

# 5 YEAR HPRAC REVIEW SUBMISSION - WEIGHING THE BALANCE

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## APPRECIATION

The Board of Directors of the Ontario Association of Medical Radiation Technologists (OAMRT) appreciates the opportunity to comment on the document "*Weighing the Balance*".

Consultation opportunities are very important to the OAMRT and to the people of Ontario. The fact that our viewpoints and those of others are received and distributed adds to the understanding of issues, the communication process and the ultimate effectiveness and efficiency of the health care system. The fact that the Council has emphasized this is appreciated.

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President, OAMRT

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### **THE ONTARIO ASSOCIATION OF MEDICAL RADIATION TECHNOLOGISTS (OAMRT)**

The OAMRT is a voluntary association representing approximately 4,000 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 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 nine Board of Directors with 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 communication flows from the grass roots up and from the decision makers down and laterally to the various volunteers and leaders of the Association.

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 are of primary concern to the Association in meeting its Mission and Vision.

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### EXECUTIVE SUMMARY

#### General Remarks

The RHPA took ten (10) years to come into effect and certainly was ground breaking legislation. It promised to be effective, efficient, flexible and fair and provide a more level playing field amongst health professional groups. Its purpose

was to strike a new balance as well as providing a common framework for health profession governance and settle issues arising from the aftermath of the Health Disciplines Act (HDA).

The public wanted a more open, responsive and accountable regulatory system, especially in relation to complaint investigation and the discipline process. The public often felt that health professionals, particularly those governed by the HDA were more interested in protecting themselves, rather than providing justice to the complainant.

Employers had expressed frustration with the restrictions the old system placed on their ability to utilize health care providers efficiently.

The RHPA was designed to address the issues in the preceding paragraphs and advance the public's interest. In advancing the public interest, the RHPA is supposed to:

- Protect the public, to the extent possible, from unqualified, incompetent and unfit health care providers
- Provide mechanisms to encourage the provisions of high quality care
- Permit the public to exercise freedom of choice of health care providers within a range of safe options.

In the view of the OAMRT, the RHPA has generally achieved its aims. As with anything, the legislation is not perfect because of unforeseen events and compromises made during its formation. It does contain imbalances and there are areas for improvement which are described, in the main part of the submission.

#### Effectiveness

The legislation does provide an effective framework to protect the public from unqualified, incompetent and unfit health care professionals. The nature of the legislation does not protect the public from health care providers who may be able to cause serious harm. In this regard, it is important that there continues to be a mechanism where these groups are identified and brought into the RHPA.

The Scope of Practice area is problematic. It is not defined in the legislation. It means different things to different groups. It is an area which the OAMRT believes must be reviewed in terms of

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clarifying the definition and therefore its application.

In order to provide the public protection from harm, the OAMRT believes that, as previously noted, other provider groups should be brought into the RHPA using risk of harm as the primary criteria.

The present mechanisms provided to regulatory colleges concerning protection from harm are adequate in our view. How the regulatory colleges work within those guidelines is important and where possible, standardization across the regulatory colleges should be enshrined in regulations.

A weakness of the implementation of the RHPA is public awareness. Past Governments did not follow through on their promise to market the RHPA. The lack of marketing has impacted, we believe, on the public's understanding of their rights, choice and how to address their issues with a minimum of frustrating bureaucracy. It has also impacted on health professionals who have had difficulty understanding the difference between the regulated colleges and the professional associations.

The term "harm" is ambiguous and needs to be defined in order to provide better guidance to the public and decision makers.

The Controlled Act and Authorized Act system are perceived to be the meat of practice determination far more so than the scope of practice statement. We have no particular concerns in this area. There are some issues in terms of ease of understanding the concept both for the public and practitioners, the exclusion of ionizing radiation and that the list may be too restrictive.

In terms of delegation, only controlled acts or elements of them that are delegated to health professionals and not to unregulated health professionals are consistent with the objective of protecting the public from harm.

Personal Professional Liability Insurance should be carried by all health professionals and this should be mandated. The provision of the insurance should be provided by the associations and not the regulated colleges who would be, in a conflict of interest situation.

The issue of providing high quality care is an interesting one. The RHPA provides the framework to do this effectively. There are problems in how that requirement is interpreted and subsequently addressed by regulatory colleges. It is a mosaic of different programs, some more burdensome than others, some more effective than others. The downsizing of the health care system and the multitude of changes have not made the assurance of quality an easy job for anyone. Despite good intents, the legislation probably does not protect the public from harm as quality of the delivery of health care suffers. The result is a lack of effectiveness of the RHPA.

The Patient Relations Committee's only mandate is focused on sexual abuse. There are other areas of "patient relations" that should be addressed and are not. This Committee needs an expanded mandate which would make the RHPA more effective.

The requirement for mandatory reporting of sexual abuse may be one of the least effective areas.

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The psychological issues surrounding this requirement, have made this provision relatively ineffective.

The OAMRT could assist the effectiveness of the RHPA if we knew more about what was happening within the regulatory colleges. Further, more detailed information on the nature of complaints and the disposition of them is needed. The regulatory colleges are for the most part, secretive. Certainly information provided to the public who attend Council meetings is virtually nonexistent in our experience. In effect, it is a waste of time to attend. It would be prudent to educate Association Members on areas of practice which seem to be prone to complaints being filed and what the college findings are so we can prevent reoccurrence. This information is very difficult to get.

Employers, to make RHPA more effective, should be required to ensure competency of their health professional employees through effective orientation programs, retraining and continuing education (CE). This is a weakness in the Q.A. Program.

The regulatory colleges have too much to deal with without getting involved with producing approving, disapproving CE Programs. They would be more effective if this was left to the associations.

We believe effectiveness would be enhanced if there were a member from the professional association, appointed by the association's Board of Directors, on Council. This person would sit as an ex-officio member. This would provide a more accurate and a global view of what is really happening in the profession's domain.

### **Efficiency**

The regulatory colleges are not as efficient as they could be.

We have perceived areas where economics of scale could be made. Certainly the sharing of resources amongst the regulatory colleges should be explored.

The problem we have identified is one of accountability. There is no accountability to those who fund the regulatory body.

We do not suggest nor support a merger of the colleges. In our view, such a move would undermine the purpose and spirit of the RHPA.

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### **Fairness**

The sexual abuse provisions appear to be the most unfair component of the RHPA.

This addition to the legislation centers out health care professionals rather than addressing this societal problem. Our stand was and still is that the provisions need to be stand-alone legislation with references to the management of sexual abuse toward patients/clients in the RHPA so regulatory colleges know they must address it.

### **Flexibility**

The legislation appears to be flexible enough to allow for changes. The issue is response to those changes which is also an efficiency issue.

The wheels of bureaucracy are still slow. Changes to the RHPA despite the hype of being “living legislation” is half dead when it comes to making necessary changes. The system needs to be more responsive to fast pace changes of practice and policy decisions.

### **Summary of Recommendations**

The OAMRT recommends that:

- 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

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- An ADR mechanism be incorporated into the Regulations
- A clause be put into the RHPA concerning employer responsibility in assuring competency of their employees
- 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.
- 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.
- Compromise the health professionals' standards of practice.

