REGULATION OF HEALTHCARE PROFESSIONALS

A REPORT TO THE BRITISH COLUMBIA SOCIETY FOR LABORATORY SCIENCE AND THE BRITISH COLUMBIA ASSOCIATION OF MEDICAL RADIATION TECHNOLOGISTS

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Submitted by

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TABLE OF CONTENTS

1. Introduction ............................................................................................................. 2
2. Project Approach ..................................................................................................... 2
3. Health Professions Regulation in Other Provinces .............................................. 4
   3.1 Medical Laboratory Technologists ................................................................. 4
   3.2 Medical Laboratory Assistants ......................................................................... 4
   3.3 Medical Radiation Technologists ....................................................................... 5
4. Impact of Regulation on Public Safety ............................................................... 6
   4.1 Public Involvement in the Regulatory Process ................................................. 7
   4.2 Right to Practice and Scope of Practice ......................................................... 7
   4.3 Professional Misconduct and Competence Issues ......................................... 8
5. Health Professionals Supply and Mobility ........................................................... 9
6. Complaints and Disciplinary Processes ............................................................. 14
   6.1 Complaints and Hearings ................................................................................. 14
   6.2 Alternative Dispute Resolution ....................................................................... 16
   6.3 Accountability .................................................................................................... 17
7. Quality Assurance .................................................................................................. 18
8. Cost and Sustainability .......................................................................................... 22
9. Models for Health Professions Regulation ....................................................... 23
10. Scope of Practice and Joint Regulation .............................................................. 25
11. Bibliography .......................................................................................................... 29
1. **INTRODUCTION**

This study was undertaken at the request of the British Columbia Society of Medical Laboratory Science to respond to questions and concerns posed by the Ministry of Health regarding the potential regulation of medical laboratory technologists, medical laboratory assistants and medical radiation technologists.

2. **PROJECT APPROACH**

An internet search was conducted to obtain recent literature on professional regulation and related topics. The specific references are cited in the Bibliography at the end of this report. Copies of existing health professions legislation in Canada were obtained and reviewed.

Regulatory bodies for medical laboratory technologists and medical radiation technologists in Canada were contacted and asked to provide statistics from their databases. Personal interviews were conducted with College staff in Ontario and Alberta. Information was more readily available from the medical laboratory technologist regulators. Only the College of Medical Radiation Technologists of Ontario responded to the request for data.

The study set out to answer some specific questions:

- Have different regulatory regimes hindered, maintained or improved public safety in response to changes in the delivery of services, restructuring and standards of practice?

- How have regulatory bodies impacted health care professional supply and mobility and what can be done to ensure a sufficient supply of adequately trained laboratory professionals? Have entry to practice requirements escalated due to regulation? If so, has this been generally recognized as
being in the public interest? Can regulatory bodies positively influence the availability of these professionals?

- How well have regulatory bodies protected the public through the complaints and disciplinary processes? Are there better ways to handle complaints and discipline?

- How effective are quality assurance requirements in contributing to protecting public safety?

- How can a regulatory body deliver cost effective sustainable services?

- What is the feasibility of jointly regulating the two groups of health professionals?
3. HEALTH PROFESSIONS REGULATION IN OTHER PROVINCES

3.1 Medical Laboratory Technologists

Medical laboratory technologists have governing legislation in six provinces, with Manitoba and Newfoundland and Labrador currently pursuing legislation. The type of legislation varies.

