

TABLE OF CONTENTS

APPRECIATION	1
THE ASSOCIATION	2
The OAMRT	
Statement of Purpose	
Mission Statement	
Core Values	
BACKGROUNDER	3
Pre RHPA	
RHPA - The Process	
Five (5) Year Review	
Adjusting the Balance, A Review of the Regulated Health Professions Act	
Effectiveness of Colleges' Quality Assurance Programs	
Effectiveness of Colleges' Patient Relations Program	
Viability of Associations	
Sunrise/Sunset and Changes in Scopes of Practice Criteria Review	
CURRENT ISSUES - LEGISLATIVE FRAMEWORK	11
Collaboration	
OAMRT Viewpoint	
MULTI-DISCIPLINARY PRACTICE	13
Definitions	
Outside Influences	
EVOLVING AND EMERGING ISSUES	14
Introduction	
Technology	
Undergraduate Education	
Extended Practice	
Advance Practice	
The Technician	
Keeping the Association Viable	
Interoperability	
Scope of Practice	
Conflicting Legislation	
Specialty Diagnostic Imaging and Radiation Therapy Providers	
The HR Factor	
CONCLUSION	18

APPRECIATION

The Board of Directors of the Ontario Association of Medical Radiation Technologists (OAMRT) appreciates the opportunity to provide the Medical Radiation Technology Profession's beliefs and perceptions related to the safe and quality care of Ontarians.

We commend the Health Professions Regulatory Advisory Committee on your proactive actions and the consultation process you have provided, and are grateful for this opportunity.

E. Roppel, M.R.T. (R.), RTR

THE ASSOCIATION

THE ONTARIO ASSOCIATION OF MEDICAL RADIATION TECHNOLOGISTS (OAMRT)

The OAMRT is a voluntary Association representing approximately 4,500 Members.

The OAMRT is the official voice for the Profession of Medical Radiation Technology in the Province of Ontario. As such, the Association is the advocate for Medical Radiation Technologists (MRTs) representing their needs and their views to the government and other stakeholders.

The OAMRT was founded in 1935 as an independent, non-profit organization. During this time, it has been responsible for a number of initiatives that have shaped and helped to shape health care in Ontario. The Association has been a driving force concerning the evolution of Medical Radiation Technology and Radiation Therapy in Canada and will continue to be as a key partner and stakeholder in the Ontario health-care system.

The OAMRT believes in the principles of collaboration and partnership to ensure an effective, efficient and safe health-care environment.

The OAMRT is governed by a nine-Member Board of Directors, including a representative from the National Association sitting on the Board. It has representation from all areas of the Province through its regional or "Section" system. In this way, communications flow from the grass roots up and from the decision-makers down and laterally to the various volunteers and leaders of the Association.

The OAMRT is committed to building and maintaining an effective and sustainable health-care system in partnership with the government and other bodies and organizations.

Although the Association's mandate is to provide leadership advocacy and education on behalf of its Members and to represent their needs, the safety and interests of the public is of primary concern to the Association in meeting its Core Values, Vision, Beliefs and Goals.

MISSION STATEMENT

THE ONTARIO ASSOCIATION OF MEDICAL RADIATION TECHNOLOGISTS (OAMRT) IS A VOLUNTARY MEMBER-DRIVEN ORGANIZATION.

THE OAMRT PROVIDES PROFESSIONAL DEVELOPMENT AND MEMBER RECOGNITION OPPORTUNITIES FOR OUR MEMBERS WHO STRIVE FOR EXCELLENCE IN PATIENT CARE AND THE ADVANCING OF THE RADIATION SCIENCES.

THE OAMRT IS IN PARTNERSHIP AND A STRATEGIC ALLIANCE WITH THE CANADIAN ASSOCIATION OF MEDICAL RADIATION TECHNOLOGISTS (CAMRT) AND OTHER RELATED ORGANIZATIONS.