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### INTRODUCTION

Our submission does not follow the format as outlined in *“Weighing the Balance”* in terms of responding to each of the questions posed. We trust that this will not inconvenience the members of the Council in any way.

The submission does address the issues by the Section theme *“Weighing the Balance”* has incorporated. Wherever possible, we have answered the issues in a variety of ways to provide our viewpoints on and insight into the Regulated Health Professions Act (RHPA).

In preparing our submission, we have consulted with other associations whose members are regulated under the RHPA. Issues concerning the RHPA have always been included in our joint Executive meetings with the College of Medical Radiation Technologists of Ontario (CMRTO) and those experiences have also been interwoven into the submission.

We too are of the mind set that the RHPA needs to be responsive, balanced, timely, flexible, efficient, effective, but fair.

Two major areas of interest to the OAMRT are the sexual abuse provisions of the legislation and the issue of non-regulated health providers. These are addressed in the submission as we believe they impact on the “balance” within health care and its future.

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### PROTECTION FROM HARM

#### General Comments

The OAMRT realizes that the main purpose of the RHPA is to protect the public from harm. We have no argument with this and fully support that goal.

The RHPA, in our view, becomes more important as inter-Provincial trade initiatives advance and the lines of practice continue to blur because of cross-training pressures from employers and health care provider groups.

There is a perception, however, that the RHPA has put the spotlight on health care professionals in terms of accountability while non professional health care providers lack accountability. The arguments being presented include the fact that non-regulated health care providers make mistakes too. Further, their mistakes can also have serious consequences. This perception held by some of our members is that an imbalance in terms of accountability now exists because of the RHPA.

The majority of our Members believe, however, that the RHPA has provided an important means to protect the public from harm and the high cost of doing so is worth it.

The OAMRT recognizes the fact that the RHPA provides an opportunity for those health care occupations that want to be or need to be regulated, can be. This is a major improvement on the old Health Disciplines Act.

As described in the Health Professions Legislation Review<sup>1</sup> the nature and quality of health care services needed to be regulated through advancing the public interest. The Review's recommendations are aimed at advancing the public interest in four ways; they being:

1. Protecting the public, to the extent possible, from unqualified, incompetent and unfit health care providers.
2. Developing mechanisms to encourage the provision of high quality care.
3. Permitting the public to exercise freedom of choice of a health care provider within a range of safe options.
4. Promoting evolution in the roles played by individual professions and flexibility in how individual professions can be utilized, so that health services are delivered with maximum

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<sup>1</sup>Striking a New Balance: A Blueprint for the Regulation of Ontario's Health Professions, A.M. Schwartz, 1989

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efficiency.<sup>2</sup>

The Review also made recommendations on the legal and procedural provisions, scope of practice and professional titles, for the main.

The OAMRT's submission will address areas of interest to our profession in terms of the original recommendations and the resultant outcome - the RHPA.

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<sup>2</sup>Ibid, page 2

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### SCOPE OF PRACTICE

We make an observation to the Council concerning the scope of practice.

In discussions with other associations, there are mixed views as to what a scope of practice is and the value of those that various professions have in terms of effectiveness.

The recommendations of the Health Professions Legislation Review (HPLR) describes the scope of practice in general terms as areas of permitted practice. It then goes on to describe it as a “system”.<sup>3</sup> The system has three (3) elements; they being:

1. Every Professional Act contains a general statement describing, but not licensing, the professions’ scope of practice. In most cases the general statement describes the profession’s current scope of practice.
2. All potentially harmful acts and procedures are licensed. Licensed acts may be performed only by qualified health professionals authorized by their Professional Act to perform.
3. The Health Professions Procedural Code makes it an offense to treat, offer to treat, or advise in respect of any human health condition in circumstances in which the treatment, offer of treatment or advice (or any omission from them) may result in harm. An exception is granted to health professional acting within their scope of practice.

There is no definition in the RHPA concerning scope of practice or within the individual health profession Act.

“*Weighing the Balance*” states it as “a description of the profession’s activities and controlled acts that its members are permitted to perform”. The HPLR Review document again describes it as a general statement providing three (3) types of information about the profession: what the profession does; the methods it uses; the purpose for which it does it.

In the Act for our profession, it is a general statement. The authorized acts are listed as a separate item or clause within the Act.<sup>4</sup>

A definition in the RHPA for scope of practice would provide a reference, and a standard for those who are regulated and who may seek regulation. It would also clarify exactly what is meant by the term.

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<sup>3</sup>Ibid, pages 3 and 4.

<sup>4</sup>Medical Radiation Technology Act, 1991, clause 3 and 4.

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We recommend the following:

**That a definition for “Scope of Practice” be included in the RHPA.**

As a general statement, the OAMRT believes the scope of practice statement in the Medical Radiation Technology Act (MRTA) provides the desired information at this time. As it stands, it does not guide educators in terms of designing and updating curricula as it is too general in nature.

We further believe that due to the evolution of our profession and of others, the ability to revise a profession’s scope of practice to reflect the realities of the practice should be relatively simple and free of excessive red tape.

### **Number of Professions**

It is interesting that in the initial studies of the HPLR team that over seventy-five (75) health provider groups sought regulation. It was the criteria of self regulation that weeded out provider groups leaving those who are now incorporated into the RHPA.

The HPLR process was not flawless. Some groups who presented a risk of harm were excluded because they asked to be. Often that was due to the lack of desire or ability to pay. Some groups were excluded because of a lack of vision as to where the provider group was heading concerning their evolution and their potential for risk of harm.

To be honest, the process at times appeared to be more of an economic exercise rather than one of quality of health care delivery and patient care. In this regard, decisions made to exclude some health care provider groups has resulted in extra costs to the health care system and the tax payer as groups seek to be self regulated or expand their scope of practice. Balancing the books is perceived as a motive for the RHPA. Further, decisions made probably excluded groups that should have been regulated.

The RHPA should have incorporated more health care provider groups to meet the main directive of protecting the public interest and protecting the public from harm. A better balance would exist now in terms of protection, quality of care and freedom of choice if more health care providers were included under the RHPA.

### **General Provisions of RHPA**

In our view, there are adequate mechanisms that provide the regulatory colleges to ensure protection form harm.

How these tools are interpreted is often different and is therefore probably, the more appropriate issue. This matter is dealt with in other parts of the submission. Suffice to say there is an imbalance in the RHPA system.

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It is important that regulatory college ByLaws allow for the various tools to be added that would enhance the public's interest but also the regulatory college registrants interest or risk of harm. One of these tools is the Alternate Dispute Mechanism (ADR) which will be dealt with later.

From our viewing point and in terms of our regulatory college, the College of Medical Radiation Technologists of Ontario (CMRTO), there are not intentional barriers in terms of protecting the client/patient/public from harm. If anything, the barrier that exists out there is one of ignorance. The CMRTO works hard in trying to meet its mandate.

