File Number: 1205-2

Submission To The Health Professions Regulatory Advisory Council Regarding The Consultation Discussion Guide on Issues Related to the Ministerial Referral on Interprofessional Collaboration Among Health Colleges and Professionals February 2008

May 2008

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APPRECIATION

The Ontario Association of Medical Radiation Technologists (OAMRT) appreciates the opportunity afforded by the Health Professions Regulatory Advisory Council (HPRAC) to respond to the "Consultation Discussion on Issues Related to the Ministerial Referral on Interprofessional Collaboration among Health Colleges and Professionals."

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Chair of the Board and President

RESPONSE TO: INTERPROFESSIONAL CARE

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 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 OAMRT is the collective and influential voice of the Profession of Medical Radiation Technology dedicated to the support and promotion of the interests and needs of its Members.”

CORE VALUES

- **Accountability** – we believe in being accountable to our Membership, our Profession, and the public we serve.

- **Transparency** – we are committed to providing all our stakeholders, a window into the Association in order for them to see that we operate in an ethical and professional manner.

- **Integrity** – we are committed to inclusive, respectful and ethical business practices.

- **Trust** – we believe that trust comes with transparency and integrity and that this is essential for the Association's future.

- **Sensitivity to Members' Views** – we are committed to seeking out and evaluating Members' views, to move the Association forward, and providing them a community they can trust.

- **Collaboration** – we believe that the best results are achieved through collaboration and team work.

- **Wisdom through knowledge** – we are committed to seeking knowledge, in order to make sound decisions, keeping the Association nimble and build trust to create respect among Members, partners and Staff.

- **Evidence based** – we are committed to using the best available evidence and experience in making decisions.

BELIEFS

- That the welfare and dignity of the patient are paramount in the delivery of health care
- That we should strive to create and sustain an organizational environment that inspires trust, integrity, collaboration, a sense of community, personal responsibility, and well being
- That a climate of life-long learning will ensure the growth of our Members and the Association
- That participating decision-making and consultation are essential in order to achieve an effective Association
- That a diversity of perspectives leads to a deeper understanding of issues and enriched knowledge for decision making
- That the empowerment of our Members and our Employees results in our success
- That supporting calculated risk-tasking and innovation is a means to achieve organizational improvement.

INTRODUCTION:

We agree with the statement on page 26 of the referral document that Interprofessional Care and thus Collaboration (IPC) can be defined in many ways and is. This is in fact an issue, which was recently highlighted in the Canadian Health Services Research Foundation's paper "*CHSRF* Synthesis: Interprofessional Collaboration and Quality Primary Healthcare." The statement below highlights some of the issues in the practice domain.

"In these reports and papers, definitions of primary healthcare and Interprofessional Collaboration are discussed. An important drawback to all proposed definitions of Collaboration is the absence of the patient's perspective, reflecting poor conceptualization of the role of the patient / client / family in the Collaboration process, despite the fact that clients are recognized as the ultimate justification for collaborative care. To date, the terminology surrounding collaborative care has not been standardized, nor does one accepted definition of collaboration exist." www.chsrf.ca

McGill University calls it Interprofessional Practice (IPP) and are presently in the process of a project related to partnerships for patient and family – centered practice, which was initiated in December 2004. Their document points out that collaborative relationships, in terms of the human components, are related to each other through collaborative processes that are expressed differently in each relationship, which needs to be kept in mind. It also notes that success with IPP will be different, due to the professional players involved in terms of their knowledge, experience, self-esteem and skills. The project paper also notes that both Interprofessional Education (IPE) and (IPC) can only be effective if the culture and attitude required for success is incorporated within existing structures of organizations and "is accepted by the critical mass of key players and is associated with useful outcomes."

Health Force Ontario has defined IPC in their documentation as:

"The provision of comprehensive health services to patients by multiple heath-care professionals, who work collaboratively to deliver the best quality of care in every health-care setting. Interprofessional care encompasses partnership, collaboration and a multi-disciplinary approach to enhance health-care outcomes.

Based on the complexity of health issues faced by the patient, IPC describes the process by which multiple health professionals provide comprehensive health services that ensures high quality patient-centered care.