THE OAMRT ADVOCATES WITH A POWERFUL VOICE ON BEHALF OF THE COMMUNITY OF MEDICAL RADIATION TECHNOLOGISTS TO THE GOVERNMENT AND OTHER STAKEHOLDERS TO EVOLVE OUR PROFESSIONAL SCOPE OF PRACTICE AND TO PROVIDE STRONG LEADERSHIP IN A FAST-CHANGING HEALTH-CARE INDUSTRY.

Submission to: Health Professions Regulatory Advisory Committee on Existing, Evolving, and Emerging Issues

CORE VALUES

The Core Values for the Association, which drive the decision-making process and actions of the Board of Directors, Staff and Members, are:

- Accountability
- Integrity
- Transparency
- Flexibility
- Sensitivity
- Wisdom

BACKGROUND

PRE RHPA

Prior to the Regulated Health Profession's Act (RHPA), Medical Radiation Technologists (MRTs) were registered under the Board of Radiological Technicians' Act of Ontario (BRTO). Although many MRTs thought they had to belong to work, in reality, it was a registry board, not a regulatory board. When our Association was approached in 1982 in regards to a new regulatory model, we were very enthusiastic.

It should be noted that until the 1960's, training in radiation therapy (radiotherapy, as it was called then) and later nuclear medicine were "add-ons" in the sense of additional training. Both were an extra year on top of the basic X-ray course. We note this because the wheel is turning and coming back to that as an emerging issue in terms of cross and multi-disciplinary practice. The separate Disciplines, or as the regulatory body calls them, Specialties, evolved due to the sophistication of the practice in terms of the competencies required of those practitioners.

Today we still have some dual and triple certified MRTs, but retirement is quickly reducing those numbers, such that in five (5) years we predict there will be none of these individuals left.

It was during the 1960's to the 1970's that medical sonography came into being and became a major area of diagnostic imaging (DI). In those years, MRTs became Sonographers, usually through on-the-job training. As sonography evolved, political events within the Medical Radiation Technology Profession caused Sonographers to go their own way, and organizations such as the Ontario Society of Diagnostic Sonographers (OSDMS) were born. That noted, it is important to note that even today we have a number of MRTs who are also qualified Sonographers as Members of our Association. The links in the DI family are still strong.

RHPA - THE PROCESS

As noted, the Association was excited and enthusiastic about what was then the Health Professions Legislation Review (HPLR). The Association met with other Associations in a formed group called "INTERHEALTH", where we discussed common issues around the proposed legislation. As a result, we collaborated in crafting joint submissions and attending joint meetings, which were superb forums for learning about each other, and did accomplish some silo dismantling.

Major areas were:

- Risk of Harm Clause
- Credentialing
- Sexual Abuse Legislation (Bill 100)
- Scopes of Practice.

Bill 100 was particularly controversial as regulated providers seemed to be targeted, and thus potentially penalized for being regulated, when there were other "providers" in the non-regulated sector who had equal or even more opportunities to be offenders. This is an issue which is an irritant to this day.

Other matters which were items of debate, for us in particular, we have expressed in our submission to you concerning the Five (5) Year Review.

Submission to: Health Professions Regulatory Advisory Committee on Existing, Evolving, and Emerging Issues

The process was a consultative one and for the most part effective. Certainly the Project Manager, Allan Schwartz, had his own ideas, and in some cases agenda about things, but it went fairly well. We were promised some things, which did not happen, going on the fact that the RHPA was to be “living legislation”. Our observation is that it may be “living”, but at the rate of a frog in hibernation. The legislation changes needed cannot keep up with the evolution of health care. It was identified as an issue back in the late 1980's and is still one. In some cases items we raised that were dismissed by A. Schwartz have come back as practice issues to resolve.

FIVE (5) YEAR REVIEW

In our review of the RHPA after five (5) years, we had concerns about the ability of the RHPA to meet its intent being:

- Protecting the public from unqualified, incompetent and unfit health-care providers
- Providing mechanisms to encourage the provisions of high quality health care
- Permitting the public to exercise freedom of choice of health-care providers within a safe range of options
- Promoting evolution in the roles played by individual Professions/providers and flexibility on how those groups can be utilized so that health services are delivered with maximum efficiency.

