



File No: 1020-4 (MOHLTC)

1205-2(HPRAC)

The Hon. David Caplan

Minister of Health and Long-Term Care

RESPONSE

TO

THE HPRAC RECOMMENDATIONS

“Critical Links: Transforming and Supporting Patient Care: A Report to the Minister of Health and Long-Term Care on Mechanisms to Facilitate and Support Interprofessional Collaboration and a New Framework for the Prescribing and Use of Drugs by Non-Physician Regulated Health Professions”

INTRODUCTION:

On behalf of the Ontario Association of Medical Radiation Technologists (OAMRT), I am writing in response to your request for public input outlined in the Health Professions Advisory Council's (HPRAC) “Critical Links” Report.

The OAMRT is the collective voice and advocate of the Medical Radiation Technology Profession dedicated to promoting the interests of the profession and assisting our members to deliver safe, effective and efficient health care. With nearly 5,000 members, the OAMRT represents the Disciplines of Radiological Technology, Radiation Therapy,

Nuclear Medicine and Magnetic Resonance Imaging and all their sub specialty areas of practice.

OAMRT has attempted to respond intelligently despite a very tight timetable. Due to the stringent time line we have attempted to analyze the HPRAC document in depth. As with many other associations depending on volunteers, as key resources with those coming from all across the province, it has been a challenge to appropriately address all of the recommendations with the attention and care they deserve. Therefore, our approach has been to focus on the recommendations that relate directly to our profession, with the hope of supplying you with feedback that we trust can be incorporated in meaningful ways.

The OAMRT acknowledges the excellent work done by HPRAC within a very tight time line on very complex issues and the recognition given to Medical Radiation Technologists. That very complexity has in fact led us to flag issues related to the document that we need to bring to your attention for consideration. We believe that HPRAC has inadvertently, through the structure of the Report, created barriers, obstacles and potentially high costs that they never intended in their quest for ground breaking reform. We believe that there is a *disconnect* between what was stated at the beginning of the Report in terms of Interprofesional collaboration and care, enabling regulatory frameworks, standards, flexibility, and allowing practitioners to practice to the extent of their scope of practice **and** the *implementation* of the philosophies expressed in the Report.

OAMRT while supporting strongly the intent, principles and philosophies expressed in Chapter 1 of the Report, have concerns about a number of recommendations in the Report which will, ultimately, impact negatively on the delivery of safe and quality of patient care. Of particular concern is the scope of practice statement for our profession which, if accepted as recommended, has the potential to actually limit and not promote access to diagnostic and radiation therapy services patents need.

OVERVIEW

As noted the document is very complex. Some observations we have are:

- It appears to us that the language used in the body of the Report is different from the implementation language and that can cause misinterpretation which could translate into misunderstandings and subsequent costs to the health care system and Ontario society
- It is not clear to us, even with a lot of “type” spent on “Standards of Practice” as to what is really meant by that term after reading the document in its entirety

despite the definitions provided in Chapter 1 of the Report. It seems to be all encompassing in nature. The document could be enhanced through greater clarification to reduce the ambiguities and improve interpretation. It may be that the only true ‘Standard of Practice’ is a common Code of Ethics and everything else is a best practice (which is a standard by definition) for a particular profession. We find the language about profession scopes of practice and individual’s scope of practice inhibiting clarity. Individuals, we suggest, do not have a “scope of practice” but have a set of competencies that are fluid depending on the area of practice they are in or may be moving into. The key, and HPRAC stated this before suggesting professional and individual scopes of practices, is that practitioners have to practice within their competency set and we agree with that wholeheartedly.

- The Standard of Practice issue is a major one but appears to have no structure as alluded to in the bullet above. The development process particularly with regulatory colleges, that share controlled acts or have similar acts, we see as problematic. Further, it is not clear to us what happens related to existing standards or what happens when one regulatory college develops a standard. Are all those who may be a stakeholder concerning that particular standard obliged to accept it as they developed it first ?. We are not clear either whether this process just applies to new professions or all professions.
- We believe that the accountability structures are already in existence in the present regulatory framework and there is evidence, in our view, that regulatory bodies on the whole are trying to make it work. Our experience is that there is an issue with the process in that practitioners are not often held accountable and don’t hold themselves accountable in some cases to the existing scopes and standards of practice and this bears looking at before restructuring the regulatory framework.
- We have a perception that more bureaucracy might be created if the Recommendations are accepted. There could be a possible diminishing of the Minister’s powers as they presently are under the RHPA with final authority possibly sitting with HPRAC or possibly the new proposed agency or both. If our perception is correct this is not in the best interests of the health care system if the Minister loses the final say particularly in conflicting, overlapping or ambiguous situations. Further, it could negate the very nimbleness HPRAC set out to create for the health care system. Further it appears that in the end the regulatory colleges have the final say so it is not clear to us what the Council on Health Professions Regulatory Excellence (CHPRE) really is in terms of having “teeth’ or being just an “advisory” body. We would support the CHPRE as an advisory body which HPRAC originally says it is but are confused that later in the document it is suggested that it “coordinates” and “facilitates” which suggests