IPC occurs across the continuum of a patient's care with health professionals who agree to communicate and collaborate regardless of context."

Some observations OAMRT have include:

- IPC is focussing on "health professionals" and not other health-care providers, who also could be part of an IPC team.
- MRTs have been working successfully in an IPC environment for years, between Disciplines / Specialities and with other health-care providers. We would like to see this strengthened.
- The IPC Blueprint is yet to be implemented and we do not know what the impacts this may have on practice, administratively, logistically or operationally, nor how the recommended Blueprint actions will be structured such that IPC is not seen as another fad or philosophy that is segmented in nature, rather than a seamless cultural process.

CORE ISSUES

We see the Core or root issues concerning IPC as:

- Funding in terms of compensation and supporting IPC models
- Systemic issues within the health-care "system" and with health-care providing facilities
- Outdated or non-integrated legislation and regulations.

IMPACTING FACTORS

We see the following factors impacting on IPC Implementation:

- Funding
- Defining nationally what IPC is and isn't, and what are such things as core competencies for IPC
- The lack of clarity of roles of practitioners
- The lack of clarity concerning legislation and regulation, especially around Scope of Practice statements
- Buy in of unions, administrators, managers and practitioners
- Lack of standardized education among educational deliverers concerning IPC.

RESPONSE TACT

This submission will address those questions or groups of questions we believed we could comment on.

DEFINING INTERPROFESSIONAL COLLABORATION

General Comment

The OAMRT supports the philosophy of both Interprofessional Education (IPE) and Interprofessional Care (IPC). As noted in the introduction, there are a variety of definitions and interpretations, which in itself is a barrier to IPC. Medical Radiation Technologists (MRTs) have been working for years in multi-disciplinary teams, involving a variety of health-care providers. Medical Radiation Technology by its very nature is collaborative practice in action as evidenced by MRTs collaborating with radiation oncologists or as team members in image guided therapy procedures as examples.

Question 1

There are no major issues with what was stated on page 26 of the referral document. What we do suggest is the following:

- Although regulatory bodies and associations have different mandates, both groups have, as a focus, the best interest of the patient / client / family. We believe that there should be an element related to collaboration between regulatory colleges representing the public, and associations representing and defining the profession, in terms of both IPE and IPC. Associations, which are the profession, are key stakeholders in any IPC implementation activities.

- Defining and optimizing the roles of those professionals within an IPC team should be added. Knowledge and skills may be enhanced and Scopes of Practice can be changed, but who does what; who has authority for what; who is accountable for what needs to clear and concise.

- IPC is not a panacea and not applicable in all situations and thus needs to be kept in mind within the practice setting. IPC should be institued where it will do the most good.

- Add that ways need to be found to reduce the differences to IPC models to improve patient outcomes.

- Defining and clarifying what IPC is especially for the patient and their families related to their roles in the process.

ELIMINATING THE BARRIERS TO COLLABORATION AMONG THE COLLEGES

Question 2

In our experience from Member feedback, our Scope of Practice is a barrier. An example is the insertion of PICC lines where in some facilities the MRTs are told a resounding "No"; that it isn't in your "Scope of Practice", while other facilities have delegated it to the MRT. The Radiation Therapy Advance Practice project has illustrated successes within our established Scope of Practice, but also areas where there are barriers. CT and MRI practitioners are also finding our Scope of Practice a barrier in cases where vaginal tampons are needed to be inserted to enhance the examination process as another example. The distinct expertise MRTs possess needs to be recognized by other health-care providers, as mutual respect and understanding is a barrier.

Question 5

From our perspective, we would state that there are professional cultural issues that act as barriers. These are due to the fact that practitioners represent over 50% of the regulatory college Councils and are often rooted in their own experiences and beliefs. As a result those beliefs and perceptions often surface and most are turf related. Further, some of this is because regulating body decision makers, despite the time RHPA has been in effect, are not familiar with the practice of other professions.

It is all about education in the end. The "Federation" representing the regulatory colleges appears to be addressing this and this should continue, and we would suggest that they have an "IPC Implementation Plan" of their own.