Our recommendations were:

- A definition of “Scope of Practice” be included in the RHPA
- The Government provide all Members of the public with relevant information on the RHPA through the Ministry of Health and Long Term Care’s marketing plan
- A clause be put into the RHPA noting that the use of ionizing radiation is an exception or some suitable clause noting that prescribing radiation presents a serious risk of harm, so it is addressed in the RHPA, or words to that effect
- Controlled Acts ,or parts thereof, be performed only by regulated health Professionals
- Delegation should be restricted to regulated health Professionals whose scope of practice is in concert with the procedure being delegated
- The Patient Relations Committee’s mandate be expanded to include other areas of patient relations other than just sexual abuse
- Colleges use their web site to post notice of Discipline hearings and Council meetings
- An ADR mechanism be incorporated into the Regulations
- A clause be put into the RHPA concerning employer responsibility in assuring competency of their employees

Submission to: Health Professions Regulatory Advisory Committee on Existing, Evolving, and Emerging Issues

- Professional Liability Insurance be mandatory for health Professionals and that it be provided by an organization, such as the Professional organization, rather than by a regulated college to prevent conflict of interest
- The definition as to what “Public Interest/Public Need” appeared to be absent, although it was used frequently in the document. Definitions were required, we noted
- There needed to be a balance between economic needs and patient care and safety needs
- The Scope of Practice is a complex one and it needs to be addressed in context of synergy concerning the health-care environment. In our case, our Scope of Practice does not take into account evolving and existing practice in context with that of our physician colleagues (Radiologists and Oncologists, mainly)
- We suggested that, in our case, with all the legislation impacting on MRTs, they were already regulated, and possibly could be de-regulated to take an extreme position
- Regulatory colleges provide guidelines that address the clinical competency requirements as part of the Q.A. Program.
- Regulatory colleges have clearly defined parameters in terms of delivering CE Programs in terms of their role of protecting the public
- CE and Professional Development Programs be carried out by Professional Associations and Professional education providers in cooperation with the regulatory colleges
- The Council structure include a representative from the Professional Association picked by the Professional Association who is there in an ex-officio capacity
- There be a requirement in the regulations for a process of accountability to the registrants through the elected council Member
- A study be conducted with the aim of determining areas of administration and operations amongst the colleges where consolidated use of resources would result in cost effectiveness and efficiencies
- The provisions of sexual abuse be removed from the RHPA and be re-introduced as stand-alone legislation
- The RHPA include a clause, or clauses, referencing the stand-alone legislation
- The sexual abuse provisions be amended to reflect the recommendations made by the Ad Hoc Coalition of Regulated Health-Care Associations in Bill 100 in 1993
- A pardon system be considered
- Employers are held accountable to ensure that the practice environment supports the Standards of Practice of the Profession and its practice guidelines/protocols. Further, that health Professionals are provided the protection to address their employers.

ADJUSTING THE BALANCE, A REVIEW OF THE REGULATED HEALTH PROFESSIONS ACT

In November of 2001, we provided the Minister, Ministry of Health and Long-Term Care (MoHLTC) the following recommendations regarding the Council's document "Adjusting the Balance, A Review of the Regulated Health Professions Act". Those recommendations were:

- **RECOMMENDATION 1**

That all Regulated Health-Care Practitioners carry personal professional liability insurance (PLI).

- **RECOMMENDATION 2**

That the Minister of Health and Long-Term Care and the Health Professions Regulatory Advisory Council consult with Associations whose Members are Regulated Health Professionals in the same spirit and manner as is the Federation of Health Regulated Colleges to achieve a balance of viewpoints on issues related to Regulated Health Professions Act.

- **RECOMMENDATION 3**

That the terms "*disease*", "*disorder*" and "*dysfunction*" be clarified through definition.

- **RECOMMENDATION 4**

That clarification be given to subsection 27-(2) 1, of the RHPA regarding "*Communicating a Diagnosis*".

