

WHAT DOES ALL THIS MEAN FOR COLLABORATIVE CARE?

Given the regulatory complexities within and across professions and jurisdictions, it is easy to appreciate why there is a lack of understanding of regulation. Fortunately, when one digs down and examines the regulatory environment, it does not appear to contain any substantial barriers to collaboration. Unfortunately, however, there do not appear to be any substantial or consistent facilitators of collaborative care. And there need to be. Neutrality is not enough to promote collaborative care.

Consistent and clear instruments such as standards of practice, policies or guidelines for delegation, codes of ethics and consent are important enablers for effective teams.

When inconsistency or lack of clarity exists, regulators will traditionally err on the side of caution. Because of this, regulators have not traditionally supported collaborative care, as no legislative facilitators exist. The green light has not yet beamed (although the green light is beginning to be turned on in some provinces, such as Alberta and Ontario). Creating clear and consistent legislative language, which supports collaboration among professionals and colleges, will ensure that the green light comes on across the board, and stays on.

Once the green light appears, regulators should begin to develop appropriate regulatory instruments that balance the need for enforceability against the need for adaptability. Striking this balance is vital to the encouragement of collaborative care.

Consistent and clear instruments such as standards of practice, policies or guidelines for delegation, codes of ethics and consent are important enablers for effective teams. The actual instrument used should be based on

Table 4
Consent to Release Information: Consent, Confidentiality and Privacy, by Province and Territory

Province/Territory	Notes on Consent to Release Information
Yukon	◆ Only nurses are required to obtain consent to the release of information to other members of the team. Nurses must maintain patient/client confidentiality; this is part of their code of ethics, which was adopted as a standard of practice.[1] ◆ Consent is not addressed in legislation for pharmacists. They are not required by statute or regulation to maintain confidentiality, and there is no territorial privacy legislation. ◆ The Yukon Medical Council website contains the code of ethics from the Canadian Medical Association, which requires physicians to maintain confidentiality.[2] However, neither the Act nor the regulations adopt it, and adherence to it is therefore not mandatory.
Northwest Territories and Nunavut	◆ Only nurses need to be careful about obtaining consent from their patients/clients to share information with other members of their health-care team. ◆ None of the professions, except nurses, have a requirement to maintain patient/client confidentiality. ◆ Of special note, the Northwest Territories and Nunavut do not have an act that protects privacy.
British Columbia	◆ The *Freedom of Information and Protection of Privacy Act* applies to the public sector, including health colleges. The *Personal Information Protection Act* applies to the private sector. ◆ MDs have adopted the Canadian Medical Association (CMA) code, which states that personal information should not be released except to the patient/client with consent or "as provided for by law." ◆ Registered nurses (RNs) have adopted the Canadian Nurses Association (CNA) code, which allows disclosure within the team but not otherwise without consent or as required by law. ◆ For licensed practical nurses (LPNs), the local code allows sharing within the team or as required by law or to avoid significant harm. ◆ For occupational therapists (OTs), the local code, which is adapted from the national code, makes no mention of privacy or release of patient information to others. ◆ For physiotherapists (PTs), the local code set out in subsection 55 of the bylaws prohibits communication of patient information to any person without consent or unless required by law. ◆ For social workers, the local code permits disclosure with consent or where allowed or required by law. ◆ For dietitians, Local Code of Ethics Principle #6 requires members to respect confidentiality and privacy. ◆ For psychologists, the Local Code of Conduct requires disclosure of patient/client information only with consent but allows sharing with other health-care workers if the psychologist informs them of the confidential nature of the information and the patient/client gives informed consent for the ongoing sharing. ◆ For pharmacists, Local Code of Ethics (Value 5, subsection 3) requires pharmacists to respect confidentiality but permits sharing with other health professionals on a need-to-know basis. It states that the patient/client should be informed of the sharing if possible.

1 Yukon Registered Nurses Association, "Standards for Registered Nursing Practice in the Yukon" (Appendix A, Canadian Nurses Association Code of Ethics for Registered Nurses) [online]. www.yrna.ca/pdf/Standards2005.pdf.

2 Canadian Medical Association, "CMA Code of Ethics" [online].

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Table 4 ***(cont'd)***

Consent to Release Information: Consent, Confidentiality and Privacy, by Province and Territory

Province/Territory	Notes on Consent to Release Information
Alberta	◆ All health professionals are required to keep patient/client information confidential in accordance with the *Health Information Act*, R.S.A. 2000, c. H-5. ◆ Dietitians do not have a duty to maintain confidentiality, but their code of ethics recommends that they strive for "objectivity of judgment in such matters as confidentiality and conflict of interest."[3] ◆ The codes of ethics for OTs, PTs, nurses, social workers, psychologists, and pharmacists require them to maintain patient confidentiality and to not disclose information about a patient without consent. ◆ No code of ethics was found for physicians. ◆ Alberta's *Health Information Act* specifically allows the sharing of patient-specific health information without consent by all providers for the purpose of providing care.
Saskatchewan	◆ All health professionals are required to maintain their patients' or clients' confidentiality according to the *Health Information Protection Act* C.O. 021 and either their bylaws or codes of ethics or both. In order to be found not guilty of professional misconduct, they will want to ensure that they are not breaching these directives by sharing a patient's or client's information with other members of a health care team.
Manitoba	◆ The *Personal Health Information Act*[4] sets out stringent rules for health professionals regarding the collection, retention and release of patient/client information. Also, some of the professions referenced in this paper—such as doctors, occupational therapists and psychologists—have bylaws and/or codes of ethics requiring them to cooperate.[5]
Ontario	◆ In Ontario, a great deal of attention has recently been given to issues involved with health information privacy. The introduction of the *Personal Health Information Protection Act* (PHIPA), 2004 has much improved the management of private health information; but, as with any new set of requirements, it has introduced an element of uncertainty and apprehension among some health care providers.[6] ◆ The federal *Personal Information Protection and Electronic Documents Act* (PIPEDA) does not apply. The PHIPA applies to all health practitioners. In Ontario, there is a Consent to Treatment Act. ◆ Consent is required to disclose any information unless "required or allowed by law" for RNs/LPNs, OTs, PTs, audiologists, dietitians and psychologists. For MDs, the disclosure must be "required by law." For pharmacists and social workers, PHIPA permits disclosure to another health information custodian where reasonably necessary for care, where not prohibited by patient/client, and where consent is not reasonably available.

3 College of Dietitians of Alberta, "Code of Ethics" [online].

4 C.C.S.M. c. P-33.5.

5 Article 6, Schedule G, Bylaw 1, College of Physicians and Surgeons of Manitoba, *Code of Conduct*; section IC. 3. of the Code of Ethics of the College of Occupational Therapists of Manitoba, and sections I43-45 of the Code of Ethics of the Canadian Psychological Association.

6 The drafters of the legislation well recognized that its goal had to be not just the proper protection of privacy, but also to not unduly interfere with the excellent communication within the health-care team necessary to provide first-rate care and to avoid serious errors. While important efforts were made in this regard, there remain uncertainties which at best will cause anxiety as collaborative practice models are developed and at worst may produce unintended consequences that will limit the effectiveness of such models. While exhaustive analysis of the privacy legislation is beyond the scope of this report, it seems clear that some problems remain and that legislation may need to be adapted to reflect a commitment to collaborative practice. While the legislation attempts to provide for the ability to properly communicate confidential patient/client information among members of regulated health professions treating the patient/client, it seems to limit that inclusion to those who provide health care in return for payment. It is not at all clear that volunteers in a collaborative setting are included and the steps that might be necessary to exclude them from any access to confidential information could be prohibitively complicated. In addition, although social workers are included within the "circle of care" as to which interprofessional disclosure of confidential information is permitted; it appears that pastoral counsellors are not. The potential error-generating role of things like the "lock box" provision (where the patient/client chooses to withhold some or all relevant information from some or all providers) will need to be explored in more detail. (Note that nurses may report the fact that information is being withheld.) If patient/clients are to entrust their care to teams rather than individuals, they may also need to entrust their information to the team. To do this, privacy laws may need to be clarified. If collaborative practice is to be encouraged, the privacy commission must be included in the discussions and must help find ways to clarify health privacy provisions so that practices are appropriate and anxieties reduced.