As we noted in answering Question 1 of the consultation document, both the associations and regulatory bodies aim for the same outcome; safe, effective and efficient patient care. Associations, with funding, can educate their Members; the future Council members concerning IPC. The "Federation" and the CORHPA (Coalition of Regulated Health Professions' Association) can and should work together regarding educating regulatory College registrants and association members. We have done some of this with the College of Medical Radiation Technologists of Ontario (CMRTO) so it can work between bodies of a profession. CORHPA and the "Federation" can work together to formulate IPC Strategies that both groups could reinforce without stepping out of our respective mandates. Government must understand that associations drive their professions, and regulatory bodies often react to what is happening in and to the professions.

Question 6

We do not have any direct evidence, just anecdotal from Member feedback. Those Members who have raised this issue indicate that the matter has been raised, but no one appears to know the answer. There are still responsibility, and accountability issues in terms of the legislation (which is silent on it, in terms of the RHPA) and fears as to what might transpire in relations to tort law. Our assessment from Member feedback is that there needs to be a great deal of education on this issue. Our Members report that in terms of misuse and abuse, delegation and the medical directive processes and tools are problematic.

Question 7

Our answer to this question is a very strong "Yes". We qualify this by stating it needs to be "personal" professional liability insurance. Our experience is that facilities' insurance coverage may be not at all, as it is with many Independent Health Facilities (IHFs), partial in facilities or hit and miss when it comes to coverage for malpractice, criminal code violations, coroner inquests or regulatory body disciplinary hearings. We note that in the Health Force Ontario (HFO) IPC Blueprint, that in building the foundation for IPC they state what needs to happen is to "agree on terms and conditions for adequate mandatory liability insurance". We believe that for our profession it must be *mandatory personal* PLI to protect both the public in terms of costs and the practitioner who needs as much support as possible on our increasing litigious society.

Question 8

This would depend on the Scope of Practice of the profession we suggest and its potential for risk of harm. Although we are not prepared to state a dollar figure, we would suggest that it cover the following accusation categories:

- Malpractice
- Criminal Code
- Coroner Inquest.

Addendum

We see as a barrier the issue of funding. IPC will not be a success unless physicians, hospitals, IHFs and others are compensated appropriately for what they do especially as Scopes of Practice change. Proper funding of practitioners is one issue, but if funding is not accessible through the appropriate pieces of legislation for IPE then making IPC work will be extremely difficult, and since funding is a root issue, perhaps never will work as intended. Related to the funding issue is the fact that initiatives such as, the Electronic Health Record (EHR) are not part of the practice environment infrastructure and an EHR system would be an enabler of IPC.

DEVELOPING ENABLERS FOR COLLABORATION AMONG COLLEGES

General Comment

We agree that legislation and regulations should specifically encourage, require and facilitate and enable collaboration among the regulatory colleges. An issue here is that the political values and philosophies may well be a barrier to the desired outcomes of supportive, clear and concise legislation and regulations. Some of the political decisions, and processes, although well intended, are not enablers for regulatory bodies. An example is the appointment and education of the public members of Council where a College has been hampered by a lack of appointees or non-effective appointees.

Question 11

We would suggest that the politics be taken out of where a new profession should go in terms of being integrated into a existing College or having a new one established. An example for us is Medical Sonography or Ultrasound. Sonography for the most part, is a Diagnostic Imaging procedure and therapeutic sonography has an established place in radiation therapy. It makes no sense to us to have, should it occur, this professional group regulated other than with the CMRTO. At the end of the day, there are a host of efficiencies to the "system". There is nothing in the RHPA or its regulations to facilitate a situation as we just described.

That noted, we do not support any established regulatory body supporting a new regulated profession unless it will be within that established College's structure. If the government and public determine a group of practitioners needs to be regulated, then they need to assist with both the start up and establishing funding. In the end; self-regulation is the responsibility of that profession and the government.

Question 12

We are not clear on what is meant by "regulated colleges". Has this been identified through established criteria? If so, we are not aware of same.

Although when first looking at this, it sounds appealing from a cost saving and efficiency point of view. Our experience with this in the association environment has shown that it has not worked in the long term, even with the official partnership contracts / agreements.