- **RECOMMENDATION 5**

That the boundaries of a "*personal representative*" be defined.

- **RECOMMENDATION 6**

That the terms "prescribing" and "*administering*" be clarified.

- **RECOMMENDATION 7**

That the Fitness to Practice and Discipline Committees stay as is.

- **RECOMMENDATION 8**

That the proposed extension concerning the deadline for Disposition of a Complaint, not be incorporated.

- **RECOMMENDATION 9**

That full party status not be given to complainants at Discipline proceedings.

Submission to: Health Professions Regulatory Advisory Committee on Existing, Evolving, and Emerging Issues

● **RECOMMENDATION 10**

That the public access to information be consistent with privacy legislation now in effect, and proposed, and also be consistent with the principle of “innocent until proven guilty”.

● **RECOMMENDATION 11**

That the role of HPRAC stay as is.

● **RECOMMENDATION 12**

That a fixed timetable not be established concerning the review of the Profession - Specific Acts.

EFFECTIVENESS OF COLLEGE’S QUALITY ASSURANCE PROGRAMS

The response to the MoHLTC on the effectiveness of the regulatory college’s QA Program was as follows:

- We supported Recommendations 2, 4, 6, 7, 9, 10, 11, 12 and 13 as is
- Concerning Recommendation 1, we commented on the need for Association inclusion in terms of the umbrella regulatory organization and that as key stakeholders, Associations were essential to the QA process
- Concerning Recommendation 3, we commented that excluding the Professional Associations would not be in the public interest and would reduce effectiveness
- Concerning Recommendation 5, we supported the collection of medical error data as long as it would not be used for pre-emptive reasons, but for educating, to reduce the risk of harm to the public.

EFFECTIVENESS OF COLLEGE’S PATIENT RELATIONS PROGRAM

Our submission to the MoHLTC stated the following regarding the regulatory college’s Patient Relations Program.

“The OAMRT believes that the public should be educated in what the Professions actually do, in what distinguishes one Profession from another, and how to tell the difference. The public should be educated in how and where to go to have their concerns heard and dealt with.

The problem our Members have with posting a toll-free number to “complain” is that it invites reporting, including frivolous reports. What HPRAC proposes, or at least the way it proposes it, invites resistance.

We would suggest that there are other means, less antagonistic that can be used for the same purpose. Such as a publication covering all Regulated Health Professionals, including the contact information and brief description of the processes available.

Submission to: Health Professions Regulatory Advisory Committee on Existing, Evolving, and Emerging Issues

Recommendation 14 - that HPRAC's Recommendation 2, under "Public Information" not be accepted.

In terms of Recommendation 3, under "Public Information", we wonder how this will be monitored and enforced. Again, education of the public through other means may be more effective. This, of course, impacts on Recommendation 4. We suggest that what is recommended here is not practical.

We would suggest that for Recommendation 9, under "Monitoring and Evaluation" that again there is a viable role for the Associations here as well as the undergraduate training Programs.

Recommendation 15 - that the proposed monitoring system include the Professional Associations and the undergraduate Programs."

VIABILITY OF ASSOCIATIONS

This Association struggles to maintain its Membership. One of the nine (9) criteria relates to maintaining a viable Professional Association. This has become, and will become, more and more difficult as regulatory costs soar and practitioners who have to pay registration fees to the regulatory college do that, and to save money do not join the Professional Association. The regulatory and economic climate compromises an essential criteria of regulation.