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Table 4 ***(cont'd)***
Consent to Release Information: Consent, Confidentiality and Privacy, by Province and Territory

Province/Territory	Notes on Consent to Release Information
Quebec	◆ The codes of ethics of all of the professions set out the circumstances under which confidential patient/client information can be disclosed without the patient/client's consent. Examples of this include cases where the health professional believes that an act of violence will occur. With the patient/client's consent, confidential information can always be disclosed by health-care professionals in Quebec. Health professionals will therefore want to ensure that they have the patient/client's consent before sharing a patient/client's information with other team members. ◆ The *Professional Code* requires all professionals to maintain secrecy and not to disclose confidential information without their patient/client's consent.[7]
New Brunswick *(cont'd on next page)*	◆ No provincial health information privacy legislation exists, and therefore PIPEDA applies. ◆ This presents a "circle of care" problem[8] in that there have been inconsistencies in the interpretation of PIPEDA by the last two privacy commissioners, which have led to uncertainty among health professionals as to their opportunities or responsibilities to share health information with members of the collaborative team. In this circle of care, patient/client consent to information sharing may be implied within the circle of those providing direct care to the patient unless expressly prohibited by the patient/client. ◆ MDs adopted the CMA code, which prohibits release of patient/client information without consent or as "provided for by law." ◆ For RNs, their policy refers to the CNA code, which allows disclosure within a team. ◆ For LPNs, no information has been published on their policy. The national code makes no reference to privacy or consent for disclosure. ◆ For OTs, no information has been published, including their private incorporating act. Their national code requires members to "ensure confidentiality and privacy of patient personal information." ◆ For PTs, no information has been published. Regulations prohibit release of confidential patient/client information. Their national code prohibits release of patient/client information without consent or unless required by law. ◆ Audiologists, who are regulated by their association under a private act, apparently have a code of ethics but have not published it. The national code proscribes release of patient/client information without consent or unless required by law. ◆ Social workers, who are regulated by their association under a private act, subscribe to the national code of the Canadian Association of Social Workers, which requires a patient/client's informed consent or legal requirement to release patient/client information. ◆ Dietitians have adopted the national code of Dietitians of Canada, which makes no reference to privacy or consent for release of patient/client information.

7 *Professional Code* R.S.Q. c. C-26, s. 60.

8 The concept of the "circle of care" comes from a number of speeches of the federal privacy commissioner and publications of the federal privacy commission. PIPEDA was largely produced without any input from the health care community and in disregard of health care industry concerns. Only when the legislation reached the Senate was there any recognition that it would affect health care. As such, there are no provisions in the legislation for the sharing of health-care information among health professionals caring for the patient. The first federal privacy commissioner indicated that he would interpret the provisions of the legislation strictly. After he left office, the second and present federal privacy commissioner indicated that there was a legitimate concern in health care and began speaking about the concept of "circle of care." By this, she meant that in her opinion, consent could be implied (as that concept is used in PIPEDA) where health care was delivered to patients by a team. Those statements constitute the opinion of the current privacy commissioner and of her commission. The concept of circle of care and the opinion of the current privacy commissioner are nowhere found in the statute, and the government has made no effort to change or amend the statute to give the opinion of the commissioner the force of law. Given the vehemence of previous statements, the obvious differences of opinion regarding this matter, and the lack of commitment on the part of the federal government to its current interpretation, health regulators and health professions could be forgiven for being cautious about taking firm positions with respect to privacy and consent to disclosure within health teams.

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Table 4 *(cont'd)*
Consent to Release Information: Consent, Confidentiality and Privacy, by Province and Territory

Province/Territory	Notes on Consent to Release Information
New Brunswick *(cont'd)*	◆ Psychologists have a code of ethics provided for in the Act, but it has apparently not been adopted. The national code provides for no release without consent or legal requirement, but there is no evidence that it has been adopted. ◆ For pharmacists, a code of ethics has apparently been adopted, but no information on it has been published. The national code requires pharmacists to protect a patient/client's right to confidentiality but seems to permit some compromise of this if it is deemed to be in the patient/client's best interests.
Prince Edward Island	◆ No provincial health information privacy legislation exists, and therefore PIPEDA applies. ◆ This presents a "circle of care" problem in that patient/client consent to information sharing may be implied within the circle of those providing direct care to the patient/client unless expressly prohibited by the patient/client. ◆ For MDs, there does not appear to be a website or published policy. The college has adopted the CMA code, which prohibits release of patient/client information without consent or as "provided for by law." ◆ For RNs, no policy appears on their association's website, but they have adopted the CNA code, which allows disclosure within a team. ◆ For LPNs, the local code of ethics allows disclosure of patient/client information only with consent or where required by law. ◆ For OTs, regulations under subsection 6 (dd) of the Act prohibit disclosure of patient/client information without consent or legal requirement.[9] ◆ PTs adopted the national code, which, in subsection 10, prohibits release of patient/client information without consent or unless required by law.[10] ◆ Audiologists are not regulated. The national code prohibits disclosure without consent or legal requirement and also requires compliance with national and local laws. ◆ For social workers, it is professional misconduct to disclose patient/client information without consent or legal requirement.[11] ◆ Dietitians are allowed disclosure without professional misconduct sanctions if the patient/client consents or disclosure is for purposes related to the client's care.[12] ◆ Psychologists subscribe to the national code, which provides for no release without consent or legal requirement. ◆ For pharmacists, the local code permits disclosure only by consent or legal requirement but implies that judgment may be used in consulting with colleagues or other health professionals.
Nova Scotia *(cont'd on next page)*	◆ No provincial health information privacy legislation exists, and therefore PIPEDA applies. ◆ This presents a "circle of care" problem in that patient/client consent to information sharing may be implied within the circle of those providing direct care to the patient/client unless expressly prohibited by the patient/client. ◆ MDs have adopted the CMA code, which prohibits release of patient/client information without consent or as "provided for by law." ◆ For RNs, policy refers to the CNA code, which allows disclosure within a team. ◆ For LPNs, the local code allows disclosure only with consent or legal requirement. No apparent exception is made for the team. ◆ For OTs, the local code of ethics requires members to respect confidentiality of all client information. ◆ For PTs, the local code of ethics allows disclosure to a team without consent. All other disclosures require consent or legal requirement. ◆ Audiologists are not regulated. The national code prohibits disclosure without consent or legal requirement and also requires compliance with national and local laws.

9 PEI Reg. 363/97.

10 The same provision is formalized in PEI Reg. EC265/90.

11 PEI Reg. EC69/92.

12 PEI Reg. EC830/95 ss. 6 [cc].

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Table 4 ***(cont'd)***
Consent to Release Information: Consent, Confidentiality and Privacy, by Province and Territory

Province/Territory	Notes on Consent to Release Information
Nova Scotia *(cont'd)*	◆ The social workers' local code is modelled on the national code, which allows disclosure to a health team if a social worker deems that other members need to know.[13] ◆ For dietitians, a code of ethics is reported to be in progress but has not yet been adopted. The national code of Dietitians of Canada makes no reference to privacy or consent for release of patient/client information. ◆ For psychologists, the code of professional standards does not allow for release of client data without consent or legal requirement. No apparent exception is made for the health team. ◆ For pharmacists, the local code of ethics permits no disclosure without consent or legal requirement, but standards of practice documents state that discretion may be used for discussion with physicians if the patient/client is not readily available to give consent.
Newfoundland and Labrador	◆ No provincial health information privacy legislation exists, and therefore PIPEDA applies. ◆ This presents a "circle of care" problem in that patient/client consent to information sharing may be implied within the circle of those providing direct care to the patient/client unless expressly prohibited by the patient/client. ◆ MDs have adopted the CMA code, which prohibits release of patient/client information without consent or as "provided for by law." ◆ For RNs, their policy refers to the CNA code, which allows disclosure within a team. ◆ For LPNs, their local code of ethics requires members to respect the client's right to privacy and confidentiality except when it puts the client or a third party in danger. ◆ For OTs, there is no mention of privacy or confidentiality in the Act or regulations, nor was there any mention of a code of ethics. The national code makes no reference to these issues. ◆ For PTs, no website exists, but there is apparently a local code that is not published. There is no regulatory reference to privacy or confidentiality. The national code, in subsection 10, requires no release without consent or legal requirement. ◆ For psychologists, the local policy statement permits team disclosure without consent if a psychologist ensures that all team members know that the information is confidential.[14] ◆ For dietitians, no website exists. There is no mention of privacy or confidentiality in the Act, and no regulations have been filed. There is no mention of a code of ethics in regulatory documents. The national code of Dietitians of Canada makes no reference to privacy or consent for release of patient/client information. ◆ Audiologists are not regulated. The national code prohibits disclosure without consent or legal requirement and also requires compliance with national and local laws. ◆ For pharmacists, the local policy document in subsection 5 is unclear. In one section it states that disclosure can be made only with consent, but elsewhere it indicates that disclosure within a team may be in the patient's/client's best interest.

