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## **Response to HPRAC's Sunrise/Sunset and Changes in Scopes of Practice Criteria Review**

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### **INTRODUCTION**

The Association understands that the Discussion Paper has been distributed to provide input into two (2) key policy documents; they being:

- ! Request for Regulation under the RHPA, 1991
- ! Request for Change in Scope of Practice under the RHPA, 1991.

The Association further understands that the Ministry of Health and Long-Term Care (MoHLTC) did not commission the Discussion Paper. This situation is an influence on the nature of our response.

We have addressed each Part of the Discussion Paper in a more global tact, rather than answering each question posed in specific terms.

The Association appreciates the opportunity to provide feedback through this medium. We have also expressed our views as a Member of the Coalition of Professional Associations Representing Regulated Health Professions.

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### **EXECUTIVE SUMMARY**

The Association's response is premised on the fact that the Ministry of Health and Long-Term Care (MoHLTC) did not commission the Discussion Paper and that the contents of this document are provided to stimulate further discussion.

It is the general feeling of the Association's Board of Directors that, although the Discussion Paper is stimulating in terms of initiating a philosophical dialogue around process, there are matters of a higher priority. We feel that the priorities that need addressing, at this time, revolve around the recommendations of the Regulated Health Professions Act's (RHPA) Five (5) Year Review, and in regard to that, issues around the monitoring and accountability of the unregulated Medical Practitioner Sector.

The importance of Professional Associations to the process appears to be minimized, and our response suggests that Associations are key stakeholders in the delivery of Health Care and should be addressed as such.

The Criterion to apply to be regulated needs to be revisited to achieve clarity and address gaps. The Criterion, and what might be established as Sunset Criterion, would have a direct relationship on each other.

The definition of what the "Public Interest/Public Need" appears to be absent, and as this is used throughout the Discussion Paper as a fulcrum for the dialogue and questions, it needs to be defined.

We suggest that the economic considerations, while understandable, are of concern because it is easy to perceive that economics may drive "regulation" versus health-care outcomes. Accordingly, there needs to be a balance.

The evaluation of Scopes of Practices is a complicated one and addressing this in the context of synergy within the health-care system is a subject which requires further uni-focuses attention.

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### **GENERAL COMMENTS**

#### **RESEARCH**

The Association carried out a review of the following documents in preparing this response; they being:

- ! The RHPA
- ! "Adjusting the Balance: A Review of the Regulated Health Professions Act"
- ! Presentation Notes: "Regulating, De-Regulating and Changing Scopes of Practice; Is it a Question of Why or Why Not?", by Robert Morton, Vice Chair, HPRAC
- ! "Final Report to the Minister of Health and Long-Term Care: Effectiveness of Colleges' Complaints and Disciplines Procedures for Professional Misconduct of a Sexual Nature"
- ! "Report to the Minister of Health and Long-Term Care: Effectiveness of Colleges' Quality Assurance Programs"
- ! "Effectiveness of Colleges' Patient Relations Programs: Advice to the Minister of Health and Long-Term Care"
- ! OAMRT responses concerning the RHPA including topics concerning the RHPA Five (5) Year Review.

#### **GENERAL COMMENTS**

The literature is full of references as to the importance of Associations to the social fabric of our society in Canada, and indeed, North America. It is our perception that the role of the Professional Associations in Ontario's Health Care System is not as valued as it should be, from what we have experienced and read. The Discussion Paper does nothing to dispel this belief.

It would be appropriate to acknowledge the critical role Associations play in the health-care system, which we believe is equal to or, at times, more important than the Regulatory Colleges.

In our case, it could be argued that we should be de-regulated, as both federal and provincial legislation regulate the practice of Medical Radiation Technology, other than MRI. If this course was pursued, and successful, the Association would be the self-regulating organization, as it once was, and is, in other parts of the country, where the Regulatory Body and the Association are one and the same (Quebec and Alberta). A model which appears to work very well, in fact.

There is no doubt that on the subject of de-regulation of our Profession there is significant and compelling evidence of the expertise that exists. The OAMRT continues to provide Member education, best practice advice, advocacy, and recognition. We could easily reactivate a Quality Assurance (QA) Program, which was more demanding than the present CMRTO QA Program, as well as the complaints and disciplines process. Even with the presence of the CMRTO, this Association continues to have as a core value, and a priority, quality patient care.