We see any "amalgamation" as problematic, which could threaten a profession's autonomy and thus compromise "self-regulation". We made a similar comment during the Five Year Review RHPA Consultation process, which also looked at Umbrella Colleges, integrating administration, operations and logistics.

STRUCTURAL MECHANISMS

Questions 13 & 14

The OAMRT suggests that the exploration of common frameworks, structures and processes would be a worthwhile path to take. It will become much more complicated as Scopes of Practice overlap and IPC teams go about their business and an adverse event or a perceived one occurs.

There is an issue now of what should happen and how it should be handled. Presently, from our understanding, it goes to individual Colleges. The issue here is that if two or more IPC Members are involved in an adverse event concerning the same or similar competencies, they could be dealt with differently. This could be very confusing to the patient and send the public a negative signal about due process and justice of a system dedicated to patient-centered care.

In exploring a common solution in terms of complaints and disciplines, one has to remember that pending are the changes made through Bill 171 concerning complaints, discipline and QA structures and processes. In exploring a solution, it would need to be kept in mind that what must not be created is a more adversarial environment resulting in an opposite outcome of the intended one. Whatever the framework, structures and processes are such that they should be high quality and that safe patient care is enhanced, not compromised. The system should be such that it educates practitioners rather than the perception; it is there to punish them. Some of our Members look at the CMRTO as there to punish them and not to help them, which is unfortunate and not accurate in reality.

Question 15

The OAMRT does believe there needs to be better flexibility. We would suggest that legislation and / or regulations permit the exchange of information related to investigations concerning complaints. This disclosure is important to the process in terms of fairness to those involved.

Question 16

Our concern here with the example, is how that would be structured and worked in reality. It is possible this could cause disharmony, rather than be a collaborative success.

RHPA is all about self regulation and in our view the College the practitioner belongs to should be the body that handles the issue. As we noted in Question 15, the exchange of information or using a common, agreed upon, investigation may be a better route. Perhaps, as the police

have in place, a special investigation unit for complaints related to IPC team activities is a consideration.

A standardized, as far as it can go, complaints and disciplines process among the Colleges will assist in gaining public trust as well as independent investigators.

Question 17

In reviewing the literature, our belief is that the RHPA model is still world leading in terms of self-regulation. A single complaints model is setting up more bureaucracy for the patient, which could result in further delays to dispose of a complaint and thus erode public confidence.

Questions 18 to 21

As we have previously stated, the complaints should go to the individual colleges with the information that other regulated providers are involved. We suggest that in IPC team situations, that a special investigation unit investigate the complaint and where warranted, on a negative finding, the results go to the specific college of the individuals involved.

There should be full disclosure between colleges in our view.

OAMRT perceives that if our suggestion is adopted, legislative and / or regulatory change would be required.

Question 22 to 28

OAMRT notes, as it did earlier, that the term “related college” is not defined. Presently, QA Programs are different among the colleges, which would have to be resolved. The Regulations allow that flexibility, and this would be lost if “related colleges” adopt a joint QA Program.

What has to be factored in is that the QA Program is designed to foster continuing competence, but it is also to deal with a fall out of a disciplinary activity – remediation. We are not convinced that in a self-regulatory model, that IP remediation would be workable or it could be a compromise at best, which in the end, sets the system up for repeating occurrences.

In the case of similar Scopes of Practice, there are areas where “best practices” could be the same, but not in others. A profession may have a controlled act or part of a controlled act, but what they are actually doing is specific to the individual competencies of that profession or speciality / discipline within a profession. We don’t see this being done through legislation, but through institutional protocols. In our profession we observe radiologists and oncologists, as an example, who may do the same exam, but using different protocols. Trying to standardize

these among professional groups is a challenge we don't recommend, nor see being successful.

Through education and perhaps web site resource centres, best practice and protocols can be published and shared leaving practitioners to adopt what fits their institutional culture and still provides safe, high quality and efficient patient care.

The "Federation" is a good forum for colleges to use to decide on appropriate tools for practitioners to use. The recent medical directive development tools are good examples of collaborative activity in this regard.