The public, as a whole, is not that well informed about RHPA, the individual professions, the professions' regulatory college, or what the process is if they wish to explore the practice of a health care professional from whom they have received treatment from.

The Provincial Government has not addressed the public education issue as it promised it would (first the Liberals then the NDP). The Government did an excellent job on the Consent to Treatment Act and the Substitution Decisions Act and then the Health Care Consent Act. The public received all kinds of relevant, informative and interesting information on these. This was not the case with the RHPA.

We believe the present Government should honour the pledges of the two former Governments and educate the public in the RHPA and what it means or should mean to them. We recommend that:

**The Government provide all members of the public with relevant information on the RHPA.**

### **Concept of Harm**

The concept of harm is not well defined in the RHPA or its subordinate Acts.

The term "harm" does have different meanings within RHPA and with different health care professionals and providers.

The HPLR recommendations included a definition of "harm" which stated that harm included any or increased physical or mental disease, disorder, dysfunction, injury or pain and death or earlier death.<sup>5</sup>

In the RHPA, article 3001, it refers to physical harm. There is no definition provided, as previously noted.

The RHPA does deal with harm in a variety of indirect ways. It deals with it from both a medical and

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<sup>5</sup>Striking a New Balance: A Blueprint for the Regulation of Ontario's Health Profession, A.M. Schwartz, 1989, page 112, clause 27.04

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sexual abuse perspective. This promotes ambiguity.

The fact that there is no definition in the legislation means that it makes it more difficult for regulatory college discipline committees to be consistent and/or arrive at a fair decision. It also means that it could go to the courts to decide which would burden everyone concerned.

There are, of course, pros and cons, in terms of defining “harm”. Defining the term may cause even more problems with flexibility for complaints and discipline committees being restricted in terms of the decision making process. On the pro side, is the fact that there is no standard for making appropriate decisions, defining “harm” will provide direction.

We have not heard of any particular concerns with the term “harm” and its concept. Perhaps though, consideration should be given in terms of providing guidance to regulatory colleges by the Minister.

### **Controlled Acts**

We understand this is the second element of the regulatory model with the Scope of Practice Statement being the first element.

The HPLR team recognized that the list of controlled acts may have omissions and that evolution in medical practice could require an expansion of the listing. They concluded, however, that the controlled act list captured every potentially hazardous health care activity.

We suggest that the recommendations and observations of the review team were basically sound. That being said, logic dictates that the list cannot and does not present an all inclusive catalogue of procedures that have or have the potential of being ones of high risk or having elements of high risk.

The fact that the controlled act listing is not all inclusive is not of major concern to us. The RHPA allows for the amending of the list. However, it is important that the amending process be timely and free from unnecessary restrictions.

At this time, we are not convinced that the amending process is such that it is a timely one in terms of getting an amendment approved from the point of submission. The impact of a sluggish bureaucratic process reduces the effectiveness and efficiency of the health care system. It also runs counter to one of the purposes of the RHPA.

As was noted earlier, the listing of controlled acts is not of major concern to us. We do have some issues around them that are described in the subsequent paragraphs.

The fact that ionizing radiation is not listed as a controlled act presents a problem. We understand that the fact it is not listed as a controlled act is because it is covered under the Healing Arts Radiation Protection (H.A.R.P) Act. We had asked the review team to make a reference in the RHPA to the effect that ionizing radiation for medical purposes be noted in the Act in some manner.

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It would have served as a cross-reference and as an educational tool that the H.A.R.P. existed. The fact that some health care provider groups, in our experience, still do not recognize the impacts of H.A.R.P. adds to the belief that clarification needs to go into the RHPA. We recommend that:

**A clause be put into the RHPA noting that the use of ionizing radiation is an exception or some suitable clause noting that prescribing ionizing radiation presents a serious risk of harm so it is addressed in the RHPA, or words to that effect.**

For some members of our professions the concepts of authorized and delegated acts have not been easy to understand. From the evidence we have received from the "field" we would venture to say we are not alone in this regard.

Other health professions and employers are having problems with comprehending the impact of these terms as well. The CMRTO also has had the matter of authorized and delegated acts on their agenda frequently as our Members seek advice and direction from them.

There is still evidence of situations where Medical Radiation Technologists (MRTs) are doing procedures that they were doing before RHPA. MRTs believe they can still perform them because of confusion and ignorance of those supervising/managing them and their own lack of knowledge and familiarity between the two terms.

The pressure from employers to have individuals cross train to save money rather than have other specialized providers provide the service has added to the problem. These same employers are also trying to save money by having non regulated employees perform controlled acts or parts thereof. This is all undermining the RHPA in terms of protection from harm.

From the feedback from Members<sup>6</sup> we have had over the years, there is confusion and a lack of control in some sectors on what is delegated, how often it is being delegated and to whom. As an organization, it is impossible to provide the exact statistics of what our Members have been delegated officially or unofficially despite our attempts to do so.<sup>7,8</sup> This raises the specter of "risk of harm" in our view.

We believe that the RHPA does not assure protection in regard to the responsibilities of the delegator and employers concerning the training and competency of individuals, controlled acts or elements of controlled acts that are delegated.

The most important issue for us is the delegation of a controlled act or part thereof to non-regulated

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<sup>6</sup>OAMRT Annual Membership Surveys, 1996, 1997, 1998

<sup>7</sup>OAMRT Annual Membership Survey, 1999

<sup>8</sup>Discussions with the Ontario Radiology Managers Association, 1998.

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health care providers. To us this undermines the purpose of the RHPA and is economically driven more than providing quality service. It would be better, in our view, to include more health care provider occupations under the RHPA. The present system, we believe, provides a loophole for those who are motivated in terms of saving money to have procedures performed by non-professionals. To the OAMRT, this is not safeguarding the principle of protection from harm. We recommend the following:

- **That 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.**

An area of delegation which should be noted is that of professional liability. This is not well addressed in the RHPA and in our view needs to be.

We believe that mandatory liability, legal defense and sexual misconduct insurance should be required of all health care professionals.

It is our view that the requirement must be in the regulatory college ByLaw since they have the authority to do this.<sup>9</sup> The best situation would be to have it included in the Regulations.

We would suggest that although the regulatory college should require it, they should not provide it. There is a perceived conflict of interest in terms of the college being the agency of which a registrant obtains their professional liability insurance (PLI). The perception is one in which it is seen that the regulatory college would control the monies particularly concerning a possible finding of guilt or in the adjudicating a case in terms of the disbursement of awards. This would impact negatively on the prevention of mental and social harm.

Insurance coverage should be provided by the associations representing the regulated health professions' registrants.

### **Title Protection**

Title protection was a hot issue in the deliberations of the process leading to the RHPA. From our experience, it still is with many of our colleagues.

From an OAMRT membership point of view, it is not much of an issue. Members have accepted

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<sup>9</sup>RHPA, Chapter 18, Schedule 2, Sec. 94(1)(q), pages 52 and 53 and Schedule G, Sec. 94 1(y).

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it well for the most part. There is some confusion about the use of it versus the association's designation which is a national certification one, in terms of Certification.