We have concerns that the Five (5) Year HPRAC Review Submissions and recommendations have never been responded to officially. We have further concerns that, as an Association, the consultation process is might be more effective if balanced with the Regulatory Colleges' viewpoints. This raises the ethical principles of trust

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and transparency and as to how these are perceived.

### **OBSERVATIONS**

The Discussion Paper appears to be trying to advance into areas, which while needed, is premature, when the HPRAC Five (5) Year Review Recommendations are still awaiting review and action by the MoHLTC.

The RHPA was to be "living" legislation. The "living" appears to not be "dynamic", as advertised. It is not living up to promise.

The Professional Associations, including us, are an integral part of the evolution of our health-care system. Professional Associations can be a major player in achieving health care system synergy, which every system needs to function effectively and efficiently.

We have observed that, although there are many excellent points and recommendations made, there could be a negative shift of the balance between self regulation and the public's expectations of regulation. In our view, it is essential to balance and value the stakeholders, if public trust and confidence are to be assured.

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## **PART 1**

### **INTRODUCTION**

Part I of the Discussion Paper address the appropriateness of the current criteria for regulation under the RHPA.

The nine (9) criteria to become regulated were reviewed in preparing this response, along with the four (4) issues presented in the Discussion Paper.

### **GENERAL COMMENTS**

We agree that the focus of the RHPA is to protect the public and that what constitutes "Public Interest" can and does change, as society changes, the culture changes, and the knowledge of the general public changes. It must be stated that this Association also has the public's interest at stake, and it is one of our Core Values. Our Members are also members of the public and users of health care.

We wonder why the burden is being placed on the health-care provider group who is interested in being regulated. It would seem to us that public concern/interest should be the driver.

We note that for a health-care occupational group to address regulation, it is a very expensive course of action. Many provider groups do not have the resources, so may never apply. Further, they are penalized at the moment of regulation, because the Regulatory Body becomes the focus and the Association, by the very nature of the system, is reduced in relevance. It could mean self destruction.

### **ECONOMIC THEME**

We have concerns about the economic theme. In fact, the economics issue is a thread which weaves its way into all parts of the Discussion Paper. There is a danger that costs will overshadow the issue of delivering safe, quality health care in terms of deciding who is regulated and who is not.

### **LABOUR/MOBILITY**

We agree that labour and mobility issues are important. We are fortunate that in our Profession we have a national Certification Process and Examinations. That noted, there is a danger that regulation can undermine a national standard if the Regulatory College wishes to have their own examination process, because of political differences, as an example. The "national standard", could be compromised and, therefore, practice standards and mobility of a Practitioner within Canada. The Association, one can conclude, still has a regulatory function in terms of setting entry-to-practice standards, in our Profession's case, nationally. Further, the Profession is the driving force in terms of evolving the practice and providing the tools to assess competency at various levels. We agree that Mutual Recognition Agreements (MRA) are a necessary tool.

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### **EDUCATION**

It is generally acknowledged that it is the Association's role to be the hub concerning the education of the health-care provider and not the Regulatory College.

We believe that there needs to be a synergy created in terms of undergraduate education up to and including advanced levels. In order to do this, there needs to be close collaboration among the various parties; the Association, Regulatory College, Employers and Educational Institutions and Government.

In our view, if it is working correctly, the Regulatory College mainly reacts, adapts, and supports, the Association is the catalyst for the evolution of the practice.

We agree that all education should stand the test of evaluation and validity.

### **EFFICACY**

We would suggest that whether a health-care occupation is regulated or not, what they do, should provide safe, efficient and effective outcomes. We have concerns that the focus is solely on Regulated Professions in this regard.

### **PRACTITIONER AVAILABILITY**

We are all aware of the Human Resource issues concerning Health Care. Our issues are no less acute than nursing, although not well recognized by others, especially the public. In such a situation, danger lurks.

It is our view that there needs to be stronger safeguards, through legislation, to prevent employers or whomever, in hiring individuals without the requisite competencies. This does happen, and is happening, in both the regulated and non-regulated sectors, because of economic and HR shortage issues. This is putting the public at risk of harm.

### **REGULATION CRITERIA**

We do recommend that the criteria for a provider group to apply for regulation, be reviewed and amended.

We noted earlier that, in our view, it is the public and government that should be the drivers to start the regulation process. That noted, things being as they are, we have concerns about the existing criteria.