SUNRISE/SUNSET AND CHANGES IN SCOPES OF PRACTICE CRITERIA REVIEW

The Sunrise/Sunset and Changes in Scopes of Practice Criteria Review is an interesting document that we reviewed. Our comments and observations included:

- The importance of Professional Associations was perceived as one where they were minimized and not of much importance
- The criterion provider groups need to meet to be regulated, needed revision in terms of substance and clarity
- Changes to the RHPA is not an easy process
- the Professional Association should have the role of educating registrants vs. the regulatory college, as it is a conflict of interest for them in many ways
- Professional Associations can be, and many are, proactive, whereas the regulatory college bound by legislation, is reactive and even there, slow at best
- The apparent focus is on regulated practitioners in terms of accountability, yet there is little requirement or controls existing in relation to the unregulated sector
- The impacts of shortage of providers, could lead to changes of Scopes of Practice, but also could result in medical errors due to stress and assembly-line production to satisfy certain political needs, also resulting in less than competent providers. This is a risk of harm issue,

Submission to: Health Professions Regulatory Advisory Committee on Existing, Evolving, and Emerging Issues

in our view

- What specific data exists in Ontario related to the experience of the RHPA and quality risk reduction care
- The problem with health-care providers is not having a good and clear understanding of what each does, and the undermining that occurs at times, or the flagrant actions of ignoring legislation that is in place. We used the example of Registered Nurses, who continue to violate the Healing Arts Radiation Protection Act (HARP), and their own Standards of Practice, because they believe they can do anything. Despite the RHPA, internal policing has failed. This was a catalyst for introducing RHPA in the first place, except the complaint was related to physicians.

CURRENT ISSUES - LEGISLATIVE FRAMEWORK

COLLABORATION

The OAMRT is a participant in the “Professional Associations Representing Regulated Health Professions” group. In that regard, the OAMRT supports the comments and submissions from this assembly of Associations.

The OAMRT therefore is in support of the issues and matters expressed by Mr. Bruce Squires on behalf of the group relating to the legislative framework.

OAMRT VIEWPOINT

The “Background” section of this document provides the recommendations we submitted related to the RHPA, whether initiated by the HPRAC or the MoHLTC. It is our viewpoint that all of the recommendations from all the submitted documents still apply except for:

- Regulatory colleges provide guidelines that address the clinical competency requirements as part of the QA Program. This is being addressed
- Becoming de-regulated.

We believe there is an accountability issue concerning regulatory colleges. To the registrants, there is a perception in our Profession that there is none. There is no requirement for those elected to report back to those elected. There is frustration that registration fees can be raised at will, and nothing can be done about it. In our Professional environment situation, when the College of Medical Radiation Technologists of Ontario (CMRTO) raised the fees, we received a large outcry. The CMRTO did not, due to fears of reprisal mainly, the other was a sense of “what’s the sense - we cannot change things”. When we went to government, there was a great deal of concern and empathy. This concern was mainly driven by HR issues in that raised fees could prevent people entering the field and be a catalyst for early retirement. In any regard, the government said they could talk to the CMRTO, but could do nothing as they were “independent of government”. The ire of CMRTO registrants resulted in comments such as:

“They use a lawyer for everything, whether they need one or not”.

“The place (CMRTO offices) is better than Saddam Hussein’s palace”.

“They hire consultants for everything when they could use Staff”.

There is a concern, as expressed earlier in the document, regarding the survivability of the Professional Association. Climbing regulatory college registration fees could be the demise of the Professional Association, which would not be in the public interest in terms of what Professional Associations add to quality health care.

Although in its infancy, the CMRTO’s Peer Assessment process has raised concerns about meeting its philosophy, which is based on the 360 degree feedback model. The key concerns relate to objectivity and how this will improve MRTs competency, including behaviours. Further still, is the support, or what appears to be a lack of, related to how one can improve themselves related to the feedback one receives, when employers are not providing much support, in many cases for professional development.

Submission to: Health Professions Regulatory Advisory Committee on Existing, Evolving, and Emerging Issues

As we noted previously in the document, the legislated framework of the RHPA and its subordinate regulated college Acts do not permit regulatory colleges to have “nimbleness” or the ability to turn on a dime to face the challenges of the environment. Where there may be a will on the part of the regulatory body, the ability to do it is confined by barriers. These obstacles are of concern when a Profession needs to change its Scope of Practice to meet the challenges of the practice environment.

MULTI-DISCIPLINARY PRACTICE

DEFINITIONS

One of the problems with the “multi-disciplinary” practice issues is - what does it mean? There are a variety of definitions out there and it means different things to different people and groups. Sometimes even within a Profession it means different things.