In our experience with the public, we find that the public still are not well informed or knowledgeable to understand the differences between regulated and unregulated health care providers. The lack of a public information campaign concerning the RHPA, as we noted earlier in this submission, has probably contributed to this situation. Another factor, in our view, is that the regulated college's patient relations program focuses solely on sexual abuse so matters like title protection are not addressed in terms of public education. The public still thinks that female MRTs are nurses and male MRTs are doctors.

Therefore the OAMRT has concluded that the title protection clause has not achieved its purpose.

#### **Patient Relations Committee**

We have concerns relating to the name and scope of this standing committee.

We would suggest that with the focus it has within the RHPA that it is misnamed. It should be called the Sexual Abuse Committee.

We would suggest that there is more to patient relations than sexual abuse. There are other areas other than sexual abuse where patient relations initiatives help to prevent risk of harm.

One of the areas we have already mentioned is the title protection area. Both regulatory college registrants and the public require education in this area as well as guidelines.

From the OAMRT perspective, there are numerous areas concerning registrant education in terms of image, education, conduct, etc. to serve the public interest that should be incorporated into the patient relations program. We recommend that:

**The Patient Relations Committee's mandate to be expanded to include other areas of patient relations other than just sexual abuse.**

#### **Mandatory Reporting of Sexual Abuse**

The only comment the OAMRT has here is we wonder how well this really works. The provision is important but the realities are probably undermining this provision to some extent.

We can report that from feedback we have received, there is a real reluctance to do this despite the threat of fines and potential misconduct changes. The reluctance is from fear. The fear is perceived and also real in terms of being labeled, the social stigma of reporting someone, and all the usual and documented reasons of not wanting to.

Another factor is that the rules do not apply equally in the health care system. Unregulated health care providers are not subject to mandatory reporting but health professionals are. This imbalance,

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we surmise, has also impacted on situations where mandatory reporting may have been in order.

### Complaints and Discipline

The problem in discussing this subject area is that the OAMRT is basically in the dark as to the nature and number of complaints our regulatory college deals with and what goes to the Discipline Committee. The process, in fact, concerning informing the public of a Discipline Hearing is not adequate, in our view.

From a protection from harm perspective, we would like to know the details of complaints so we can devise education programs that address the common areas of patients' complaints. Similarly, we would like to know the details of Discipline hearings so we can educate our Members or produce best practice protocols and risk management guidelines for our Members. This in turn would reduce the potential of harm to patients/clients.

We find the notice of Discipline hearings inadequate. We do not receive the publication(s) where it is announced and this is the case with many of our Members. We recommend that:

- **Colleges provide their affiliated association(s) with advance notices of all Discipline Hearings so representatives from the association can attend those that are open to the public.**
- **Colleges use their web site to post notice of Discipline Hearings.**

Due to the fact we are not in the loop, so to say, as to what comes in and what goes to Discipline, it is difficult to comment on. We do believe that the CMRTO does its best to expedite the process and reduce barriers to patients/clients seeking satisfaction. Only patient/client complaints concerning the CMRTO's handling and complaints process, can really shed light on this matter. That being noted, we are concerned that the investigation process be done only by trained and certified investigators who are at arms length to the regulatory college concerned. We are not sure this is the case. This is an issue of fairness.

We would support any process that allows a complaint to be settled quickly and fairly. Such a process may well include an alternate dispute mechanism (ADR). Further, a time limit for filing a complaint should be expressly set out in the Act as it is in the Human Rights Code.

We suggest that mediation would be a viable component in the complaints process. It has the potential of a win/win scenario for all concerned. As the literature suggests, it can be a useful tool for some sexual abuse cases where harassment is an issue. We believe that the empowerment that mediation brings through an ADR mechanism brings responsibility to the parties to solve the problem in such a way that they are committed to making the outcome work. It is also less adversarial than the present process regulated colleges use.

If done properly, mediation can provide enhanced privacy for those involved, takes less time than

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the present process and can cost less in terms of time, staff, legal fees and other costs.

We believe that mediation should be available and offered to a complainant. If they choose not to take that route after careful explanation of the various mechanisms to address their concern then fine, the present system pertains.

We would suggest that specific criteria be adopted as to when mediation is not appropriate and this be standard across all regulatory colleges.

We realize that providing a mediation mechanism means that there are burdens placed on the regulatory colleges in terms of obtaining qualified mediators whether internal or external, educating registrants and the public. It means time, we realize, to ensure solid preparation for the process so the chances of a satisfactory outcome are enhanced and staff time.

It may well be that internal mediators for most colleges is cost prohibitive. Certainly the stress on registrants in terms of registration fees is high enough as it is. The fact that over 90% of a regulated college's income is from registration fees raising them to accommodate internal mediators will not be popular with most professions.

Internal mediation raises the concern over conflict of interest. Outside mediation is generally regarded as being neutral.

The use of external mediation raises the issue of how many trained mediators exist and their availability. It would not serve the purpose of expediting a patient's concern if finding a qualified mediator prolongs what should be faster outcome.

Incorporating an ADR mechanism is perceived as reducing protection from harm. We therefore recommend that:

- **It should be included in the Regulations with the principles defined including when it should not be used so all regulatory colleges are working from the same criteria.**
- **It is voluntary**
- **Independent qualified mediators be used.**

The OAMRT does not believe that what a "complaint" is or isn't should be defined. All complaints should be accepted as valid as no doubt they are to the person who makes it. The processes now in place and the addition of the ADR mechanism allows for, and would allow for, complaints to be analyzed and dealt with appropriately. We will submit, however, that there needs to be consistency among the colleges as to how they assess and dispose of complaints, especially frivolous ones.

The OAMRT would suggest, as well, that proper education of the public would also help in terms of providing the public of what is and what isn't a legitimate complaint. As we noted earlier in the

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submission under “title protection”, the public is still very ignorant of who does what, who can do what and what the practice standards are for each profession. Sad to say that this ignorance extends into the health profession sector itself where one health provider group doesn’t know much at all about another health provider group. Education all around is weak concerning reasonable expectations which impacts on the complaint and discipline process. What could be reasonable practice to the profession could be perceived as malpractice by an outsider.

The issue of sexual abuse is a big one in our view. If there is a major imbalance in the RHPA it is in the area of sexual abuse provisions. In terms of relating it to protection from harm, it is important that the RHPA addresses it. How the RHPA addresses it is a problem and one which was well presented when Bill 100 was being considered. Our submission will deal with the sexual abuse provision later in this document. Suffice to say that it centers out health care professionals solely and is weighted towards the accuser rather than taking a balanced approach. Sexual abuse is a societal problem “according to Governments” not just a regulated health profession’s issue.

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### QUALITY OF CARE

#### General Comments

The OAMRT has been an advocate of Total Quality Management (TQM) and Continuous Quality Improvement (CQI) for some years now.

Long before the CMRTO came into existence, we had a voluntary "QA Program". We called it the Professional Activities Record (PAR) Program. We also had developed a Peer Review Program in case it should be needed. We had anticipated in 1981 that the day would come when these programs might become mandatory.