13 www.nsasw.org/Code%20of%20Ethics%201994.pdf.

14 The Newfoundland Board of Examiners in Psychology, *Standards of Professional Conduct* [online]. (July 2005), [cited March 6, 2007]. http://nbep.info/Stds%20of%20Prof%20Conduct.05.pdf, p. 6.

Source: The Conference Board of Canada.

public protection while allowing for flexibility to enable team evolution. It should express general guidelines, leaving the more specific requirements to be dealt with at the professional association, organization or health provider level.

Developing consistent and clear standards can be done in many ways. The options are wide open. It does not have to be done through legislation, nor does it have to be through regulation. These standards could be developed at the college level, either as a solitary exercise or in collaboration with other colleges. They could come in the form of a standard of practice, a policy or a guideline, depending on the risk and need for flexibility.

Whichever way is chosen, someone must assume responsibility for this daunting task. Clearly, the road to success will not be easy given the complexity of the subject and the general inertia that seems to stall any attempts to make progress.

Building on the current state of regulatory knowledge, identifying strategies, creating implementation plans to support collaboration and ensuring an appropriate evaluation framework will ensure that the changes made are effective in the long run.

CHAPTER 4

Develop Supportive Strategies and Identify Better Practices to Boost Collaborative Care

Chapter Summary

- In this chapter, we examine practices, from Canada or any of the other eight countries we studied, that best address the barriers or facilitators identified in Chapter 3.
- We provide suggestions for areas of focus that are not addressed in this report.
- Evaluation and measurement in the regulatory environment are key to clarity and consistency.

In order to support changes for collaborative care at the regulatory level, legislation must be put in place that allows for a clear interpretation in favour of interdisciplinary collaborative care. For example, adding another object to the college to promote collaborative care would convey to regulators the importance of this model of care delivery. Similarly, regulators and other standards-developing organizations could send the same message to their members by updating and creating new instruments for delegation or codes of ethics that support collaborative care. Working across disciplines or jurisdictions would ensure a level of consistency and build on the trust and respect required for successful collaboration. Reforms will require partnerships among key human resource sectors, including regulators, governments and educators.

CONSISTENT REGULATORY PRINCIPLES OR OBJECTS

One regulatory principle is consistent across the country: the principle of public protection—a very important objective. As is common, however, in any environment, there are usually trade-offs. Given the impending human resources challenges we will inevitably face in all sectors of the economy including health, trade-offs will have to be made. The importance of public protection will never lose its status within regulation; however, other principles or objects will need to be considered. In Ontario, for example, potential changes to legislation currently before the Legislative Assembly are intended to add more objects to the *Regulated Health Professions Act*. These include the following:

- Colleges are to promote and enhance relations between the college and its members, other health professionals colleges, key stakeholders and the public.
- Colleges are to promote interdisciplinary collaboration with other health profession colleges.
- Colleges are to develop, establish and maintain standards and programs to promote the ability of members to respond to changes in practice environments, advances in technology and other emerging issues.

Regulatory colleges in Ontario will then need to balance public protection with stakeholder relations, promotion of collaboration and the ability of members to respond to changes in the practice environment. These differing objects ultimately bring with them tough choices that

colleges will have to make. Risk assessment and regulatory impact analysis will likely be used to guide decisions.

As described earlier, the Pew Commission in the United States[1] articulated a set of five principles for the regulation of health-care professionals that would, in its view, best serve the public interest. They include promoting health outcomes and protecting the public; holding regulators accountable; respecting consumer choice of providers and options; encouraging a flexible and rational cost-effective health-care system; and facilitating professional and geographic mobility. All of these principles have very different aims and potential measures for success. Balancing public protection with a rational cost-effective health-care system would bring many differing viewpoints and opinions. Reaching a consensus on the appropriate balance would be challenging, but worthwhile.

Collaboration among regulators, educators, governments and the public will provide the support needed for a paradigm shift that supports collaboration.

One must begin, however, with a common view of the appropriate principles for regulation provincially or nationally. The development of consensus on the appropriate principles for the future of regulation, reached through a collaboration of regulators (and other standard developing organizations), educators, governments and the public would ensure that patients/clients:

- are protected from harm;
- have access to the right provider at the right time and place; and
- have an affordable health (and regulatory) system today and in the future.

During our consultation with regulators, it became apparent that they have concerns with respect to the sustainability of the current regulatory system and that they are willing to be part of the required changes. Regulators have unique skills that allow them to provide insights on the rules and legal "jargon" typical of the legislative and regulatory environment. Bringing stakeholders together to create the common principles for self-regulation would be a great way to renew the current regulatory environment and bring all those affected on board to support the changes necessary to protect the public protection and bolster collaboration.

In John Kotter's book *Leading Change*,[2] he describes the eight steps required to bring about change. They are:

- establishing a sense of urgency;
- creating a guiding coalition;
- developing a vision or strategy;
- communicating the vision;
- empowering employees for action;
- generating short-term wins;
- consolidating gains; and
- anchoring new approaches in the culture.

These steps could form the basis for an implementation plan that would align stakeholders and ensure buy-in. Without a good strategy or implementation plan, it is unlikely that we will reach a consensus on the principles that will ensure the future of self-regulation. Anchoring the principle of collaboration in the regulatory environment by following Kotter's steps would ensure that stakeholders ultimately embrace the necessary culture shift.

Michael Decter, former Chair of the Health Council of Canada, believes that one of the greatest barriers to change in health care is our collective failure to implement change,[3] and as a result, our change efforts are in vain. We seldom anchor the necessary changes in the culture of our systems. To do this, we must slow down, engage stakeholders, give them the time to reflect and develop consensus around key issues like principles or legislative objects. It is a truism that people own what they create. Change requires not only top-down leadership but also ground-up support. Collaboration among regulators, educators, governments and the public will provide the support needed for a paradigm shift that

1 Taskforce on Health Care Workforce Regulation, *Reforming Health Care Workforce Regulation: Policy Considerations for the 21st Century*.

2 John P. Kotter, *Leading Change* (Boston: Harvard Business School Press, 1996).

3 Michael Decter, "Introduction." In Ruth Wilson, S.E.D. Shortt and John Dorland (eds.), *Implementing Primary Care Reform: Barriers and Facilitators* (Kingston, Ont.: McGill-Queen's University Press, 2004), p. 1.

supports collaboration. People will own the principle of collaboration if we follow the eight steps required to bring about successful change.

CREATING LEGISLATIVE SUPPORT FOR COLLABORATION

During the course of our analysis, it became clear that the current legislation contains few barriers or facilitators to collaboration—essentially, it is silent or legally neutral. It does not support or provide incentives to collaboration, nor does it deter it. Given the inherent risk associated with regulation, regulators rightly err on the side of caution. Without a clear legislative mandate to undertake a specific program, regulators are reluctant to spend time and resources—which are after all limited—on something that is not *legally* required of them. Giving regulators clear instructions—through legislation—to promote collaboration between colleges and among members would ensure that regulators are similarly supportive of collaboration.

There are interesting international examples of better practices in this area. For instance, in New Zealand, it is well recognized that multidisciplinary teamwork in health care is a key aspect of quality improvement and that it requires good relationships among all participants, particularly between those delivering and those receiving care and support.[4] In addition, modern health care in that country is considered a team activity, with more than 80 per cent of the hands-on care being provided by non-physicians. Each of the myriad of specialized caregivers often focuses on only one aspect of the patient's care, and therefore information about the technical aspects of care must be communicated and acted upon by the various caregivers in a coordinated manner.[5]

In New Zealand, there is a legal duty on all providers of health and disability services to work and communicate effectively in or between teams. The *Code of Health and Disability Services Consumers' Rights 1996 (Code of Rights)* specifies rights for consumers receiving a health or disability service. Right 4 is the umbrella provision that underpins the right of every consumer of health care to receive good quality care ("services of an appropriate standard").[6] Right 4(5) of the Code states that "every consumer has the right to co-operation among providers to ensure quality and continuity of services."[7] This clear instruction in legislation led to the development of team-based care.