- ! **Criterion #2** - although not a change, why are the applicants being asked about liability insurance coverage? That noted, we believe it is important and essential that Practitioners carry personal liability insurance. Further, that the Regulatory College should require it, and the Association provide it. It would be a conflict of interest for the Regulatory College to provide it.

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- ! **Criterion #3** - we are not clear on what "A significant number of Practitioners" constitutes.
- ! **Criterion #5** - this is onerous! It could exclude a group who should be regulated, but do not have the resources to do the research, etc. It is therefore discriminatory.
- ! **Criterion #6** - the questions should be reviewed in terms of drawing out differences within an occupation of the training and competencies required. As an example, in medical sonography, there are various groups who have different training requirements and levels, and this needs to be drawn out in an application. We wonder what weighing is given to the questions.
- ! **Criterion #7** - we are not really sure what this means. How does this really fit into the public policy/public interest?
- ! **Criterion #8** - we made an observation that "collaboration" or attitudes has more weight than practice facts. This Criterion opens the door to the potential of the turf war phenomenon versus meeting the need of the so called "public interest".
- ! **Criterion #9** - it is noted that "the Profession must be able to maintain a separate Professional Association". The questions posed do not address that statement. What happens if the Regulatory College hikes their fees so much there is no Professional Association anymore? Does de-regulation occur? Are you really asking whether the Profession has the ability to separate the roles?

In our view the risk of harm is the primary Criterion.

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## **PART II**

### **INTRODUCTION**

We understand that Part II invites a discussion regarding criteria to de-regulate under a process called "Sunset Review".

The question about de-regulation has surfaced from time-to-time, in our Association. This topic has been raised as some Members in three (3) of our Disciplines, who believe they are regulated "to death". The subject then is of interest to us.

### **UNDERLYING TENSIONS**

We are not clear on what the "public Interest" actually is. It is therefore difficult for us to buy into the statement that de-regulation is based, in part, on underlying tension "between public interest and Professions' interest". It is not clear, either, as to what "Profession's interests" means in the document. There is an inference that this is the Association. If this inference is perceived correctly, then we suggest that this is incorrect, as there are issues on how the Regulatory Colleges handle complaints, disciplines its Registrants and ensures competency.

### **SOCIAL ENVIRONMENT**

We agree that the health-care environment is changing. This is certainly impacting on Scopes of Practice and turfs. Whether a Profession is de-regulated, or is opened up to include other groups, is still a huge area for discussion. The goal should still be the same; safe, effective and efficient patient care, which results in outcomes, which improves the patients' quality of life.

### **ECONOMIC CONSIDERATIONS**

As noted in addressing Part I, the economic consideration must be balanced and viewed in the context that economic data can be shaped to suit the situation. It is a factor, but only a factor.

### **DE-REGULATION**

In our view, the main criteria concerning de-regulation should revolve around existing legislation, which holds the Practitioner accountable, or other legislation that invoked, assures accountability to the public, the Employer and the Profession. If the legislation is there, then regulating that provider group has been accomplished.

We have concerns that until the unregulated sector is held accountable, then there is an argument that de-regulation should not be provided as an avenue, unless the other legislation, as noted, is in place, and thus the RHPA is not required for this Profession.

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### **PROFESSIONS' EFFECTIVENESS**

We note that "Professions' effectiveness" is clearly not defined. We wonder how would that be determined. It should be noted that "effectiveness" could vary from one year to the next, as is evidenced in hospital and education programs accreditation processes.

We observed that should a Regulatory College not be performing properly, it does not mean that the Profession itself is not. It could well be a board and governance issue, rather than actual practice matters.

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### **PART III**

#### **INTRODUCTION**

Part III of the Discussion Paper, as we understand it, deals with current criteria for changes in Scopes of Practice.

We are not clear on what is meant by “collaborative Scopes of Practice” in the document.

We are in an environment where there are overlapping Scopes of Practice among RHPA Professions, and between RHPA Professions and unregulated providers. In other words, the boundaries are blurred and becoming more so. Will this lead to different expectations and, therefore, double standards?

The “silo” mentality still exists, and always will, in some form, and this factor alone impacts on the evolution of Scopes of Practice. Despite the OHA's efforts in hosting two (2) Scopes of Practice Summits, we see little change in behaviours. Until behaviours are changed, progress will be very difficult.