We were disappointed that the CMRTO did not adopt our PAR Program which was highly developed. That being stated, the present CMRTO Program as it stands is accommodating and the requirement of obtaining twenty-five hours is not that difficult for our Members.

The area of concerns our Members have expressed, other than the initial reaction of fear of change, is the documentation process. They find it burdensome.

The other area which we feel needs addressing is the assurance of clinical competence and a requirement of employers to ensure an employee is competent. There is an issue of protection of harm here as well as the quality of care.

It is our observation that QA Programs vary as to their structure and purpose depending on the regulatory college. The RHPA does not put any limitations of the QA requirements that regulatory colleges may implement.

The CMRTO did go through a process using focus groups of MRTs to come up with the present program. We commend them on this as the RHPA does not require input from the associations, non OAMRT MRTS, nor the public in general. The CMRTO did consult widely concerning their Q.A. Program. We would suggest that perhaps there should be a requirement for such input as philosophies of College Councils could change as personnel change.

With the time and resources available, our assessment is that the CMRTO has done a good job in addressing the quality of care provisions. We cannot comment on other regulatory colleges.

The CMRTO has done a good job but needs to do more in terms of addressing the assessment of clinical competence. Clinical competence is an essential element concerning performance of the professional and improving patient/client outcomes.

There is no effective retraining program offered by the CMRTO. This is not that the CMRTO isn't aware and concerned about it but it hasn't been able to accomplish this. Partnerships with us and educational institutes that provide undergraduate training are required. The fact that re-training opportunities are limited for those who have not practiced for five (5) years or more presents a barrier for those who want to return to the work place. This could present a problem as shortages

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of MRTs looms larger. As a result, quality of care suffers.

A bigger deficiency from our perspective is the lack of requiring proof of clinical competency when someone is off work for some time within the five (5) year time limit such as in WSIB leave or has been doing a particular task for sometime and is moved into another by the employer.

There are no requirements or guidelines in the CMRTO's QA Program that we are aware of to address the situation in the proceeding paragraph.

There is no requirement of the employer to ensure competence in such situations as calls to us from managers and staff MRTs have illustrated. The employer often assumes because you have the protected title behind your name, that you are competent in everything. This is not the case especially in a highly specialized profession such as ours where there are four (4) professions within the umbrella profession of Medical Radiation Technology and each of which has a multitude of specialties. There needs to be a provision in the RHPA that compels employers to provide the ways and means for health professionals to regain their competency in areas where skills have eroded or have gone below the standard.

There is a responsibility for employers to report incompetent health professionals but none to provide the ways and means of maintaining competency. We would suggest that there is an implied responsibility, of employers in partnership with regulatory colleges, to maintain and improve the competence of their staff to improve patient outcomes. We recommend that:

- **A clause is put into the RHPA concerning the employers responsibility, in partnership with the regulatory colleges, to assure competency of health professions.**
- **Regulatory Colleges provide guidelines that address the clinical competency requirements as part of the Q.A. Program.**

The importance of assessing clinical competency has already been noted. For our profession this has been an area of weakness. The present Q.A. Program, as it stands, allows for didactic continuing education. There is no provision, in terms of measuring clinical competency, in the CMRTO's Q.A. program. This is a shortcoming as previously noted. What model would be best, we are not sure. Certainly a model to consider is the CMA's Conjoint on Accreditation's process. This could be adapted in terms of clinical assessment. The model has both physicians and, in our case, MRTs on the assessment team. This is a model to consider. If straight peer review is considered, we would suggest that the individuals would be exemplary MRTs who would be on a list co-developed and approved by both the regulatory college and the association. In our case, we need experts in particular areas of practice because of the specialization that exists. Further, conflict of interest would be an important factor especially as the numbers of our profession are such that there could be personal connections involved.

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### Standards of Practice

We would not support Standards of Practice being incorporated into the Act. Standards of Practice are occupationally specific. Having them in the Act would be a barrier to the tailoring to each health profession and trying to get them changed would present, in our view, major problems. The evolutionary process is so fast these days. The present approval systems are not responsive to the pace that is being set.

### Continuing Education

It is the position of the OAMRT that in terms of providing continuing education to registrants, regulatory colleges should leave this to the associations and educational facilities to do.

Other continuing education (CE) initiatives should be focused on patients/clients/public and be a responsibility of the Patient Relations Committee.

In terms of the registrants, regulatory colleges should only produce guidelines for registrants on areas they are specifically mandated to address. What would be helpful is for regulatory colleges to determine areas that CE is required from their assessment process and pass this to the association to develop programs to address the identified needs. In our case, the CMRTO has expressed their cooperation in doing this. It is not their place, we believe, to contract out education projects to favoured institutions or do it themselves but rather identify the needs and alert the professional community to the situation. Further, it is not their place to approve or not approve of C.E. Programs for their registrants as this is a professional issue.

As a final comment, we have found the CMRTO very helpful to our Members in understanding and completing the Q.A. Program's requirements.

The OAMRT recommends that:

- **Regulatory Colleges have clearly defined parameters in terms of delivering continuing education programs in their role to protect the public.**
- **Continuing Education and professional development programs should be carried out by professional associations and professional education providers in cooperation with regulatory colleges.**

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### ACCOUNTABILITY

#### Structure of College Councils

We have received complaints from Members who have sat on our regulatory college Council that the Executive has too much power and makes all the decisions. The Executive as we understand it, is supposed to deal with urgent issues between Council meetings. The complaints we have received are that the Executive has already made the decisions and the rest of Council is put into a position of just ratifying decisions. Not having a seat on Council, the OAMRT cannot verify the accuracy of the complaints but offer the comments for consideration.

A seat on Council as an ex-officio member is a consideration. We have found attending Council meetings as public members that there is misinformation at times as to what is happening in the profession's domain. Most often, the MRTs on Council, not holding a position in the association, are not well informed of issues and events despite the opportunities to do so. Instead, they bring their experience of their facility and therefore have a silo perspective rather than a global one more often than not.

This lack of being current can be attributed to a couple of factors. One factor is time or lack of it due to the pressures of the workplace and society. Another is, and this is of concern, is the lack of accountability to the region the health professional on Council was elected from. There is no formal requirement in terms of communications to and from the electoral regions from the elected Council Members. In our experience, even informal communications do not occur. It begs the question as to why there are elections at all.

There is also no way for a public member attending a Council meeting to provide input when misinformation is being presented.

To the credit of the CMRTO, there is an opportunity for input through the joint Executive meetings we have twice a year. Further, the opportunity is there for our President to dialogue with the CMRTO President and for the Executive Director of the OAMRT to dialogue with the Registrar or Deputy Registrar. Despite these avenues, misinformation occurs.

Misinformation causes problems and poor decision making. It can be avoided. To do that, we recommend:

- **That the Council structure include a representative from the professional association picked by the professional association who is there in an ex-officio capacity.**
- **That there be a requirement in the regulations for a process of accountability to the registrants through the elected Council member.**

In our view, regulatory colleges have a blank cheque to do what they want. Our Members have expressed concerns about spending and business practices in terms of cost-efficiency. This lack

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of accountability presents an imbalance amongst the regulatory colleges, the professions and the public. The requirement may be accountability of health professions to the public in terms of harm, but the nature of the design begs accountability all around to assure there is indeed a balance.