The term multi-disciplinary practice, as an example, could mean to some “cross-practice”. Compound that with the fact that our regulatory college uses the term “Specialty”. In our world, our term “Discipline” is the same as “Specialty”. In the Profession, the term “Specialty” means a specialized area of practice within a Discipline. As an example, Mammography is a specialty under the Discipline of Radiological Technology.

In the paragraph above, the term “cross-practice” was used. This is another term that requires defining in relation to multi-disciplinary practice, because there are multiple perceptions as to what it is.

One of our problems is that we, as the Professional body, are working in concert with our national Association and our sister Member Medical Radiation Technology Associations. We, as a Profession, will set out definitions, positions, etc., but the regulatory body will take an entirely different stance on terminology, etc., which is confusing to the public and the practitioners.

We believe that it is the Profession that is the appropriate body to decide Disciplines, Specialties and practice terminology. We further believe it is the responsibility of the regulatory body to take those things and apply them appropriately to the legislative framework. It appears at times to be a power and control issue; on both sides at times. Again, this is not in the best interests of the public or practitioners within and external to the Profession.

OUTSIDE INFLUENCES

The Ontario Association of Radiologists (OAR) have expressed to us that they want a multi-disciplinary and cross-practice capable and competent MRT. They have not defined the terms either. They are looking for someone who can do Ultrasound, CT, MRI and general Radiography. This presents challenges for the education system and for the MRT.

Another influence relates to the government initiative concerning wait time and shortages. The recent recommendations concerning CT are stating that all graduates from a Radiological Technology Program should be competent to operate a 16-slice CT unit. This raises the situation as to what was a specialty will now become an entry-to-practice competency. What might be a “multi-disciplinary” practice requirement today is an entry-to-practice competency tomorrow.

The merging of technologies in our Profession is also muddying the waters in terms of the “cross-practice” and “multi-disciplinary” issue. The emergence of molecular imaging is a multiplier in the complexity of our Profession’s practice environment. The legislative framework and processes need to accommodate all of this with nimbleness, effectiveness, and efficiency.

EVOLVING AND EMERGING ISSUES

INTRODUCTION

Diagnostic Imaging and Radiation Therapy are the most rapidly changing and evolving sectors in health care. In reality, while nursing may be the heart of health care, our Profession is the hub of health care, because all patients see us at some point in their assessment and care.

The evolution and revolution occurring in health care demands that we, as a Profession, are in a dynamic situation and one in which collaboration, cooperation and communication must be in synergy within the health-care environment.

TECHNOLOGY

The technology is evolving, and rapidly, in our Profession. At times, the technology outpaces the abilities to use it effectively in assessment and treatment. This places huge demands on the practitioners to meet the expectations and demands of other providers and the public. These demands can translate into a risk of harm in terms of proper use of the technology, the qualifications as to who uses it, and for the purposes it is used for.

Presently we see combinations of modalities such as CT/SPECT, PET/CT and others. As noted under the multi-disciplinary practice section, it raises matters related to undergraduate education, post-graduate education, Professional development, cross-Profession practice and more.

We have already realized flaws in the HARP Act related to who can operate modalities where, if you are a Member of a particular regulated college, you can order procedures involving ionizing radiation or operate equipment producing harmful radiations. This privilege is granted whether one is trained and competent to do so or not.

UNDERGRADUATE EDUCATION

The Association has been working with government to address the wait time and Human Resource (HR) issue. The pressures on everyone to have successful solutions, while saving money, is immense. A fallout of that is when undergraduate Programs try and save money, but reduce the clinical hands-on training time. This would save money as clinical sites would not need to be paid as much, or in some cases, not at all. At the same time, clinical sites are complaining about the fact the undergraduate education Programs are not funding them for the actual costs. That is compounded by the fact that the new technology of PACS, Computed Radiography (CR) and other electronic systems' demands are burdening the Staff MRT, who is supposed to be teaching the Student, but cannot give the time the Student needs.