When the RHPA was first established, it was understood that the government was responsible to educate the public, rather than the colleges taking on this role, unless significant resources were provided. Successive governments have not followed through and colleges do not have the resources. Putting the burden on the colleges would cripple the associations due to the high college fees, causing severe loss of Membership. The government should educate the public on the regulatory model and the role of the health professions. Jointly, associations, regulatory bodies and educational institutions should educate practitioners "in-training" and practising on the regulatory model and the roles of the specific profession and the other professions. Presently, this is a well identified issue – the lack of understanding of each other's roles among providers.

As the government did with nursing, monies should be provided to develop best practices for a profession. The government, in our view as the driver of IPC, should fund research into guidelines that would be useful for IPC teams of various configurations and provide a web site as a resource centre. We do not support an independent arm's-length organization to facilitate and support collaboration. This is a costly answer to a situation in terms of what we don't know; what will IPC look like and be?

The answer to the overlapping Scopes of Practice disagreement is to have Scopes of Practice that are clear, concise and unambiguous and authorized acts stated in a similar fashion. Setting up a specific body to resolve disagreements will be an unnecessary cost in our view. We await what the Implementation Plan of the related to HFOs IPC Blueprint before further commenting.

Questions 29 – 32

OAMRT is of the mindset that although the Minister has wide ranging powers, that they should not be used unless it is highly evident that patient safety and quality are an issue or the sustainability of the health-care system is compromised.

We believe the Minister's role is to provide leadership vs. dictatorship and thus using his / her vision and guidance to have us buy in as to what needs to be done.

Such initiatives such as the IPC Blueprint, the Allied Health Professional Development Fund and so on become influencers to both colleges and associations to follow positive paths to deliver effective and efficient patient-centered care.

We do support a report card from the Federation regarding IPC, which would go to the Minister and subsequently to the public. The IPC initiative must be transparent to the public. Individual colleges could produce an annual report laying out courses of action taken and what happened along that course in terms of successes, set backs, barriers and lessons learned, which would be published on their web sites.

We would suggest that there are areas (Question 32) where common policies, procedures and guidelines could be established among the colleges. These could include:

- Advertising
- Annual Reporting / Report Card
- Conflict of Interest Guidelines
- Privacy Guidelines
- Record Keeping
- Exchange of data.

Question 33

OAMRT has often wondered whether there is a model, which could be adopted in terms of describing and laying out standards of practice. They vary from college to college and must be confusing to a Member of the public when looking up and comparing, and they will if an IPC team is involved.

We would need to see researched evidence in terms of common standards of practice and professional practice guidelines for an entire group of professions or among colleges. As we noted earlier, practice guidelines are individual and institutional specific in many cases and should be an IPC team decision based on the patient care they are delivering.

Question 34 and 35

The proposed list is consistent with what OAMRT supported at the October 2007 association workshop, should it fall out as suggested.

It is our suggestion that the “Federation” can develop templates and the tools whether as a group or such groups with representatives of the Ministry and the associations involved. In order to do that, specific funding should be targeted to do this as well as funding to educate practitioners to the associations and to the colleges. The HFO IPC Implementation Plan, we suggest, should in fact be looking at the facilitation, education, tools and templates among other bridging mechanisms and processes.

COLLEGE AUTONOMY, AUTHORITY AND ACCOUNTABILITY

General Comment

One of the issues that OAMRT sees is the fact that there is a plethora of legislation and regulations that pertain to the health-care "system" and practitioners. They include the Public Hospitals Act, the Independent Health Facilities Act, consent and capacity legislation, and so on. There are numerous authorities, responsibilities and accountabilities galore, some of which are conflicting and there are identified gaps. They are all barriers to some degree, enablers in some cases. In any regard, there needs to be a reconciliation of all "related" legislation we suggest to define barriers, enablers and gaps related to IPC's successful implementation.

Question 36

OAMRT does not believe that professional practice guidelines should be legally enforceable. The term "guideline" means just that; it is a tool to guide practitioners. Practice is a moving target and thus guidelines will change. In our profession it would be extremely difficult to enforce this. We could support standards of practice being legally enforceable depending on what is accepted as a definition. It is not defined in Section 1 of RHPA, nor in Schedule 2 of the Act, The Health Professions Procedure Code. Schedule 2 only states under Article 3. (1), 3 that they are "To develop, establish, and maintain programs and standards of practice to assure quality of the practice of the profession". The enforcement comes under the Complaints, Discipline and QA processes where the practitioner is judged on a standard in a self-regulated environment. The patient, if not satisfied, can still utilize the court system.