In New Zealand, modern health care is considered a team activity, with more than 80 per cent of the hands-on care being provided by non-physicians.

In Germany, legislative amendments have been implemented to facilitate new models of health-care provision. The *Statutory Health Insurance Modernization Act* of 2004 removed barriers to starting integrated care models. It enacted provisions "expected to lead to a diversification of ambulatory care models via the introduction of a right to establish so-called medical centres, i.e. multidisciplinary institutions providing ambulatory care."[8] These integrated care models must involve different categories and levels of providers.

In the United Kingdom, a 2004 Council for the Regulation of Healthcare Professionals (CRHP) scoping exercise concluded that professional duties include "a responsibility to work collaboratively in team settings while also retaining responsibility for one's own clinical work."[9]

Canada would do well to keep its eye on the European Union (EU), a union of 25 independent states based on the European Communities and founded to enhance

4 K.W. Kizer, "Patient-centred Care: Essential but Probably Not Sufficient," *Safety and Quality in Health Care* 11 (2002), pp. 117–18. Cited in www.moh.govt.nz/moh.nsf/f872666357c511eb4c25666d000c8888/40aba87eaa538dcecc256d4000016ff0/$FILE/IQSystems.pdf, p. 5.

5 http://qshc.bmj.com/cgi/content/full/11/2/117.

6 www.health.vic.gov.au/archive/archive2003/healthcomplaints/paterson.doc.

7 Ibid.

8 R. Busse and A. Riesberg, *Health Care Systems in Transition: Germany* (Copenhagen: WHO Regional Office for Europe on Behalf of the European Observatory on Health Systems and Policies, 2004).

9 Judith Allsop, Kathryn Jones, Liz Meerabeau, Linda Mulcahy and David Price, *Regulation of the Health Professions: A Scoping Exercise Carried Out on Behalf of the Council for the Regulation of Healthcare Professionals* (London: CRHP, February 2004), p. 67.

political, economic and social cooperation. It will be important to watch how the EU chooses to: synchronize standards; better design legislation for, and regulation of, the health-care workforce; and develop a system that encourages teamwork, coordination and integration of health-care delivery in all member countries.

In looking within our own borders for direction, this report's analysis suggests that the mode or order of legislation does not appear to influence how much importance is placed on collaboration across the country. Whether or not one mode or order is better at promoting collaboration will remain a matter of conjecture until we have the appropriate measurement tool in place to assess the level and effectiveness of collaboration across jurisdictions and professions.

There is, however, a great deal of inconsistency across the country on the use of such terms as *scope of practice*. It can refer to what a health professional can do. It can mean a type or mode of legislation, or it could be a catch-all term used to describe a problem some feel is found within regulation. Without a common definition of scope of practice, there are likely 13 different regulatory languages at play across the country, one for each of the provinces and territories. A synchronization or clear definition of this term will ensure that there is a common understanding of what it means in any discussion of regulatory reform.

It is not a requirement in some jurisdictions and professions for active members to hold minimum coverage for malpractice insurance. It is required however, that all members pay their annual fee.

Inconsistencies across the country on who is regulated raise questions about the safety of patients/clients in different jurisdictions. Are patients/clients in fact safer when they are cared for by regulated health professionals? Does regulation make a difference? This brings us to a related question: Are we over-regulating or under-regulating health-care professionals? It could be argued that limited regulation of health professionals in general is a boon to collaboration, as members of health-care teams can more easily and lawfully perform acts within the other members' areas of practice. While it is hard to test this hypothesis at present, it is worthy of further study using a recognized and agreed-upon method that tests effective communication of colleges and health professionals across jurisdictions.

Other health-care legislation similarly needs to be examined and amended to allow for and support collaborative practice. Most of the legislation was created before the emergence of collaborative, team-based care. As a result, many pieces of legislation do not reflect the current roles of both individuals and teams.

Legislation should allow professionals to practice collaboratively and autonomously and not depend automatically on authorization from another profession.

For example, updating the public hospitals acts and the legislation governing privacy and consent to treatment to reflect the emergence of collaborative care would reinforce the importance of and need for greater access to a team of providers. Updating acts in this way would foster an environment of collaboration to develop. There is a widespread perception in Ontario—at least among members of health professions that have few or no controlled acts—regarding all team care provided in hospitals or hospital-based programs. It is believed that all care given by practitioners other than physicians, nurses in the extended class, midwives and dentists must be authorized, in writing, by a member of one of those groups. This perception is based on a section of the Public Hospital Management Regulations[10] made pursuant to the *Public Hospitals Act*.[11] Although outdated, this regulation still requires that a written order be provided by one of the listed professions for every act of treatment or test.

Legislation should be flexible enough to allow for various models of collaborative practice, including virtual teams. To reflect recent advances in practice models, legislation

10 R.R.O. 1990, Reg. 965 ss. 24.

11 R.S.O. 1990, c. P-40.

should allow professionals to practice collaboratively and autonomously and not depend automatically on authorization from another profession.

Self-regulation is evolving across the country and an opportunity exists to shape its future to promote collaborative care through partnerships across professions, jurisdictions and possibly sectors.

CREATING REGULATORY SUPPORT FOR COLLABORATION

Regulation is designed to fill the gaps that arise from the generalities associated with principles (or objects) and legislation. Regulators then design programs, standards and appropriate documentation to fill these gaps. Examples of these include the following:

- **Standards for certification, licensure or entry to practice.** Health professionals who wish to become licensed or certified to practise must pass "board exams." These exams are developed by colleges individually or in consultation with experts to ensure that students have the knowledge, skills and judgment to practise their chosen profession. The standards set by regulators are ultimately used by educators to develop their curriculum for students. This curriculum is then used to train health professionals. Educators attempt to ensure that students wishing to practise in a given jurisdiction have received sufficient education to pass the board exams. Upon successful completion of them, members are then granted the privilege to practise through the licensure or certification process. The development of regulatory standards requiring an educational course in collaboration would ensure that students receive this type of training and education.

  Members pay an annual fee to maintain their registration or status within a college. A number of registration categories typically exist, including active, inactive and retired membership. The fee is set by the college and administered on an annual basis, depending on the category. Active membership is typically for members of a profession who practise on a regular basis. The fee is usually highest in the active category. A slightly smaller fee is charged to an inactive or retired member. Inactive members are typically health professionals who do not actively practise but wish to maintain their status within a college. This category would typically include health professionals who play a major role in educating students or completing research. Retired members are those professionals who do not practise but wish to maintain their professional status. In all instances, members are asked to complete a registration form, which deals with information on practice patterns, criminal history, complaints and discipline history, and level and type of malpractice insurance. It is not necessarily a requirement to fill out all aspects of the form in all jurisdictions. For example, it is not a requirement in some jurisdictions and professions for active members to hold minimum coverage for malpractice insurance. It is required however, that all members pay their annual fee.
- **Quality assurance programs to ensure health professionals maintain their competency over time.** These programs may include the development of standards of practice, policies or guidelines, which ensure that members practise at a minimum level of standard. As well, programs such as peer assessment and recertification programs are developed to assess the competencies of active health professionals. These programs help members to meet a certain level of standards, which are set by individual colleges in consultation with stakeholders. Research indicates that members can lose a level of competency over a 10-year time frame.[12] These programs, along with standards of practice for continuous learning, ensure members maintain their competency over time. Periodic assessment of member's competencies (in the form of peer assessment or recertification) helps to ensure that health professionals are meeting quality of care standards and the public is protected from harm. The possibility exists to develop and implement these types of programs across disciplines.
- **Dealing with complaints about, and the discipline of, members who are perceived or found to be non-compliant with standards.** The public, patients, health professionals, health organizations, insurers and governments have the right to lodge a complaint

12 P.G. Norton and D. Faulkner, "A Longitudinal Study of Performance of Physicians' Office Practices: Data From the Peer Assessment Program in Ontario, Canada," *The Joint Commission Journal on Quality Improvement* 25, 5 (May 1999), p. 254.

about a member who, in their eyes, is not meeting quality of care standards. Once lodged, the complaint is dealt with by colleges using alternative dispute resolution mechanisms or is handled in the usual way by a complaints committee set up on behalf of the college to hear the specifics of the case and to decide on the complaint's appropriate disposition. The complaints committee is typically composed of members from the profession, but it also has significant public representation. The complaints committee often acts in a screening capacity, deciding whether there are grounds to refer the matter to a discipline committee or some other more appropriate venue, such as a quality assurance (QA) committee, or to simply caution the member about his or her conduct. If the matter proceeds to a discipline committee, then full quasi-judicial proceedings take place against the member, with serious consequences should the member be found to have violated the applicable standards of practice. There typically is an opportunity for members who disagree with the decision of a discipline committee to challenge the ruling.