### **Public Members**

We believe the representation is acceptable. What concerns us is the process of appointing public members. There have been times when issues of importance to our profession have not been able to be addressed in a timely manner because public members have ended their term and have not have been immediately replaced.

A suggestion is that there be a process in place whereby replacement dates are flagged by a suitable Government department and the replacement recruited/appointed in advance. Further, the public member in waiting could receive an orientation by the regulatory college before they start, making the transition much easier.

We do not know if the public members who have served and are serving feel if they were/are properly oriented, etc. to be on Council. We hope that they have been requested to answer question 3c. We note that it is very important for public members to be up-to-speed because the potential is there for the health professionals on Council to get their way on items which may not be in the interest of the public because of personal agendas.

### **Review**

The OAMRT position is that the RHPA should be reviewed every five (5) years. Another option is to examine particular components of the RHPA every five (5) years and review the RHPA as a whole every ten (10) years. We have no preference either way as long as it is reviewed regularly.

### **Mandate**

Some of our Members have had difficulty in understanding why the regulatory college is there and some still do. The matter arises every year on our Annual Membership Surveys (AMS). The comments on the AMS more frequently center around the cost and why should they pay hefty fees for the privilege of being complained against. For the OAMRT and the CMRTO it has been an ongoing education process.

To be frank and honest, the information relating to the purpose of the regulatory college and in our profession's case, the CMRTO, has been left to the undergraduate training programs for students while we and the CMRTO tackle the graduate population. Some training programs do the education concerning the RHPA well. Some do not as we have discovered.

In our view, undergraduate training programs should have a course on the RHPA, the profession, standards of practice, etc. and be examined on it formally.

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### EFFICIENCY

#### General Comments

It is the perception of this Association that operations of some regulatory colleges, including the CMRTO, may not be as cost efficient as it could be. We noted this briefly in an earlier part of the submission.

Concerns of our Members, who are also CMRTO registrants, have focused around how expensive some of the publications appear to be including the annual report. Further, that the use of consultants in the norm is excessive. There are matters which, in our view, consultants have been hired and have not been necessary. The impression by some of our Members who previously served on Council and by others who have been sitting as public members at Council meeting is that the business practices are not as good as they could be.

In terms of other areas of operations, there have been no major concerns raised. We empathize with our regulatory college that only so much can be done in a day.

#### Collaboration

There is no doubt that collaboration between regulated colleges is necessary and would result in some positive outcomes in terms of effectiveness and efficiencies.

We are aware that there is cooperation amongst the regulatory colleges through what we understand as the "Federation". We would support the use of that forum in dealing with issues of common interest but as an informal forum. The issue of the Federation is dealt with later in this submission.

We do not have enough information to determine what barriers exist, can be overcome or other areas of administration or operations could be shared. The idea, however, needs to be explored. We therefore recommend that:

**A study be conducted with the aim of determining areas of administration and operations amongst the colleges where the consolidated use of resources would result in cost effectiveness and efficiencies.**

It is the OAMRT's position that the above recommendation does not imply a master or umbrella regulatory college. We have heard that this concept is being considered. We would suggest that a "master" or "super" college would erode the purpose of the RHPA and its subordinate acts. Professions could and probably would lose control of its own destiny with the most powerful professions taking control.

Consideration might be given to housing all the regulatory colleges in one building, perhaps a government building, where boardrooms can be shared, a secretarial pool, telephone services, etc.

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Another option could involve bulk purchasing and use of services such as printers where volume could save monies. In other words, a similar purchasing system as hospitals use. To take this a step further, perhaps, with some products or services, the regulatory colleges could become partners with the Metro Toronto Hospital system.

### **Mergers**

With the present regulated health professions we see no advantage to any of the merging. Who would they merge with and why was a question we asked ourselves. We could not answer it.

The research that went into the recommendations was intense and thorough. If there was any possibility of merger of the recommended groups then it would have emerged at that time. It did not emerge.

Although the OAMRT does not support mergers of any present regulatory health professions colleges that doesn't mean that we are opposed to the concept from a different avenue. As we noted earlier in this submission there were around seventy-five health care occupations who were interested in being regulated. They were weeded out because they decided against it for whatever reason or because they didn't meet the review team's established criteria.

Ultrasound or medical sonography was a group who decided not to proceed and are now seeking regulation. We support this group, as we had in the past, in the fact that they should be regulated. Further, we support sonographers being regulated under the CMRTO. We would suggest that as healthcare occupations see regulation or the Minister deems that they should be regulated, that one of the criteria continue to be to assess if the occupation should be regulated under an appropriate existing regulatory college. That being stated, it would have to be done with sensitivity and caution in terms of serving the public as a whole or in part.

### **Changes to the Legislation**

We would submit that despite the good intent of everyone concerned and especially our present Minister, the wheels move too slowly to initiate timely changes.

The Red Tape Reduction Act itself took far too long to get through just to reduce the barriers that existed. We have no real evidence yet that this Act has had any impact on improving timely changes.

Another problem is the priority rating that changes have. Often, amendments are not high on the Government's order paper concerning the RHPA because of other pressing political issues. The process gives us the impression that once the hype is over and the Act gets passed, it is not of much consequences unless there is a public outcry of some sort. Urgent issues to those directly impacted by RHPA are not perceived as urgent to the Government. Having stated that, our experience has been that most of the Government bureaucrats we work for understand and

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empathize with our concerns but have their own hoops to jump through. This is going to get worse as the Government downsizes.

The referral system of using HPRAC, to the OAMRT, is a good one. We were quite concerned when we heard rumours that HPRAC could go when the Red Tape Reduction Act deliberations were on. We will continue to support a referral system that is unbiased and fair.

### **Registration Fees**

At this point in time, we believe the registration fees set by the CMRTO are reasonable.

The costs of the regulatory college are borne by the registrants who have no say at all on how the administration and operations are conducted. This lack of accountability has already been noted in this submission.

The registrants can accept the fees as long as they know the monies are being spent wisely. There is a lack of confidence, to some extent, that this is not happening. This we noted under the “collaboration” section. The fear is that the fees could become excessive due to the lack of accountability. Registrants are trapped or as some have said, are “victims”. They have to be registered to work so therefore have to pay what the CMRTO sets.

To this point, other than the criticism we have given about the less than frugal use of monies, to be fair, the CMRTO Council has worked hard not to raise fees.

### **Summary**

The OAMRT does not have the personal experience to assess effectively whether provision of the RHPA or the MRTA has been amended with “ease”. The term “ease” was not defined and therefore difficult to relate to. In the view of the OAMRT, despite being “living legislation” as the RHPA was termed, appears to us to be still too slow to meet in a timely way the necessary changes RHPA requires or would require. We will know when we see what you recommend to the Minister from this review and how fast it gets incorporated - that will be the telling performance indicator.