Table 1

<table>
<thead>
<tr>
<th>Province</th>
<th>Enacted</th>
<th>Name</th>
<th>Statute</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nova Scotia</td>
<td>2004</td>
<td>Nova Scotia College of Medical Laboratory Technologists</td>
<td>Medical Laboratory Technology Act</td>
</tr>
<tr>
<td>New Brunswick</td>
<td>1991</td>
<td>New Brunswick Society of Medical Technologists</td>
<td>An Act Respecting the New Brunswick Society of Medical Laboratory Technologists</td>
</tr>
<tr>
<td>Quebec</td>
<td>1973</td>
<td>Ordre des technologistes médicaux du Québec</td>
<td>Code des Professions: Medical Laboratory Technologists Act</td>
</tr>
<tr>
<td>Ontario</td>
<td>1991</td>
<td>College of Medical Laboratory Technologists of Ontario</td>
<td>An Act respecting the regulation of the Profession of Medical Laboratory Technology</td>
</tr>
<tr>
<td>Saskatchewan</td>
<td>1995</td>
<td>Saskatchewan Society of Medical Laboratory Technologists</td>
<td>The Medical Laboratory Technologists Act</td>
</tr>
<tr>
<td>Alberta</td>
<td>1995/2002</td>
<td>Alberta College of Medical Laboratory Technologists</td>
<td>Health Disciplines Act (95)/Health Professions Act (02)</td>
</tr>
</tbody>
</table>

Ontario is the only province having a regulatory body that is distinct and separate from the professional society. Other provincial bodies combine the functions of regulation and professional advocacy. The effectiveness of this dual role is questionable and this will be addressed in a subsequent section.

3.2 Medical Laboratory Assistants

There is no legislation in Canada for the professional regulation of medical laboratory assistants. Alberta is considering making application for their inclusion in the College and there has been some discussion in Ontario. Ontario regulates
the practice of medical laboratory assistants/technicians through the Laboratory and Specimen Collection Licensing Act; the Act lists the duties they may perform and states that they may not perform any actions that require the use of independent judgment. In other professions, nursing assistants are the only precedent, being regulated in most provinces. There is an application pending in Ontario to include pharmacy assistants/technicians under the College of Pharmacists.

The medical laboratory technologist profession has chosen to voluntarily define an entry to practice standard for medical laboratory assistants. Ontario has had a curriculum and competencies defined for almost twenty years and administers a certification examination. The Canadian Society for Medical Laboratory Science re-introduced a medical laboratory assistant certification examination three years ago, after a lapse of more than fifteen years.

3.3 Medical Radiation Technologists
Legislation for the regulation of medical radiation technologists has been enacted in three provinces (Table 2). Ontario is the only regulatory body that is distinct and separate from the professional society. Ultrasonographers are not included in the Ontario legislation; Magnetic Resonance Imaging (MRI) technologists were recently required to register with the College.
Table 2

<table>
<thead>
<tr>
<th>Province</th>
<th>Enacted</th>
<th>Name</th>
<th>Statute</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alberta</td>
<td>1985/2005</td>
<td>Alberta College of Medical Diagnostic and Therapeutic Technologists</td>
<td>Health Disciplines Act (95)/Health Professions Act (05)</td>
</tr>
<tr>
<td>Saskatchewan</td>
<td>1987</td>
<td>Saskatchewan Association of Medical Radiation Technologists</td>
<td>The Medical Radiation Technologists Act</td>
</tr>
<tr>
<td>Ontario</td>
<td>1991</td>
<td>College of Medical Radiation Technologists</td>
<td>Regulated Health Professions Act</td>
</tr>
<tr>
<td>Quebec</td>
<td>1973</td>
<td>Ordre des technologies en radiology du Québec</td>
<td>Radiology Technologists Act</td>
</tr>
<tr>
<td>Nova Scotia</td>
<td>1989</td>
<td>Nova Scotia Society of Medical Radiation Technologists</td>
<td>Medical Radiation Technologists Act</td>
</tr>
</tbody>
</table>

4. IMPACT OF REGULATION ON PUBLIC SAFETY

Health professions legislation is enacted for the purpose of regulating the practitioners through standards of practice, continuing competence, and complaints and disciplinary processes. The expectation is one of increased public protection through the assurance of competent practitioners, who are subject to investigation in the event of a report of non-competence or professional misconduct. The public has direct access to make a complaint about the conduct of a professional and the regulatory body is obliged to assess the complaint and if appropriate, conduct an investigation. There does not appear to be any definitive literature that specifically addresses the impact of professional regulation on public safety. It is not unreasonable to draw a correlation between the number of disciplinary activities reported by regulated professions and an assumed impact on public safety.
4.1 Public Involvement in the Regulatory Process

A Board or Council that includes public appointees governs most regulatory bodies. These public representatives play a key role in bringing the public perspective to the regulatory process, at both Board and Committee levels. Ontario legislation is the most prescriptive of the role of the public members. For public appointees to remain completely impartial, the government that appoints them and not the regulatory body should fund them.