Question 38 and 39

We would suggest that the philosophy of the RHPA be upheld; the practitioner and the employer are accountable. We feel that the present college framework under RHPA is more than adequate to hold the practitioner accountable. The weakness, as we see it, rests in the employer domain in terms of accountability. They would rather fire a practitioner, rather than going through due process as recent situations with some of our Members has revealed. The RHPA needs to be strengthened to ensure employer responsibility, accountability, fairness and transparency.

INTERPROFESSIONAL CARE AT THE CLINICAL LEVEL

General Comment

IPC can only be successful at the workplace and involves team dynamics, interpersonal communication skills, writing skills, intercultural communication skills and problem solving and critical thinking skills. This can't be legislated, it is an education issue and a leadership issue. Clarify roles, eliminate barriers and clarify legislation.

Question 40 to 43

OAMRT believes that as IPC is a primary goal of government and thus a driver concerning the delivery of health- care changes to the RHPA are not needed. Focussed funding to encourage or reward IPC initiatives in relation to the strategic paths and tactics that result from the IPC Blueprint Implementation Plan will have far more success than regulating the colleges' environments to make them collaborate.

We suggest that what needs to be done is perhaps put in place mechanisms to have the Federation identify where the highest gains would be in facilitating IPC and be awarded subsequently with specific targeted funding to action identified "wins".

We also suggest that perhaps in the accountability agreements within LHINs that facilities are required to show gains related to IPC to part of their funding. Further, facilities need to be held accountable in terms of their working environment related to working conditions, ethics, and management, which has been a recent focus of the Canadian college of Health Service Executives. If the working environment is bad, IPC will fail.

OAMRT suggests, as it has earlier, that the RHPA Model is still world leading and should not adopt the New Zealand Model (Question 42). To us it is an ethical expectation that health-care providers should and must cooperate with and among each other to ensure quality and continuity of services. It is a sad day if this has to be legislated, as it means the education system has failed and so has effective leadership at many levels.

CONCLUSION

In addressing the IPC issue related to regulatory colleges and its registrants, IPC has to be clearly defined and the definition bought into. Presently, IPC is being interpreted in different ways as to what it entails as the Canadian Health Research Foundation succinctly notes. Further, the plan that the Health Force Ontario Blueprint's implementation team has adopted by the Minister down the road is a big factor, in our view, as to how IPC will proceed and this could impact on a variety of legislative and regulatory pieces, governance and management at the delivery end and thus influence what regulatory colleges can do strategically and operationally.

The RHPA Model works well overall. It would seem to us that regulatory colleges could work together more using the Federation mechanism that introducing enabling legislation. Clarifying roles, Scopes of Practice, educating practitioners and the public on roles would be more productive and cost effective in the end.

There is an issue, in our view, that IPC includes both regulated and non-regulated providers. Specific, restructuring legislation related to regulatory colleges would not foster the building of an IPC team containing non-regulated Members such as Physician Assistants (PAs) alongside a Radiological Technologist CT expert and an RN, for example.

Harmonizing the various legislative documents, we believe, would have a greater synergistic effect than making the RHPA more cumbersome and restrictive.

Education, both undergraduate and post graduate, combined with effective leadership is a key strategy in our view and resources should be focused on this and provided to associations, educational facilities and to some extent the regulatory bodies, consistent with their mandate. Education and effective leadership will build trust. Using effective IPC Models and providing resources, such as through a web site resource centre, will help facilitate the learning. Administrations, owners, managers, unions, associations, regulatory bodies, and last but not least, the government needs to exercise strong leadership.

Lastly, funding is a key factor for without it, all will fail. Whether this is proper compensation for all, not just physicians, whose work needs to be adequately paid for; whether it is educational funding for educational institutions, facilities or direct to practitioners; whether it is for tools to enhance IPC such as a comprehensive electronic record system and tele-consulting system; funding is the key factor.