Economics of scales are always possible and everything possible should be done to maximize efficiencies in a cost effective manner without sacrificing the quality and intent of the RHPA.

## **FLEXIBILITY**

### **Minister’s Latitude**

The only comment we have here is that the Minister has great powers and therefore the responsibility to use them wisely.

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The prudent use of those powers require the proper checks and balances in place.

One of the check and balance tools is the need for compulsory consultation with all stakeholders including all the political parties before decisions are contemplated let alone made.

As we noted earlier, the fact that HPRAC exists and is utilized has been worthwhile and therefore is an important one of the check and balance tools.

### **Colleges' Latitude**

We support the concept that the RHPA and its regulations should be a strong and clear piece of legislation that acts as a framework for regulatory colleges to make regulations and ByLaws.

Within a clear solid legislative framework regulatory Colleges should have the flexibility to make regulations and ByLaws. This saves time and money.

We emphasized “clear” and “solid” in terms of the legislation because without it, regulatory Colleges could take actions which are not in the best interest of the public or the registrants.

Certainly, in some areas, the RHPA is vague. Sufficient guidelines do not exist and as a result regulatory colleges can do what they want. We have seen this in the area of the Q.A. program where different Colleges are doing vastly different things and in some cases burdening the registrants needlessly. Another example, is in the area of continuing education where the regulatory college was exceeding their mandate because of insufficient guidance in the RHPA regulations.

### **Changing Practice**

The OAMRT believes that the RHPA can do what it was designed for but it does not appear to be happening as designed in terms of adaptability and accommodating changes of practice in the fast evolutionary environment that health care is in.

As an example, within the CMRTO there is a specialty called Radiography. This is not an acceptable term to us as the “specialty” or as the profession terms it, the “Discipline”, is Radiological Technology. We do not seem to be able to get this changed despite bringing it to the attention of the CMRTO. The entire professions except for some senior individuals, know the specialty/Discipline as Radiological Technology. This is being conveyed to the public. The fact the CMRTO does not want to or cannot change the term easily to reflect the professional reality confuses the public and to some extent their registrants.

The example in the last paragraph is an example but it highlights the difficulty of making changes.

Five years ago, we alerted the CMRTO to the fact that the day may come that aboriginal health care providers trained to take limited x-rays in areas above the 50<sup>th</sup> parallel may be required to be

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members at some point as limited practice members. Who initiates this is not clear. Should the CMRTO initiate this themselves? They did not think so. Is it the professional association who initiates this? We do not know whether this should go to HPRAC or through the CMRTO. In this situation, there is a problem with responding to change and need and what the process is.

It appears to the OAMRT that initiating change is still a cumbersome process and not clear to consumers of any type.

### **Shifts**

Shifts in health care do present challenges, in our view, to the regulatory system.

The issue of cross-training and multi-disciplinary training is one of them. Problems of who regulates who in different practice situations arise. Using an example, if sonography is regulated, an RN is doing obstetric ultrasound part of the day, is she responsible to the CMRTO for her practice or the CNO in regard to sonography? At present we have Radiological Technologists dual qualified in sonography. Part of the day they are regulated, the other part they are not.

Another issue is the impact of internal free trade. We do not know the impact of this yet on RHPA but we suspect that it could have. We would be opposed to any changes of the RHPA that lower the practice standards.

If changes occur such that a form of de-regulation occurs, then the whole RHPA should be scrapped and in its place a health occupations act, for lack of a better term, should perhaps be considered. This Act would do much of the same as the RHPA. It could cover all health care practitioners whether professional or not but meet the major principles of the RHPA in terms of protecting the public from harm, flexibility, accountability, quality of care and fairness. Some might even prefer this type of legislation as it might be more balanced in the areas of accountability, especially the sexual abuse provisions.

### **Summary**

We believe the flexibility is there. What is required is that the legislation be clarified in the areas where it is silent or vague so regulatory colleges can implement the ByLaws they need to run the college effectively and efficiently.

The Minister needs to ensure that red tape is minimized and perhaps in every sitting of the Legislature there is on the order paper/agenda the RHPA as a standing item from the Minister so it is seen as a priority and issues are dealt with in a timely manner to preserve and ensure flexibility.

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### FAIRNESS

#### Sexual Abuse

To the OAMRT, this is a major area where there is not a balance.

The OAMRT supports the philosophy of zero tolerance for sexual abuse and harassment. That being said, the OAMRT does not believe that the sexual abuse provisions of the RHPA are fair.

As we stated at the time of the Bill 100 deliberations and still state, health care professionals have been centered out. What went into the RHPA was politically driven and although we empathize with the survivors of sexual abuse totally, it is not balanced legislation in terms of being innocent until proven guilty.

It was the position of the OAMRT and still is, that the provisions in the RHPA should have been stand alone legislation. According to the literature, sexual abuse is a societal problem. Further, other health care occupations and support occupations can cause the public harm concerning actions of a sexual abuse nature. It is insulting that health care professionals have been centered out. We recommend that:

- **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 present provisions have put regulatory colleges in a position where they have to reprimand an individual or worse. An example could be the following scenario:

An individual treats a patient for several sessions. Two years later, the patient and provider meet at a party. They fall in love. A couple of years later they separate. The ex patient lays a complaint out of spite. The regulatory college investigates. The present rules require them to discipline the health professional and they give a reprimand. This now has put a blot on that person's career and possibly affects negatively the quality of care to other patients. It could also lead to a competent dedicated health professional leaving the field.

This is not justice.

The problem of under-reporting exists. It is our assessment, based on verbal field reports, that there is a reluctance for health professions to report other health professionals. It is therefore difficult to determine whether the requirement is working without hard data which we do not have.

It would be interesting to see how many cases were brought before each regulatory college as a result of mandatory reporting, as opposed to patient/client complaints.

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The analysis of the data, however, would have to be related to a factor which is one of knowledge. How many of the complaints may end up being the result of a lack of knowledge of the practice requirements of the health professional accused. If it is one thing the RHPA process illustrated, it was the lack of knowledge health care providers have of each others training and their detailed scope of practice.

We still find the definition of sexual abuse in terms of mandatory reporting problematic. The problem is in the “behaviour”, “remarks” and “touching” categories. As we proposed during the Bill 100 deliberations, we would still suggest that the term should be “duty to intervene”. We therefore recommend that:

**The clause(s) be amended to reflect the proposal made by the Ad Hoc Coalition of Regulated Health Care Association on Bill 100 in 1993.**

The Therapy and Counseling Fund provisions, in the view of OAMRT, is also problematic. Innocent health care practitioners have to burden the costs created by those health care professionals that are found guilty. This presents an unbalanced situation and is unwarranted. It also puts, in our view, the regulated colleges in a perceived conflict of interest in terms of the decisions they might make. This undermines the principles and objectives underlying the RHPA.