more of an oversight body. Is HPRAC suggesting the UK model or an Ontario solution as an advisory body?: This is what we would like clarity on?

- We share the concerns expressed by the College of Medical Radiation Technologists of Ontario (CMRTO) related to impacts that would be costly in terms of them conducting their business effectively and efficiently in terms of the regulatory framework. Those impacts would fall out to affect our Members both directly and indirectly as well as the OAMRT as an organization in terms of moving the profession forward
- A lot of “good will” is expected in the recommendations along with more advanced requirements for the regulatory college and the practitioner to be responsible and accountable regarding practicing within their scope of practice. What is not addressed is the accountability related to employers. Within our profession (and speaking to other associations), there is an issue with employers who are not held accountable concerning pushing practitioners to practice in areas they may not be competent to do so. The evidence is that employers will short circuit things especially in difficult economic times. This puts the regulatory college and the practitioner in a hard and ethically challenging place and needs to be addressed
- There are inaccuracies in the Report which may be due to the timeline factor HPRAC was under but never the less, if taken as gospel, could result in the wrong decisions being made. We make note of some of those inaccuracies later in this response.
- Medical Radiation Technologists (MRTs) education and training is through a national accredited process. The competencies they acquired are addressed in our joint submission with the CMRTO. The inhibitor of an MRT in practice is not acquiring new competencies for their present practice but the present regulatory framework where MRTs in order to exercise their acquired competencies need to have procedures (controlled acts) delegated to them. We are pleased that HPRAC is recommending adoption of the controlled acts we jointly proposed. What has been clouded, in our view, is that HPRAC is suggesting that we need to acquire new competencies to do what MRTs are authorized to do now whether by regulation or delegation.

MEDICAL RADIATION TECHNOLOGY SCOPE OF PRACTICE

We are very grateful and pleased by the recommendations regarding our profession’s controlled acts.

The main area of concern relates to the scope of practice statement. HPRAC has chosen not to accept the scope of practice statement proposed in our joint submission

with the CMRTO. That joint submission was developed following an extensive review process, and extensive research involving frontline practitioners, educators, managers, other health care organizations. In reading the HPRAC document we find the arguments presented related to the change of wording to what we jointly submitted of concern. It is our view that the scope of practice statement proposed by HPRAC would place new and unnecessary restrictions on the practice of Medical Radiation Technology and that would introduce new barriers to the profession that would negate the very reform that HPRAC believes in and you Minister, value. The issues are related to the term “assessment” and the matter of performing therapeutic procedures “as prescribed by regulations are of particular concern to our profession.

In regard to the term “assessment”, HPRAC is interpreting what we have asked for as asking to “diagnose” rather than “assess”. There is a significant difference. MRTs already have the competencies to assess. In our meetings with HPRAC and in our joint submission with the CMRTO nowhere did we state that we want to diagnose. We believe that HPRAC has taken a leap and is jumping to a conclusion without any empirical evidence. Further confusing the issue is that HPRAC defines, in our case that “assessing” is *diagnosing*, yet in their discussion regarding the Physiotherapy profession’s scope of practice they distinguish “assessment” from “diagnosis” by including both in that profession’s proposed scope of practice.