For a member of the public to lodge a complaint or make an inquiry about a professional, they must first be aware of both the legislation and the practice of the profession. Regulators and government share responsibility for raising public awareness of professional regulation. Web sites are the most commonly used tool and most professional regulators have a web site. The CMLTO reported almost 50,000 visits to their site in 2000.

4.2 Right to Practice and Scope of Practice

Legislation limits the health professionals in varying degrees. Some statutes limit the use of title only, while others specify the tasks or activities the health professional may or may not perform. The Ontario Regulated Health Professions Act lists thirteen controlled acts; each regulated profession is permitted to perform one or more of the controlled acts. The 2003 review of this legislation notes that this model has encountered a number of problems due to its rigidity. Other provinces use delegated or licensed acts models. What the public expects is a competent practitioner; they do not need to understand the process behind the authorization to practice.
4.3. Professional Misconduct and Competence Issues

A big issue that drew a lot of media attention fifteen to twenty years ago is sexual abuse of patients by health professionals. This in turn led to the inclusion of specific requirements in legislation in an attempt to prevent or discipline abuse. The public is the beneficiary of the tight scrutiny applied to health professionals’ practice today. A finding of professional misconduct for sexual abuse results in the loss of the right to practice.

The Health Professions Advisory Council in Ontario prepared a report for the Ministry on the effectiveness of the Complaints and Discipline processes of the regulatory Colleges in handling reports of sexual abuse. They observed that a large proportion of the public does not know where to file a complaint. A series of recommendations were made to increase responsiveness of Colleges’ complaints and discipline processes and to encourage complainants to come forward.

A similar but very different matter is the effect of debilitating illness on a health professional’s ability to practice safely. Fitness to practice provisions direct a regulatory body to investigate and to impose limitations on practice where appropriate. Keeping this separate from a disciplinary process that is punitive is a good idea and increases the likelihood of compliance.

All health professions have defined and adopted a Code of Ethics to guide practice in the best interests of fellow professionals and the public.

The number of complaints received by a regulatory body is only a partial measure of public protection. The number proceeding to the disciplinary process is a more definitive indicator. Details of complaints are not made public, only numbers are published. Many are dismissed as being unfounded or having insufficient evidence to proceed further. In some cases the professional may be
cautioned, admonished or required to complete an education program, without going to discipline, if there is an admission of being at fault and the transgression is minor. A complaints process is built on the assumption that the public has sufficient knowledge of the practice of a profession to know when professional misconduct has occurred. The public has a limited understanding of medical laboratory technology.

There are significantly more complaints and discipline proceedings in Ontario. This can be attributed to a greater need or to a greater diligence. It is difficult to believe that practitioners in other provinces are any more competent or less prone to negligence. The format of the Ontario legislation places a greater onus on the Colleges to protect the public. The Colleges undertake public awareness campaigns, both individually and collectively through the Federation of Health Regulatory Colleges. There is also a mandatory reporting requirement in the Ontario legislation; employers are required to report the dismissal of a medical laboratory technologist if it is for reasons of incompetence or professional negligence.

Studies have documented the benefits of quality assurance programs. Programs require participation in continuing education as a minimum and sometimes include competence assessment or peer review. Practitioners participating in these programs should have a reduced risk of error or professional incompetence.