There has been a great deal of debate on the appropriate way to ensure that quality assurance and complaints/discipline is disconnected. In most colleges, when a member is found by the QA committee to require additional remedial support, the matter is typically maintained within the purview of the QA committee and not referred to discipline. It is thought that in this way, members are more likely to comply with QA programs and outcomes. Some in fact believe that colleges should not even maintain the dual role of assuring quality and handling complaints/discipline. This debate will not be resolved easily.

REGULATORY COMMITTEES AND PROGRAMS THAT SUPPORT COLLABORATION

Regulators could assume an active, leading role in handling interdisciplinary complaints and discipline matters and in developing more appropriate certification and licensure of members. At the regulators' meeting, it was readily apparent that all were willing to participate. Regulators believe that developing various regulatory instruments or participating in joint interdisciplinary committees on complaints or discipline is not only desirable but may be their best way forward. In each group, regulators were asked to develop interdisciplinary committees for quality assurance, complaints and discipline. Each group completed the task with a great deal of interest, cooperation, enthusiasm and success. Pooling resources in this way would allow regulators to share the costs of quality assurance, complaints and discipline—and they are significant—and enhance the sustainability of the regulatory environment. It may also improve the outcomes for patients/clients, regulators and health professionals, as diversity of opinion usually improves outcomes and decisions. Pooling resources would, in its own way, provide evidence to members of a profession of the importance of collaboration to regulators and would also co-create the rules of engagement for members of a health-care team.

Pooling resources would allow regulators to share the costs of quality assurance, complaints and discipline and enhance the sustainability of the regulatory environment.

There are many aspects to consider when developing a model for handling complaints and discipline within the context of collaborative care:

- Who should be on the committee?
- Can one have a collaborative committee that does not include representation from all health professions, or at least all colleges?
- Who should the committee report to? Should the leadership rotate?
- Would physicians be comfortable with any other health professional at the helm?
- What is the role of the public?
- What are the practice issues? What should the committee be focusing on—finding blame or preventing the problem from recurring?

These are important questions that require answers, but until definite answers are forthcoming, there are examples to follow in Canada and abroad.

At the regulators' meeting, they displayed interest in the role of collaboration in the Quebec regulatory environment. As mentioned earlier, the Quebec Interprofessional Council creates opportunities for the exchange of ideas and information among regulators. It could serve

as the natural platform for the development of joint interprofessional committees for quality assurance, complaints, discipline or other regulatory instruments in that province. Similar structures in other jurisdictions could be developed with the same goals in mind. Collaboration would thus become a powerful tool for regulators to share, and to reflect and act upon—either across professions or jurisdictions.

Similar international examples of regulation exist. Within the United Kingdom's National Health Service (NHS), the Health Professions Council (HPC)—an independent statutory regulatory council—sets standards for training, conduct and performance. It was formed to regulate the 13 professions that are outside the standard medical and nursing professions. Individuals wishing to practise in one of these professions must be registered with the HPC.

Clear standards that permit delegations will signal to employers and health professionals the opportunities available to them to share the tasks required of a team.

The Council for Healthcare Regulatory Excellence (CHRE) also has an important role to play in promoting collaboration and sharing best practices. The CHRE, previously the Council for the Regulation of Healthcare Professionals, was established in April 2003 by the NHS Reform and the *Health Care Professions Act 2002*. This organization is independent of the U.K. Department of Health, is accountable only to Parliament and applies throughout the entire United Kingdom. The CHRE investigates and reports on how regulators function, recommends changes, and often compares the performance of the various regulators. It also enforces consistent standards of practice across the self-regulated councils. This Council promotes best practice in professionally led regulation and cooperation, and consistency across the regulation of all the health-care professions. Also, and most importantly, CHRE can refer a regulator's decision on fitness to practise to the High Court if it deems that the regulator's decision was "unduly lenient."[13]

13 Council for Healthcare Regulatory Excellence, "Frequently Asked Questions About CHRE," [online]. (April 2005), [cited March 28, 2006]. www.chre.org.uk/Website/faq.doc.

REGULATORY INSTRUMENTS THAT SUPPORT COLLABORATION

Regulators play a key role in developing regulatory instruments, such as standards of practice, policies and guidelines. Each of these instruments has unique characteristics. Standards of practice are more enforceable than policies or guidelines but are harder to bring into force. As a result, they are less flexible and adaptable. In contrast, guidelines are less enforceable and easier to create, but they're more flexible and adaptable. The appropriate creation and use of regulatory instruments will depend on the level of risk associated with the reasons the instrument is being created. Once the risk has been assessed, the appropriate instrument can be created with clarity of language.

In the previous section of this report, we assessed the consistency of three regulatory instruments across jurisdictions and professions. These included:

- standards for delegation;
- consent and confidentiality; and
- codes of ethics.

We found considerable inconsistency across jurisdictions and professions. Some provinces regulate some disciplines while others do not.

In general, we found limited use of standards for *delegation*. Delegation is an important strategy used by members of the collaborative team to support one another. Once collaborators have developed trust and respect for each other and understand the expertise that each member brings to the table, it is appropriate to delegate tasks within the limitations imposed by regulators or employers. As indicated by the example of the silence of legislation, silence by regulators on the point of delegation leaves room for interpretation among collaborative team members. Clear standards that permit delegations will, at a minimum, signal to employers and health professionals the opportunities available to them to share the tasks required of a team. It would then be necessary for employers and other health organizations to develop more detailed policies clarifying the appropriateness and use of delegation among team members.

More detailed standards for delegation could include the specific rules for transferring responsibility. Specifying

such rules would ensure that delegation could be carried out safely and appropriately. Appropriate delegation could enhance sharing of tasks, reduce workload and burnout, and may ultimately improve work–life balance for team members. Two heads (or more) are usually better than one. Developing joint statements for delegation across disciplines (or even jurisdictions) would reinforce the importance placed on collaboration and probably improve standards and the likelihood of their use. In Nova Scotia, for example, regulators for medicine and nursing have developed a joint standard for delegation. And in Ontario, pharmacy and nursing have collaboratively developed a policy on delegation by pharmacists to nurses.[14] These serve as examples worth emulating. Similar standards could be developed by the various regulators for all members of the collaborative team. In Australia, general standards of practice have been developed for health professionals. They incorporate five areas: interaction with the client; the health professional; the practice environment; interaction with professional colleges; and responsibilities to the community.[15]

Compared to standards for delegation, there was a great deal more consistency across jurisdictions and professions in the use of *codes of ethics*. In some instances, the codes were developed by regulators; in others, they were adopted from the national associations. There was, however, inconsistency across jurisdictions and professions in the recognition of, or importance placed on, promoting collaboration or effective communication within these codes of ethics. Colleges could create or adopt provincial or national association statements that indicate support and promote collaboration and effective communication. Taking up this challenge would reinforce to health practitioners the importance placed by regulators on collaboration and effective communication.

In the area of *consent, confidentiality and privacy*, there appears to be much greater focus on confidentiality and privacy, and this is likely the result of the development of PIPEDA and/or the use of provincial privacy legislation. Inconsistencies in the interpretation of privacy legislation have caused professions to be cautious about taking firm positions with respect to privacy and consent to disclosure within health teams. Changes to PIPEDA are required to rectify this situation.

The collaborative development of regulatory instruments that support the sharing of health information is needed. However, safeguards must be put in place to ensure patients and providers have access to health information in an appropriate and timely way.

There was inconsistency across jurisdictions and professions in the recognition of, or importance placed on, promoting collaboration or effective communication within these codes of ethics.