The solution is to reduce the hands-on clinical time and use "simulation". Simulation has its place, but if we are going to reduce the burden of long-range costs, reduce medical errors - which has another set of costs, reduce the risk of harm to patients, reduce the potential for stress in the workplace - which impacts on the HR matter, cutting hands-on clinical time is not a rational option when one looks at the big picture. The issue is that the short-term solution is more attractive than the long-term one, in relation to costs and political survivability.

Another matter is the issue of the Degree to enter practice for our Profession. We have presently a two-tiered system in that for the Radiological Technology Discipline (Specialty), some undergraduate Programs are

Submission to: Health Professions Regulatory Advisory Committee on Existing, Evolving, and Emerging Issues

Degree Exit (3), and the remainder are Diploma Exit (4). When looking at the long term and particularly how our Profession is evolving, the Degree Exit graduate is, and will be, better prepared to be a competent MRT in all aspects of the concept. This includes the Independent Health Facilities (IHF) sector, where often the MRT is on their own with the Radiologist miles away.

EXTENDED PRACTICE

One of the issues is - what is “extended practice” vs. “advanced practice”? Until this is officially defined by the Profession on a national basis or legislated some way, our perception of extended practice is:

“Competencies that are acquired that are not part of the original entry-to-practice competencies obtained and are not those presently required of another provider group outside our Profession”.

Some examples of extended practice, at this time, would be: Dosimetry, Bone Mineral Densitometry (BMD), CT and SPECT.

One of the issues we have is that the Specialties of a Discipline do not require official training in that there is no mandatory training specified by the regulatory body. This is a risk of harm matter. The regulatory body’s position is that the practitioner can do anything within the Scope of Practice, which is vague, as long as one has the knowledge, skills and judgement (KSJs) or competences. We believe this is an accountability, and therefore, a public trust issue. Practitioners must take courses of instruction that meet quality-care outcomes and the standards of the Profession, and the expectations of society. Presently, within our Profession, there are MRTs who have not taken academically and clinically-sound education and that to us, is an issue, especially as it concerns the new and evolving technology. The present legislative framework allows this, unfortunately.

ADVANCE PRACTICE

This is a key emerging issue for our Profession. It is presently a very active issue in the United States in terms of physician assistants and physician extenders. The United Kingdom has proven the worth of MRTs as being colleagues in practice with Radiologists and Oncologists.

Currently in Ontario there are “advance practice” activities occurring with MRTs performing barium studies, as an example. The Radiation Therapists are heavily involved in this area concerning their Discipline with a project funded by the Provincial Government. The government is interested!

The concept of “advanced practice” is supported by the Canadian Association of Radiologists (CAR), but is not met with much enthusiasm by the Ontario Association of Radiologists (OAR), who state that they have grave liability concerns. They feel that ultimate liability is theirs. Although the OAR has that stance, many Radiologists support the concept as they see it as a natural evolution, especially with the workload they face, caused by the new technologies. A recent report in Diagnostic Imaging, a well renowned publication, stated that in a multi-modality DI facility, there was 27 hours of work per day for the Radiologist.

For the Council’s information, we have attached two (2) documents for your review, they being:

- Extended Roles and Advance Practice for Radiological Technologists in Ontario
- Extended Roles for Medical Radiation Technologists in Canada.

Submission to: Health Professions Regulatory Advisory Committee on Existing, Evolving, and Emerging Issues

THE “TECHNICIAN”

We see as an emerging issue that as Radiologists and Oncologists hand off their less complicated advance practice tasks to “advance practice MRTs” so too the MRTs will need to hand down their less demanding practice areas to “technicians”. The Medical Laboratory Technologists do have a technician practice level and we see this as a potential event for our Profession. The legislative framework needs to be able to accommodate such an event easily and prudently.

KEEPING THE ASSOCIATION VIABLE

As we have presented earlier in the document, Professional Associations in the RHPA environment fight for survival as Membership is voluntary.