5. HEALTH PROFESSIONALS SUPPLY AND MOBILITY

A fear often expressed by those opposed to regulation of health professionals is that the supply of practitioners will be limited by the entry to practice standards. Defining and enforcing entry to practice standards is an essential part of professional regulation. A study done for the Labour Market Policy Directorate,
Human Resources and Skills Development Canada in 2001 identified the existence of partial barriers in the medical laboratory technologist and medical radiation technologist professions due to the inconsistency of regulation across Canada. Where regulation exists for these professions regulators have in most cases made a conscious effort to identify and eliminate or minimize barriers. Both medical laboratory technologists and medical radiation technologists are educated in nationally accredited programs and write examinations administered by national societies. This uniformity greatly simplifies mobility across the country. Each profession has negotiated and signed an Interprovincial Mobility Agreement, in accordance with the requirements of the Labour Mobility Chapter of the Agreement on Internal Trade. The Medical Laboratory Technologist Agreement is in Appendix A.

Entry to practice standards for both professions are based on competencies defined by the national societies. Medical radiation technology has moved from a diploma to a degree entry requirement over the past ten years.

When there is a shortage of health professionals, employers would like to be able to hire foreign trained people to fill vacancies. The responsibility of a regulatory body is to ensure that the same standards of practice are applied to all practitioners. Both professions utilize a prior learning assessment process for foreign trained applicants. In Saskatchewan and New Brunswick the medical laboratory technology regulatory bodies do not have a Registration Committee process; the Registrar/Executive Director screens applications. Over the last five years, Alberta has had 111 new applications, 27 were declined, 30 approved and 54 were approved with conditions. Most new applicants are from other countries following the closure of so many Canadian education programs for both professions. Quebec is the exception to the program closures and information for this province is tabulated in Table 3; the number of applicants is higher than other provinces, as is the number declined. This may be attributable to the structure of the legislation; membership has not been required for practice, but
recent changes in delegated acts have increased the need to be a member. Figures from Ontario (Table 4) demonstrate that the prior learning assessment process is not an obstacle to gaining entry to practice. An applicant may not be refused registration without going through the Registration Committee process in Ontario.

Table 3
Quebec MLT Registration Statistics

<table>
<thead>
<tr>
<th>Year</th>
<th># of applicants declined</th>
<th># approved</th>
</tr>
</thead>
<tbody>
<tr>
<td>2000</td>
<td>27</td>
<td>256</td>
</tr>
<tr>
<td>2001</td>
<td>44</td>
<td>252</td>
</tr>
<tr>
<td>2002</td>
<td>15</td>
<td>204</td>
</tr>
<tr>
<td>2003</td>
<td>67</td>
<td>695</td>
</tr>
<tr>
<td>2004</td>
<td>89</td>
<td>337</td>
</tr>
</tbody>
</table>

Table 4
Ontario MLT Registration Statistics

<table>
<thead>
<tr>
<th>Year</th>
<th>Number of registrants</th>
<th>Total number of new applicants</th>
<th>Cases referred to the Registration Committee</th>
<th>Declined</th>
<th>Approved with conditions</th>
<th>Approved with no conditions</th>
<th>Pending at year end (requested more information)*</th>
</tr>
</thead>
<tbody>
<tr>
<td>1995</td>
<td>8691</td>
<td>399</td>
<td>102</td>
<td>14</td>
<td>88</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>1996</td>
<td>8703</td>
<td>178</td>
<td>40</td>
<td>4</td>
<td>36</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>1997</td>
<td>8354</td>
<td>100</td>
<td>20</td>
<td>1</td>
<td>16</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>1998</td>
<td>7953</td>
<td>186</td>
<td>30</td>
<td>4</td>
<td>21</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>1999</td>
<td>7821</td>
<td>198</td>
<td>29</td>
<td>2</td>
<td>22</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>2000</td>
<td>7630</td>
<td>189</td>
<td>29</td>
<td>3</td>
<td>26</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>2001</td>
<td>7497</td>
<td>264</td>
<td>66</td>
<td>1</td>
<td>65</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>2002</td>
<td>7692</td>
<td>293</td>
<td>159</td>
<td>2</td>
<td>157</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>2003</td>
<td>7764</td>
<td>279</td>
<td>128</td>
<td>2</td>
<td>126</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>2004</td>
<td>7757</td>
<td>327</td>
<td>127</td>
<td>3</td>
<td>123</td>
<td>1</td>
<td></td>
</tr>
</tbody>
</table>