There is also the problem with delegated and authorized acts related to the RHPA. This involves the area of education, supervision and accountability, and thus has ethical implications.

#### **PUBLIC INTEREST/PUBLIC NEED**

Again, we raise the issue that we do not really know what is meant in the Discussion Paper by public “interest” and public “need”. Without this clarification, it is difficult to comment.

There are many dynamics at work in causing Scopes of Practice to change and the resultant effects. All of these need to be factored into the problem-solving equation.

#### **COLLABORATIVE SCOPES OF PRACTICE**

We commented earlier in our response on the “Collaborative” issue.

We wonder, at times, how well health-care providers can work together effectively, given the approaches to training where, often, there is a lack of knowledge of other health professional groups or, from time to time, active efforts to demean another group.

We wonder where the lines are drawn, as to who can delegate, under what circumstances, and when?

#### **ECONOMIC CONSIDERATIONS**

As noted previously, in our response, economic considerations, if not balanced, could be very problematic.

The present shortage situation has highlighted, as an example, that employers' last thoughts are not so much

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on the public's interest, but on the economics ( bottom line). Some have had no second thoughts of attempting to put non-qualified personnel in jobs beyond that person's competencies. Some have tried, despite existing legislation, as our Profession has experienced first hand. This, again, raises the issue of ethics in health-care governance.

Although economic impact may be helpful in illuminating whether or not the public interest is being served, it also could cloud the situation causing poor decision making.

### **EDUCATION**

The issue of competency is a core issue and key to providing safe, effective and efficient patient care that provides the desired outcomes. This pertains to whether it is a regulated or unregulated provider group.

We wonder how the public would, or could, determine what changes are required, whether it be entry-to-practice, or at the highest level of the Professions' Advanced/Extended Practice ladder.

Changes in medical care are too rapid for the public to be the determining body as to what the Profession should be advocating its practitioners and others on. Further, change for a Profession may be driven by other Professions, or the economic factors such as shortages. The test should be that the education minimizes the risk of harm.

The public's need for service could be different depending on where the public lives. Further, interests can be deliberately shaped through television and the internet, which raises the question of validity.

Educational Programs are designed differently, depending on the content and the delivery model. Evaluation must be consistent with the stated outcomes, and validation must be conducted on tried and true methodologies. There is no "best evolution" process, in our view.

### **TITLE PROTECTION**

We would like to note that there is an issue regarding title protection and overlapping/collaborative practice. The "title" a person uses may have to be revisited. The accountability as to the Regulatory College which the person should be accountable to, is an issue. It certainly could be confusing, not only to the health-care provider, but more so to the public.

We have noted a trend where the unregulated sector is using titles very close to the protected titles used, and there is no recourse for the Health Professional regulated under the RHPA, and no accountability of the unregulated health practitioner in doing this.

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### **CONCLUSION**

We have provided comments and observations on the Discussion Paper as a courtesy and as a preliminary submission, which is why we have not responded to the specific questions posed in the Discussion Paper. Should the MoHLTC request us to address the Sunrise/Sunset/Scope of Practice issues, we will use this document as the basis for our response.

We would hope that the issues and recommendations of the RHPA Five (5) Year Review are addressed before moving on to the matters in the Discussion Paper. It may well be that what comes out of the long outstanding recommendations, may alter the Sunrise/Sunset/Scope of Practice approach for input.

The issue of what is meant by "Public Interest/Public Need" needs to be defined as it is used throughout the Discussion Paper as a major plank of the Paper's platform.

The economic thread throughout the document raises a trust issue in that it could well be perceived that regulation could end up being mainly driven by money.

The key, in our view, is that whatever the situation, the Health Care Provider, whether regulated or unregulated, have the competencies to provide effective, efficient quality patient care. Risk of harm is the primary or core criteria.

The Profession will be the key driver of the evolution of its Scope of Practice, and in doing so, must be open to include health-care providers who will be taught the competencies required to fill jobs vacated by those who have moved up the Scope of Practice. This noted, other stakeholders do need to be involved in shaping the Scope of Practice.

Education, no matter its form or model, must be evaluated and validated on tried and true educational theory and doctrine test.

Finally, unregulated Practitioners need to be held accountable, because presently it is perceived that regulated Professions are discriminated against, which is creating a movement to consider de-regulation.

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