As we have noted in several areas of this submission, the double standard of having the regulated health professional accountable and the unregulated health care provider unaccountable is not fair. In the unregulated health care sector, there are no minimal standards of practice; no accountability. This is of particular concern where treatments could well be therapeutically useless or damaging to patients. We still stand by the recommendations made to the Government of the day by the Ad Hoc Coalition of Associations concerning the Therapy and Counseling Fund.

### **Health Professions Appeal and Review Board (HPARB) Hearings**

The OAMRT has no direct experience with this component of the RHPA. We will report that individuals who have gone this route find it far too long a process.

The fact that decisions take what appears to be an eternity impacts on the individuals’ livelihood and adds to their stress and the person, in a sense, becomes a victim. We suggest that the legislation include time lines to guide and govern the HPARB process.

### **CMRTO Implementation of the RHPA**

In terms of fairness, we can say that at this point in time, our regulatory college, the CMRTO, has implemented the requirements of RHPA as fairly as the legislation allows.

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On the whole, based on feedback from our Members, the CMRTO respects the rights of all parties concerned. That being stated, we do not have the inside experience to make a judgement as to whether this is a result of the individuals operating the CMRTO more so than the legislation or not. We do know that, from our experience, fairness is a value the CMRTO Council and staff practice overall.

### **Profession of Choice**

We are not convinced that the provisions and implementation of the RHPA has provided the public with access to health professions of choice.

The public often do not have a choice. Further, they do not know what choice they have because they are not well informed on what choices there are. That is not to say that some members of the public do not know but we would suggest that most have no idea of the health professional's menu. The patient/client gets sent to whoever by the gatekeepers of the health care system. In some cases, that is for some services, there is only one choice because, in reality, the practice is exclusive.

### **Equality**

Although the RHPA was aimed at creating a level playing field, this has not happened. In terms of legislation and technically we may be "equal" but reality says different. We do not believe there will ever be equality just because of the differences of practice and the continuing battles for turf and the status some professions have versus others. What we hope will come will be respect for each other. There have been some gains in this area but there is still much work to be done here.

The RHPA deliberations galvanized health care professions. It was in this period that professional groups started to discover each other. Since the passing of the RHPA, this cross-discovery process has come to a halt almost. It is now only crisis situations or exercises such as this Review which brings us back together. To the OAMRT, the more we partner and interact, the better for all concerned, especially the patient/client. RHPA should be the beacon to use to accomplish partnerships and well it could be. It takes the political will of each health profession to do this. Some have it; some do not.

### **Balance of Rights**

In the OAMRT's view, as we have noted previously, the RHPA in terms of the sexual abuse provisions is not balanced. It promotes fear in the health professional rather than project an image of fairness.

The inclusion of ADR, in our view, would be helpful as a balancing tool in terms of handling complaints, as we have suggested.

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We have not had enough experience and thus feedback from our Members to accurately assess the balance of power between the Colleges and the rights/interests of professional members. There certainly has been no outcry of any imbalance here from our Members on any of the last five (5) years worth of AMS's we have received.

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### SUPPLEMENTAL

#### Role of HPRAC

The “*Weighing the Balance*” document does not request input to either criticize or validate the role of HPRAC in providing guidance to the Minister. This should be part of the process.

#### Internal Free Trade

We noted in the submission that there could be an impact concerning the inter-provincial free trade agreement. We suggest an assessment is required in terms of the impact of the RHPA on Labour Mobility requirements.

#### College Council Meetings

We have found the College Council meetings frustrating from a public perspective. The public is allowed to attend and listen to the discussion. No documentation is provided to public member attendees by the CMRTO.

The lack of documentation was not always the case. The CMRTO made a decision to stop providing copies of reports and other documents. In our view, this was an over reaction to a situation where a document was provided and shouldn't have been - at least that is our sense of it all.

The regulatory colleges in our view, have a responsibility to let the public know what they are doing and why. In our view, there is no reason that the public members attending Council meetings cannot have documents which are not confidential or sensitive in nature. In our view, the present practice creates unnecessary suspicion which grows because of the inherent lack of accountability that exists. This accountability issue we addressed earlier in the submission.

We note again that notice of council meetings is a problem. Attendance of the public at Council meetings of the CMRTO is low. A big factor is the fact no one knows about them.

#### Federation of Health Regulatory Colleges of Ontario (FHRCO)

This organization is not part of the RHPA structure. Is it an official organization? If so, under what authorization? If they are not, then why are items and issues accepted from them by the Government? If they are not, then what exactly is this organization?

If FHRCO is an organization for enhancing communications and discussing issues of mutual concern, then we are not concerned. If it is more than that, then it could possibly contravene the “public” and “self-regulatory” principles by which the regulatory colleges are mandated to operate.

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### **Pardons**

Consideration should be given to a process to remove findings of professional misconduct from a registrant's file. Currently there is a patchwork of rules as to how long a finding of professional misconduct remains available to the public. A system of permitting a disciplined member to apply for a pardon might be a consideration.

### **Roles of Professional Relations Branch**

The OAMRT is not sure anymore where the Professional Relations Branch of the Ministry of Health and Long Term Care fits into all of this. We would like to see this defined.

### **Sexual Abuse Therapy and Counseling**

Although we addressed the issue in length earlier in the submission, we have some other comments and questions concerning this topic. It concerns Ontario Regulation 59/94.

The registrants are underwriting the fund. This is disturbing as there is nothing permitting a victim from receiving treatment from an unregulated health professional who has no similar accountability to that of a regulated health care provider. We suggest there needs to be some parameters set as to who does treatment.

At the time of writing we had no data to work from. Questions that require answers to in terms of assessment include:

- Who has done treatments since RHPA was proclaimed?
- Have any funds been accessed?
- How many cases were reported?
- How many victims have sought compensation?
- How much of the "funds" have been used?

It was therefore difficult to assess this area in terms of providing input into this review.

### **Practice Environment**

We are receiving feedback on the increasing amount of stress being incurred by our Members in their practice. Much of this is a result of conflict between what the Standards of Practice are for the Profession versus the employers version of the standards of practice. The problem is that the employer controls the practice and therefore dictates it to the employee. Sometimes, the health professional finds they cannot practice in accordance with the standards of the profession. The pressures on facilities concerning funding or in the case of IHFs, income, causes the stress on the health professional. In the case of the MRT, they find themselves using outdated or under-serviced

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equipment, third class supplies, no support due to lack of staffing and an erosion of competency because of job assignment decisions. The situation is getting worse in our view.

We see this issue as a problem in that a Member could well be disciplined for a situation not of her/his making. The problem is made worse because the College has to deal with the complaint based on their Standards of Practice with little flexibility to take into account the root of the incident and little means to rectify the situation.

The OAMRT would suggest that the legislation needs to have power to investigate and hold accountable the employer or the third party facility. The Association believes that employers have a responsibility for responsible quality of care. One of the responsibilities is to acknowledge and uphold the standards of practice and practice guidelines of the health professionals who provide them the service. To the OAMRT, it is a matter of simple Risk Management and Quality Assurance.

Regulatory Colleges need a clear jurisdiction to rectify employer identified deficiencies. This authority would require protection for the health professional who “blows the whistle” and this needs to be incorporated into the legislation.