We understand clearly the role of the regulatory body vs. the Professional Association and respect that. That stated, we believe that the regulatory bodies have a responsibility to promote Membership in their associated Professional Association(s). There is a link related to competency and a practitioner’s involvement with their Professional Association, as well as a way and means to give back to society and their personal overall character development.

We see an evolution of a complementary nature whereby regulated colleges overtly promote Membership with the Professional Association(s) and in the case of disciplinary hearings, take into account whether the provider is well schooled in the Profession (globally), and if the individual has been found culpable for an action that if not a Member of the Professional Association, they be directed to become a Member. This does not guarantee a competent practitioner, but it improves the odds.

INTEROPERABILITY

The digital electronic environment we are living in raises the issue of interoperability and this directly involves providers, whether it is the mutual use of technology, or privacy and ethical issues.

The interoperability matter relates directly to Scopes and Standards of Practice. In our environment, individuals want to operate equipment, manipulate and transmit images that do not have the requisite competencies to do so. We have experienced situations whereby the person thinks that just because they are a “X” provider, they can have access to images and even make their own reports. This is a risk of harm issue and it could go out of control easily.

SCOPE OF PRACTICE

An old, but still emerging, issue is related to the problem of our Scope of Practice Statement.

In the early days of the RHPA process, the Profession saw the future and the need for MRTs to eventually give their opinion or interpretation concerning images. Medical Sonography, an unregulated provider group, do give “technical opinions”, which in reality are relied upon heavily by the physicians involved.

In our case, the Scope of Practice is a major barrier to present day practice, and as well for the future “advance practice” environment. Our Scope of Practice statement needs revision to accommodate the

Submission to: Health Professions Regulatory Advisory Committee on Existing, Evolving, and Emerging Issues

predicted future concerning our Profession.

CONFLICTING LEGISLATION

We, like other providers, have many pieces of legislation impacting on our practice. Many are out of “sync” with each other.

We would suggest that not only should the RHPA be updated and made “nimble”, but complimentary legislation also must be harmonized. As an example, in our case, the HARP Act is not in concert with the Occupational Health and Safety Act and is not harmonized with the Federal Safety Codes. This all has impacts on practice and how it is applied. It also has impacts on regulatory colleges, employers, educational institutes, suppliers and other stakeholders.

We see potential issues concerning the Agreement in Free Trade in terms of national portability across Canada.

SPECIALTY DIAGNOSTIC IMAGING AND RADIATION THERAPY PROVIDERS

We see emerging the need to group those providers that are doing diagnostic and therapeutic procedures using radiant energy under one (1) regulated body. By radiant energies, we mean those energies contained within the electromagnetic spectrum. This includes medical sonography, PET, laser operators, etc.

The medical sonography area has evolved into a viable, reputable Profession, yet remains unregulated. The ties between medical sonography and radiology, nuclear medicine and radiation therapy are clear and strong. This group has proven to meet all of the criteria of a regulated Profession, yet await this anointment. The legislative process has proven to be a barrier. The process needs to be able to be fast tracked when the criteria has been proven to have been met.

As other “special provider areas” pop up, there needs to be a process to flag them and determine where they fit in. The “Sunrise/Sunset and Changes in Scopes of Practice Criteria Review” was a start in this regard, but it has emerged as an issue that needs to be looked at.

THE HR FACTOR

The lack, or sometimes excess, of human resources is a factor which impacts on RHPA in a variety of ways that we have touched on already. It involves changes in practice, layering of practice, invasion of established silos and so on.

The HR factor influences legislators. In this regard, the legislative framework needs to be flexible, but strong. It needs to be strong so that fluctuations or trends do not compromise patient safety or quality care.

The evolving issue here is the urge to reduce standards to meet political, economical and short-sighted, short-term gains.

CONCLUSION

We hope that we have provided some insight on the Profession's experience, previous positions and observations, and our perception of emerging and evolving issues for the Council. We hope that this will be a viable tool for the workshop discussions later this month.

We note that although we have addressed many issues, we have not addressed them all, but feel we have hit the major areas.

We look forward to seeing the RHPA coming alive once again.