New Zealand could serve as an example of how to develop regulatory instruments for collaboration. In that country, the *Code of Health and Disability Services Consumers' Rights 1996* (*Code of Rights*) creates 10 rights for consumers receiving a health or disability service.[16] Correspondingly, it creates a legal duty for health and disability service providers (regulated and unregulated, publicly or privately funded, physicians to faith healers to family members providing home care) to take action to inform consumers of their rights and to enable consumers to exercise them. As mentioned earlier, Right 4(5) of the Code is of particular interest in regard to team-based care. If Canada were to add a code in this way and also ensure appropriate remedies for non-compliance, it would signal that collaboration is both a patient right and an obligation that must be upheld.

Dealing with the lack of focus on consent to share information and collaboration requires leaders who have the will and ideas and are able to execute. Leadership is required at any level—be it in developing principles, legislation or regulation. We should ask one fundamental

14 Ontario College of Pharmacists, "Delegation of Dispensing—OCP/CNO Guidelines" [online]. (February 2007). www.ocpinfo.com/client/ocp/OCPHome.nsf/web/Delegation+of+Dispensing!OpenDocument.

15 Australian Capital Territory Government, "Standards of Practice for ACT Allied Health Professionals" [online]. (2004), [cited March 31, 2006]. http://health.act.gov.au/c/health?a=sendfile&ft=p&fid=1123023524&sid=.

16 Health and Disability Commissioner, *Code of Health and Disability Services Consumers' Rights*, Regulations 1996 SR 1996/78. Available at www.hdc.org.nz/theact/theact-thecodedetail.

question when developing regulations: Is the patient/client better because of this? Clearly, the patient/client would be better off by becoming informed and providing consent to share information among members of the collaborative team.

OTHER POTENTIAL AREAS TO EXPLORE

A number of legislative or regulatory instruments were not analyzed in this report. For instance, we did not look at the principle of population health approach. There is an inherent tension between the need to provide high-quality health care to individuals and the need to provide it to populations. France could serve as an example. It amended its national *Public Health Code* to allow for health-care provider networks. The networks are able to focus on the entire population or a specific chronic disease, a certain population group, or type of care (e.g., palliative).[17,18]

This report also did not examine the collaborative principle of best possible care and services (which would potentially require an analysis of codes of ethics through this lens) and included only limited discussion with respect to patient/client engagement and access. These too are worthy of further analysis through research or consultation with regulators. Two other areas that were not explored are the incorporation of health-care professionals (which may be a barrier or facilitator to collaboration) and the interface between regulators and policies developed within health-care organizations and institutions.

Finally, we did not assess the use of standards of practice, policies or guidelines for such things as record keeping—which is a key element of good team communication and function. This is likely one of the weakest links for health professionals, as most peer assessment programs uncover poor record keeping. The weaknesses in record keeping could be a result of the narrow focus placed on chart audits but are likely also due to workload and professional biases and behaviours. Standards that are developed collaboratively (across jurisdictions and professions) are necessary in order to promote good individual and collaborative record keeping.

A NOTE ON EVALUATION AND MEASUREMENT: YOU CANNOT MANAGE WHAT YOU DO NOT MEASURE

It has been found that little is known about the regulatory environment. There are two main reasons for this: complexity and lack of focus. As indicated throughout this report, the legislative and self-regulatory environment is filled with legal jargon, lack of clarity, complexity and inconsistency, sometimes for good reason but sometimes not. Together these factors explain why little is known about the regulatory environment.

There is a wealth of expertise within the regulatory world that, when tapped, could uncover and improve knowledge in this important arena. It is noteworthy that Ontario currently has before its legislature a bill that is attempting to raise the transparency and accountability of regulation in Ontario and, by doing so, promote better outcomes for all.

The legislative and self-regulatory environment is filled with legal jargon, lack of clarity, complexity and inconsistency, sometimes for good reason but sometimes not.

One source of regulatory information is the many annual reports produced by regulators. These documents are available to the public, but the information they contain has not been aggregated for analysis.

These annual reports typically provide information about the nature and level of quality assurance activities, complaints and discipline, and costs of managing and administering the college. Aggregating the nature and

17 Simone Sandier, Valérie Paris and Dominique Polton, *Health Care Systems in Transition: France* (Copenhagen: WHO Regional Office for Europe on Behalf of the European Observatory on Health Systems and Policies, 2004). Available at www.euro.who.int/document/e83126.pdf, p. 67.

18 Participants in these provider networks sign a Network Charter that sets out the obligations of various professionals and ethical principles to guide the network. Most importantly, this legislative amendment allows networks to experiment with financial aspects such as tariffs, services reimbursed and remuneration of professionals.

level of quality assurance activities, complaints and discipline and the cost of self-regulation across professions and jurisdictions is an important step to better understanding the regulatory environment. Taking this step would likely improve public protection and help clarify the sustainability challenge voiced by regulators. Although painful, it would certainly be worth the effort.

In the United States, for example, a National Practitioner Data Bank (NPDB) registers disciplinary actions taken by state licensing boards and hospitals and is primarily an alert or flagging system intended to facilitate a comprehensive review of health-care practitioners' professional credentials. State licensing boards, hospitals and other health-care entities, and professional societies are encouraged to identify and discipline those who engage in unprofessional behaviour and to restrict the ability of incompetent physicians, dentists and other health-care practitioners to move from state to state without disclosing information on a practitioner's licensure, professional society memberships, medical malpractice payment history, and record of clinical privileges. The information contained in the NPDB can be considered together with other relevant data in evaluating a practitioner's credentials.[19]

Furthermore, the development of agreed-upon comparative indicators—using the principles of collaboration as the evaluation framework—across jurisdictions and professions would lead to better information, clearer understanding and potentially better management of the regulatory environment and possibly even of the health-care systems at large.

Although Decter maintains that our failure to reform is generally due to implementation failure, we believe, as well, that promoting collaboration at the regulatory level requires time to build partnerships. Partnerships are necessary in order to:

- develop a reform strategy;
- formulate an implementation plan and evaluation framework that the partnerships can then lead and own;
- agree on their purpose; and
- set goals, targets, measures and evaluation frameworks.

19 www.npdb-hipdb.hrsa.gov/npdb.html.

Under certain conditions, such partnerships can succeed. They will need to develop their purpose and goals as principles and frameworks. They will need a change vision that builds on the principles of public protection, the support for collaboration—including better human resources management—with improved health outcomes. Put simply, the vision must be a better health-care system for all through improvements to legislation and regulation. Once the vision has been created, a guiding coalition must be formed in order to develop the strategy and plan, which will ultimately lead to a change in system culture that supports collaboration.

Whoever takes on the role of coordinating the efforts of regulators should follow Kotter's steps, which could form the basis for the reform strategy and plan.

The partnership, however created, requires infrastructure and support. One example worthy of consideration is found in the United States. The Council on Licensure, Enforcement and Regulation (CLEAR) is an independent forum for professional regulation stakeholders. It provides resources for organizations or individuals involved in the licensure, non-voluntary certification or registration of regulated occupations and professions. CLEAR promotes regulatory excellence by assisting its members in carrying out their shared mission of public protection. There are three core areas of substantive inquiry: professional discipline; credentialing/examination issues; and policy and administration. Through its education and consultative mandate, CLEAR has been proactive in identifying critical regulatory issues and providing a neutral forum for the discussion and dissemination of information. CLEAR maintains its neutrality by not lobbying or taking positions on contested matters. In Canada, the Canadian Network of National Association of Regulators (CNNAR) serves as an interesting example worth further exploration, support and exposure.

Whoever takes on the role of coordinating the efforts of regulators should follow Kotter's steps, which could form the basis for the reform strategy and plan. The steps would ensure implementation based on the vision of a better health-care system for all through improvements to legislation and regulation.

CHAPTER 5

Conclusions and Recommendations

Chapter Summary

- Beyond offering conclusions, this chapter contains recommendations for regulators, policy-makers, educators and the public.
- Partnerships should be the new paradigm for self-regulation in Canada.