As we and CMRTO have stated, and in fact HPRAC has acknowledged, we are asking for only those things of which the MRT is presently engaging in. Further, by the definition HPRAC is working from (“Critical Links: Chapter 1, Page 18) it defines the procedures, actions, and processes a specific registered individual may perform. MRTs presently “assess” patients and images and provide opinions to those that do the actual diagnosing – the radiologist or radiation oncologist. MRTs, as hands on practitioners, have to constantly assess the patient’s condition before during and at the end of a procedure and take the appropriate action whether that be a Radiation Therapist preparing a patient for treatment or in their clinical specialist role, or a Radiological Technologist performing a lower gastro-intestinal procedure where the anatomy and pathophysiology assessment directs how they fluoroscope the patient next, flag a potential disease site for the radiologist’s attention. The MRT must also conduct a 15 - 20 minute patient interview which is required. Another example is the MRT having to perform a voiding cystogram including catheterizing the bladder, or a CT or MRI operator who has to assess the image to ensure the right protocols are performed and that right images got to the radiologist for diagnosis, or in another clinical situation the Nuclear Medicine Technologist who is assessing the physiology in order to perform the examination so an accurate diagnosis can be made.

The HPRAC document alludes to the fact that doing Barium Enemas for example is leaving the practice arena with the advent of CT Colonography. The evidence is actually

to the contrary. In fact Barium enemas are performed often before the CT Colonography examination and if not before, afterwards. Dr D. H. Taves, a radiologist at St Joseph's Hospital in London Ontario and Dr G. Stevenson former Chief of Radiology at McMaster Medical Centre will testify to the value of the MRT performing GI examinations as will the radiologists at Thunder Bay Regional Hospital's Diagnostic Imaging Department. The accuracy of MRTs performing GI examinations is also validated in the studies performed in Quebec by MRTs. Their testimonials invalidate the argument HPRAC presented which was presented to them by a special interest radiologist group. It is all about assessment. MRTs are in fact doing this now under the present regulatory framework and taking advantage of practicing to the extent of their present scope of practice..

Other professions already have the term "assessment" in their scopes of practice and we would ask you Minister to consider that day to day assessment is the MRT's reality. In fact, MRTs have more actual competencies related to assess images than do those professions who are asking to have 'diagnosis' as part of their scope of practice including diagnostic image interpretation and diagnosis – yet we are not asking for this privilege. We would like MRTs to be recognized for the skills they have by allowing the MRT to practice to the "full extent of their training and abilities" (HPRAC Critical Links, page 1).

MRTs, on a daily basis, evaluate, appraise, apprise, assay and do estimations on patients and images. There may be concerns about MRTs doing what we call "wet reads" and interpreting it as diagnosing. Nothing could be farther from the truth. MRTs have unique competencies related to knowing what they see and interpreting what they see related to anatomy, physiology and pathophysiology. MRTs whether in the ER, the OR etc provide another expert opinion to physicians and others who under pressure and within understaffed facilities who seek guidance on what they are viewing. MRTs opinions / assessment on the front lines are sought and in many cases expected by physicians as a professional obligation by MRTs.

In Radiation Therapy the Radiation Therapist, as a routine, has to assess the patient images in terms of treatment fields and portal images especially in terms of performing Tomotherapy and Cone Beam procedures as the radiation therapy managers will attest.

We fear that if the word assessment is not in our scope of practice statement the fall out could impact negatively on the effectiveness and efficiency of the Ontario health care system and could negate efforts regarding Interprofesional care. MRTs have and are adapting to rising patient expectations and our rapidly evolving technology.

Another major concern related to the scope of practice HPRAC has recommended is the suggestion that Medical Radiation Technologists only be able to perform therapeutic procedures “as prescribed by regulation”. We see this as a problematic requirement and are not sure, given the joint submission with CMRTO and the consultation process, why HPRAC has recommended this. If this recommendation was accepted Minister, it would have an immediate and negative impact on current practices by the profession and would inadvertently undermine your priorities for our health care system especially in cancer care delivery. Should the proposed scope of practice be accepted, we predict that it would constitute a regulatory burden that would cripple the effective practice of Medical Radiation Technology, increase wait times, and create barriers to timely access to high quality care. It appears to us that the proposed approach of prescribing specific procedures is not in concert with the spirit of the RHPA and unintentionally undermines self-regulation with respect to autonomous decision making while at the same time compromising the established role of the health regulatory colleges.

We also note that the Report had several inaccuracies and omissions concerning the profession which translates into misinformation. As an example, radiation oncologists are the specialist physicians working in radiation therapy not radiologists and that Radiation Therapists use “assessment” processes concerning a patient’s anatomy to do image matches to ensure the correct area is being treated.