To effect change that supports further collaborative interdisciplinary practice, we conclude that:

- Regulators have an important part to play in supporting collaborative practice. Regulators have unique skills and talents that can enable them to fulfill leadership roles in their respective professions.
- Regulatory sustainability necessitates change. Many regulatory authorities face financial and other resource challenges, which are partly a result of the enormous costs involved in regulating a profession.
- Legislators must give regulatory authorities the necessary statutory tools to do the job. Given the fact that all regulators' authority is devolved from the legislature, governments cannot expect regulators to implement and support government health human resources policy without the necessary express legal authority to do so.
- The health-care system's size and complexity must not be an excuse to do nothing. Given the size of the health-care system, change on many fronts is required. Other improvements must be undertaken, in concert with making regulatory changes that support collaboration. Regulators must be proactive within their respective jurisdictions in order to achieve and maintain the public's trust, which lies at the very heart of health-care profession regulation in its current form. If the public loses confidence and trust in the regulatory institutions and mechanisms, then massive reform will be the order of the day, as it was in the United Kingdom.[1, 2]

As a result of this analysis, we offer the following five key recommendations to stakeholders interested in regulation:

1. **End the legislative silence or neutrality.** The law should do more than simply "not prohibit" collaborative practice; it must encourage or require it. Governments need to update the various items of health profession legislation to allow the various health professionals and

1 The Bristol Royal Infirmary Inquiry's mandate was to inquire into the management of the care of children receiving complex cardiac surgical services at the Bristol Royal Infirmary between 1984 and 1995 and relevant related issues in the aftermath of gross violations of clinical practice and hearings by the General Medical Council into the professional conduct of three doctors at the Infirmary. Just as the Shipman Inquiry was critical of the culture of the General Medical Council, so too was the Bristol Royal Infirmary critical of the culture of the National Health Service.

2 Clare Dyer, "Doctors Lose Power to Regulate Their Profession," *British Medical Journal* 334, 389 (February 24, 2007), pp. 1–2.

their regulators to work together. Without a clear legislative mandate to undertake a specific program, regulators are reluctant to spend time and resources—which are, after all, limited—on something that is not legally required of them. Alternatively, the development of clear government policy indicating support for collaboration and directed towards regulators would reinforce its importance.

2. **Amend ancillary legislation.** Similarly, other health-care legislation needs to be examined and amended to allow for and support collaborative practice. Most of the legislation was created before the emergence of collaborative team-based care. As a result, many pieces of legislation do not reflect the current roles of both individuals and teams.
   – For example, updating the public hospitals acts and privacy and consent to treatment legislation to better reflect the emergence of collaborative care would reinforce the importance and need for greater access to a team of providers.
3. **Provide financial incentives to regulators to develop instruments such as standards for delegation, consent to share information and codes of ethics** to support collaborative care. Provincial/territorial regulators and governments will need to work together to ensure that appropriate resources are available to make this happen. Regulators will need to encourage, support and respect professional cultural differences and facilitate consensus.
4. **Encourage regulators to work together in the area of quality assurance, complaints and discipline.** There are interesting examples in Canada and abroad whereby regulators have collectively joined forces to deal with various issues of self-regulation. Quebec and the United Kingdom serve as interesting examples of better practices to emulate. Regulators have an important role to play in supporting collaborative practice. Leadership and infrastructure support on the part of regulators and governments will ensure that collaborative care public safety issues are dealt with most effectively and efficiently.
5. **Federally fund an arm's-length organization dedicated to creating and sharing information among regulators.** This organization would be an independent forum of professions, provincial/territorial regulators and ministries of health, with a clear mandate to research, educate and disseminate best practices across the country. Organizations such as the American Council on Licensure, Enforcement and Regulation (CLEAR) or the Canadian Network of National Association of Regulators (CNNAR) could serve as interesting examples on which to build. It should begin with three key functions:
   – Develop templates for various regulatory instruments that could be adopted or adapted by regulators. In Ontario, for example, the Federation of Health Regulatory Colleges recently developed templates for delegation. This could be done for various regulatory instruments at the pan-Canadian level much more cost-effectively.
   – Create and maintain a data warehouse to track regulatory indicators such as the level and nature of quality assurance activities, complaints and disciplinary actions, and the cost of regulation.
   – Facilitate a continuing scoping review among stakeholders with the mandate to develop and support a pan-Canadian principle-based framework for self-regulation. It should allow for provincial/territorial flexibility and adaptability, while reinforcing the principle of portability in the *Canada Health Act*.

AFTERTHOUGHT

Regulators have told us that they do not own all of the problems. One must realize that along with regulation, there are other and perhaps more important barriers to collaboration than regulation. For example, the impact of funding models on how, and from whom, the patient/client receives care needs careful attention. It is not the purpose of this report to address the funding of health care, but it must be acknowledged that funding overwhelmingly influences the behaviour of health professionals. Where there are explicit requirements that all care paid for by the public system be provided by certain categories of practitioners who must make a visit in person to the patient/client and where complex and restrictive requirements relating to delegation are present, fears of fraud and abuse may form a barrier to many collaborative care arrangements.

We have highlighted throughout this report the steps required for successful change without discussing the first step: establishing a sense of urgency or the burning platform. While it is generally believed that the current health-care system is unsustainable, it is not clear how, exactly, this relates to regulation or regulators. Regulators voiced consistent concerns about the sustainability of the self-regulatory system in many jurisdictions and professions. But what better way to light a match than to wait for a crisis?

In the United Kingdom, such a crisis occurred, due at least in part to inaction by regulators. In the case commonly known as the Bristol Royal Infirmary (BRI) scandal, repeated concerns about the quality of care and performance of a unit that provided cardiac surgery for both adults and children were largely ignored. Ultimately, the death of an infant sparked a public outcry, a public inquiry and, finally, widespread change. The subsequent Kennedy Report about this scandal highlighted the need for reconnection between the regulated professions and the expectations of patients/clients and the public. It recommended the creation of the Council for the Regulation of Healthcare Professionals (now called the Council for Healthcare Regulatory Excellence) in order to ensure consistency and good practice among regulators. The crisis also spurred the development of revalidation programs by regulators of medicine, dentistry and optometry to ensure that health-care professionals are maintaining appropriate competencies related to their profession and clinical practice. The BRI scandal thus became the burning platform for large-scale change.

Similarly, in January 2006, the Australian government's Productivity Commission studied the issues affecting the health workforce and found that current regulatory arrangements are often rigid and subject to influence from the professional bodies themselves.[3] It recommended that an independent, statutory-based health workforce improvement agency be established to assess the implications of education and training, accreditation and registration.[4]

Now it is time for regulators to have their say. The future paradigm for regulators is partnerships; their new mantra: Two heads (or more) are better than one.

In Canada, we have a choice. We can wait for a crisis that exposes lack of recertification/revalidation, lack of accreditation of regulatory bodies or lack of regulatory instruments. Or we could wait until the demographically driven sustainability challenge hits the system in about 15 years. We will have older patients/clients with many chronic diseases. They will require teams of professionals to support them in their journey to health. A partnership between regulators, educators, governments and the public would ensure that patients/clients have access to the right provider at the right time and in the right place regardless of where they live in Canada. Waiting for the sustainability challenge to hit has already resulted in our Supreme Court adding to the debate about the future of health care in this country with its decision in *Chaoulli v. Quebec (Attorney General)*.[5]

Now it is time for regulators to have their say. Because of their unique skills and expertise, regulators can play a vital role to ensure appropriate access to health-care services. The future paradigm for regulators is partnerships; their new mantra: Two heads (or more) are better than one.

3 Australian Government, Productivity Commission, *Australia's Health Workforce: Productivity Commission Research Report* [online]. (Canberra, Australia: Productivity Commission, December 22, 2005), [cited March 29, 2006]. Available online www.pc.gov.au/study/healthworkforce/finalreport/healthworkforce.pdf.

4 Ibid.

5 1 S.C.R. 791, 2005 S.C.C. 35.

APPENDIX A

Glossary of Terms

Code of ethics. The Canadian Psychological Association defines this as the "principles, values and standards to guide members" of a profession.

Collaboration. Way and Jones define collaboration "as an interprofessional process of communication and decision-making that enables the separate and shared knowledge and skills of health care providers to synergistically influence the client/patient care provided."

Confidentiality. Health Canada defines confidentiality as the obligation of an organization or custodian to protect the information entrusted to it and not misuse or wrongfully disclose it.

Consent. Health Canada describes consent as "an ongoing process that starts with the . . . first contact with the individual and continues until the study (care) is complete or the participant (patient/client) withdraws" it. In this report, consent is discussed in terms of consent to the sharing of information among collaborative team members, not in terms of consent to treatment.

Delegation. This is defined by Webster's dictionary as the transfer of responsibility for performing an activity to another while retaining accountability for the outcome.

Guidelines. These are regulatory instruments that provide recommendations to members of a profession. Guidelines require regulatory (college) approval.

Models of regulation. There are two models or systems of self-regulation in Canada: the modes and orders of regulation.

Modes of regulation. Modes of regulation concern *how* we regulate. There are two modes of regulation: controlled acts and licensure.

Orders of regulation. Orders of regulation concern *who* regulates. There are three orders of regulation: self-regulation, self-administration and direct government regulation.

Policies. Policies are an example of a regulatory instrument. They are written and agreed-upon principles of action, drawn up by a college with the intention of helping members understand their professional responsibilities and helping regulators state their positions on a variety of issues. They describe what is acceptable in a profession.

Regulation. These are the details that support legislation. They exist pursuant to legislation and their creation typically requires consultation within various levels of health ministries. In this way, regulations are subordinate forms of legislation that may be established without the necessity of enacting a new statute.

Regulatory instruments. These comprise the regulatory interventions that influence action or behaviour of members of a health profession. In this report, we discuss three specific regulatory instruments: delegation, code of ethics, and consent to share health information.

Scope of practice. This term means many things, depending upon the context in which it is used. It can define what a health professional can or cannot do. It can describe a specific mode of regulation or describe the modes of regulation more generally.

Standards of practice. These are developed by the various regulated health professions through regulatory mechanisms reflected in legislation. They are intended to guide a profession in its delivery of health care and ensure the appropriate level of quality within a profession. They may also promote continuous learning and improvement.

APPENDIX B

Acronyms

CLEAR The Council on Licensure, Enforcement and Regulation

CNNAR Canadian Network of National Associations of Regulators

EICP Enhancing Interdisciplinary Collaboration in Primary Health Care initiative

FP Family practice

FPT Federal/provincial/territorial

GP General practice

HHR Health human resources

IECPCP Interprofessional Education for Collaborative Patient-Centred Practice (Health Canada)

LPN Licensed practical nurse

RPN Registered practical nurse in Ontario

NP Nurse practitioner

PHC Primary health care

QA Quality assurance

RN Registered nurse

RN(EC) Registered nurse, extended class (See also NP, Nurse Practitioner)

RPN Registered psychiatric nurse

SW Social workers

MD Medical doctors

OT Occupational therapists

SLPA Speech-language pathologists and audiologists

APPENDIX C

Legal Evolution of Health-Care Systems in Canada

Legal Evolution of Health-Care Systems in Canada

Date	Act	Provisions
1774	*Quebec Act*	Quebec is granted civil law.
1791	*Constitution Act*	This was an act of the British Parliament that created Upper and Lower Canada. After royal assent, it was enacted in London and gave Canada its first parliamentary constitution. The Act contains 50 articles and brought many changes. It changed the government of the province of Quebec to accommodate the numerous United Empire Loyalists—English-speaking settlers who arrived from the United States following the American Revolution. Physicians became licensed four years after the *1791 Constitution Act* came into effect.
1867	*British North America Act*	This divided rights and powers between the federal and provincial governments. Section 92 of the Act states that provinces have the exclusive right to make laws in relation to the establishment, maintenance and management of hospitals. Thus, the responsibility of health care was established as an exclusive power of the provincial legislatures. The federal government, however, maintains specific responsibility for the indigenous community, the military, quality of food and drugs, and spending powers. In 1867, the Supreme Court interpreted the *Constitution Act* (formerly known as the *British North America Act*) in such a way as to give the provinces regulatory authority over professions.
1957	*Hospital Insurance and Diagnostic Services Act*	This act was passed to provide hospital insurance coverage for Canadian citizens. By 1961, the Act was operating in all provinces, covering 99 per cent of Canada's population. The ownership of hospitals and the voluntary governance bodies were maintained as a way of keeping existing traditions. The financing arrangement in the Act provided for a federal contribution of approximately 50 per cent towards the cost of eligible hospital services.

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Legal Evolution of Health-Care Systems in Canada *(cont'd)*

Date	Act	Provisions
1966	*Medical Care Act*	This act was the result of recommendations made by Justice Emmett Hall, Chair of the Royal Commission on Health Services, to increase federal leadership and financial support for a broader basket of services. It provided coverage for physicians' services and additional services provided by dentists and other health professions. Federal contributions were given when the principles of comprehensiveness, universality, portability and public administration were met. The federal government contributed to each province half of the average per capita cost of all provinces multiplied by the number of insured persons in that province.
1977	*Established Program Financing Act*	This act developed a block fund for hospitals, medical care and post-secondary education. The federal government agreed to give up tax points to the provinces in exchange for reduced cash payments.
1982	*Constitution Act*	The Act made no substantive amendments to health-care legislation. Provinces maintained the exclusive rights to administer and deliver health-care services by deciding where their hospitals will be located, how many physicians will be required, and how much money they will spend on their health-care systems.
1984	*Canada Health Act*	This act was introduced to replace the *Hospital Insurance Act* and the *Medical Care Act*. It establishes the criteria and conditions related to insured health-care services that the provinces and territories must meet in order to receive the full federal cash transfer contribution under the current transfer mechanism (the Canada Health Transfer).
1990s		Agreements on internal trade reached in 1994 and 1997 provided the framework to identify, reduce or remove unnecessary barriers to the movement of trades and professionals across provincial boundaries. Harmonization has therefore increased, although this was not the aim of the legislation. Another milestone was the introduction of umbrella legislation such as the *Regulated Health Professions Act*. Ontario was the first province to usher in such legislation in 1991, although it was not until 1994 that it was up and running. British Columbia followed suit in the late 1990s, and other provinces have adopted similar legislation. As well, the formation of the Canadian Network of National Associations of Regulators represents a welcome hub for interprofessional dialogue.
1991	*Regulated Health Professions Act* (Ontario)	This act governs most aspects of the organization of the "controlled acts model" and of the colleges established to govern each profession. It also contains the *Health Professions Procedural Code*, which outlines the procedures to be followed in virtually all activities of those colleges. The Act also establishes Health Ministry supervisory agencies, which hear appeals and deal with regulatory proposals from colleges.
1996	*Health Professions Act* (British Columbia)	This act provided for the designation of previously unregulated health disciplines. It resulted in regulations specific to these disciplines, which set the scope of practice for each, and listed any restricted acts relevant to each discipline and any restrictions on the practice of those acts by the members of that discipline.

(cont'd on next page)

Legal Evolution of Health-Care Systems in Canada *(cont'd)*

Date	Act	Provisions
2000	*Health Professions Act* (Alberta)	With 10 parts, this act regulates 30 self-regulating professions in Alberta. Parts 1 through 9 apply to all professions and deal with the establishment and governance of the colleges, initial registration and competence, the investigation of complaints and discipline, and the protection of professional titles. Part 10 contains 27 profession-specific schedules setting out each profession's practice statement, which describes the type of services generally provided by that profession. These schedules also indicate the profession-specific titles that members can use.
1973	*Professional Code* (Quebec)	This code regulates 50 professions in Quebec, which are supervised by 45 professional orders (colleges). Each profession has many regulations; under this code, there are 575 in total. (Because Quebec is a civil law jurisdiction, almost all professional requirements have been made into regulations.)
1990 1996 1988	*Medical Profession Act*[1] *Pharmacy Act*[2] *Psychologists Act*[3] (Northwest Territories/Nunavut)	Although these acts differ in structure and function, they all address the requirements for licensure and the licensing process, the registration process and the discipline process. They all define the practice of the profession and prohibit those who are not licensed from practising. They also list the exceptions to the prohibition.
N/A	(New Brunswick)	New Brunswick has no overarching health-care professions act. All of the individual pieces of professional legislation governing the relevant health professions are private acts, which are neither consolidated nor published by the province.

1 R.S.N.W.T. 1988, c. M-9.

2 R.S.N.W.T. c. P-6.

3 R.S.N.W.T. 1988, c. P-11.

Source: Adapted from The Conference Board of Canada, *Understanding Health Care Cost Drivers and Escalators* (Ottawa: The Conference Board of Canada, 2004).

APPENDIX D

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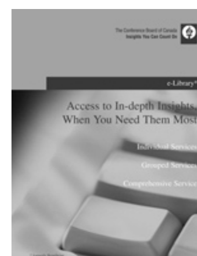

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