PROFESSIONAL LIABILITY INSURANCE (PLI)

It is not clear to us what HPRAC is suggesting in terms of what the PLI should look like; the level of mandatory PLI coverage.

We support HPRAC’s recommendation to have mandatory PLI for all health professionals which, in fact, was a recommendation by all deputy ministers of health across the country in the mid 1990s.

The document does not define PLI. We suggest that it does need to be defined and recommend that it be **personal** PLI and that PLI should include criminal code coverage, regulatory college hearings, and coroner’s inquests.

Our experience is that in the IHF sector the employer does not cover the MRT for malpractice related issues never mind a regulatory body complaint and discipline issue or criminal code charge or a civil suit.

Our experience is also that most hospitals have limited coverage and most MRTs do not know what they are covered for and when they ask they are unheard in many cases.

Our experience is that the MRT is seen as guilty before proven innocent or guilty and the immediate reaction is to terminate them.

The way that it is written at present could cause an administrative burden for our regulatory college as they work at collecting from each registrant annually proof that they have PLI; whatever that means and we empathize with them on this issue.

As a note, the HPRAC Report stated that MRTs already have mandatory PLI which is inaccurate. Both the CMRTO and OAMRT have informed HPRAC of the contrary. Those that are Members of the OAMRT have personal PLI. However, about one-third (1/3) of the profession are not members of the OAMRT, and likely to not independently carry personal PLI.

RADIATION PROTECTION IN THE PUBLIC INTEREST

Although the HPRAC document called for increased accountability, some of which is premised on good will, we have concerns about professions being granted the ability to order medical imaging procedures and interpreting those images.

Although the HPRAC Report stated that those professions seeking to order and interpret medical images have the requisite competencies, we challenge the statement. HPRAC provided no undisputable empirical evidence that those professions have the education and / or training to take that step. A review of those profession's educational courses reveals that the necessary curriculum is not in place to ensure that proper decision making protocols will be in place. We are concerned that a lack of education and training will result in the possibility of erroneous diagnostic imaging or therapeutic procedures which are not, in our view, in the public interest.

We wish to be clear that we, as the organization representing the medical radiation technology profession in Ontario have no objection to any health care profession ordering medical imaging examinations or even 'diagnosing' them *as long as they have* the requisite competencies. Those competencies should be determined by our profession, radiologists and radiation oncologists. Unfortunately the evidence is not there despite the claims. As an example, we have looked at the Nurse Practitioner Programs in Ontario and their education and training in radiation protection and biology is virtually non-existent (except for the McMaster University Program), the interpretation section is focused on interpreting a chest x-ray predominantly and extremely basic medical imaging examination orders.

We would like to suggest a solution to assist with marking the boundaries! An existing piece of legislation complete with Regulations exists where, if modernized, could be the

tool which ensures accountability of those who may be given the privilege of ordering and interpreting / diagnosing medical images. That legislation is the Healing Arts Radiation Protection (HARP) Act with its regulations and codes.

Modernizing and strengthening the HARP Act so it can enforce the existing regulation to approve courses of instruction on matters of patient radiation protection and who can order what under what circumstances would provide concrete boundaries for those practitioners.

Our experience has shown that without such enforceable boundaries liberties are taken and this destroys the spirit and intent of Interprofesional collaboration as well as potentially compromising patient care and safety. The HARP Commission is set up so that the experts, grouped in advisory committees, can address all issues related to protection of the patient from not only ionizing radiations but other radiant energies such as those emitted in magnetic resonance or ultrasound.

Minister, in closing, I must emphasize the problems that the HPRAC recommendations will cause for the profession of Medical Radiation Technology around the proposed scope of practice if adopted and subsequently implemented. We foresee significant problems for both patients and your government due to the effects leading to reduced access to necessary Medical Radiation Technology services. In our view, the draft scope of practice statement we and the CMRTO jointly submitted represents the best solution to ensure safe public access to necessary diagnostic and therapeutic procedures.

We are at your call should you or your staff wishes to discuss this further with us.

Sincerely,

Dr. R. C. Hesler

CEO

Cc: Chair of the Board & President

CMRTO Registrar, L. Gough

HPRAC Chair, B. Sullivan

A. Malik, Director of Policy, Ministers Office, MoHLTC

www.hprac.org/en/reports/resources/HPRACCriticalLinksEnglishJan_09.pdf

www.hprac.org/en/projects/resources/HPRAC-Drugs-CMRTOSubmission2.pdf