* = these applicants went to another registration committee meeting when/if the documents were provided

In medical radiation technology it is a similar situation. There are an increasing number of foreign trained applicants in Ontario and approximately 70% are approved for registration, sometimes with restrictions or conditions for an initial
period. Ontario legislation allows for appeal of Registration Committee decisions to an independent public Review Board. The Board returns a very small percentage of decisions for reconsideration.

The number of medical laboratory technologists in Ontario continues to decline; this is a product of provincial laboratory reform strategies. The number of medical radiation technologists in Ontario has increased annually for the past five years:

<table>
<thead>
<tr>
<th>Year</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>2000</td>
<td>5306</td>
</tr>
<tr>
<td>2001</td>
<td>5388</td>
</tr>
<tr>
<td>2002</td>
<td>5476</td>
</tr>
<tr>
<td>2003</td>
<td>5616</td>
</tr>
<tr>
<td>2004</td>
<td>5775</td>
</tr>
</tbody>
</table>

New Ontario regulations required medical resonance imaging technologists to be registered by the College for the first time in 2004. Radiation Therapists have increased in number in response to a provincial cancer treatment strategy. Ultrasonographers remain outside of the regulatory framework, despite extensive negotiations to bring them in under the College of Medical Radiation Technologists of Ontario.

The College of Medical Radiation Technologists of Ontario has prepared a Legislation Learning Package to provide assistance to individuals who trained outside Ontario and wish to complete the requirements for registration. It is a self study package in nine modules with a certificate of completion to be submitted to the College.

A Project Partnership was formed by four Ontario regulated health professions (the Colleges of Massage Therapists, Physiotherapists, Occupational Therapists and Medical Laboratory Technologists) and three community service agencies (Skills for Change, Accessible Community Counselling and Employment Services and the South Asian Women’s Centre) to direct research to identify barriers experienced by internationally educated professionals in two specific components within the registration process of the four health professions: examination and supervised practice. The goal was to identify unintentional
barriers and to provide solutions for removing such barriers in these two components. The Status of Women Canada funded the project and the report published in March 2004. Strategies were proposed requiring multi-stakeholder involvement to ensure effective action and progress. Stakeholders include government, regulatory Colleges, national examination bodies, community services, professional associations, employers, and educational institutions. The proposed strategies are:

- Ensure accurate and timely information about the registration process for each regulated health profession is available at all entry points to the process.

- Enhance examination preparation materials and tools.

- Include regular third party reviews in examination development process to identify cultural or language bias.

- Develop early intervention and corrective models to assist candidates who are not initially successful in either written or clinical examinations.

- Ensure supervised practice settings provide targeted and strategic clinical experience.

- Review all fees borne by candidates in the registration process to ensure they are fair and necessary.

- Improve financial support or assistance available for internationally educated professionals.
• Undertake further research on the perception and impact of language and communication to assist in the success of internationally educated professionals.

• Enhance existing resources to ensure a coordinated career support mechanism to assist internationally educated professionals to successfully complete the registration process.

6. COMPLAINTS AND DISCIPLINARY PROCESSES

6.1 Complaints and Hearings
All regulatory bodies are required to implement processes for handling complaints and disciplining members found guilty of incompetence or professional misconduct. In most cases legislation requires information about complaints and discipline be made public. The way in which this is accomplished varies considerably. A survey of provincial medical laboratory technologist regulatory bodies yielded the information in Table 5. New Brunswick did not receive any complaints or initiate any discipline hearings 2000-2004.

As previously discussed in the Impact on Public Safety section, the structure of the statutes has an impact on the number of complaints received by a regulatory body. When the regulatory and advocacy functions are combined, an organization is less inclined to actively solicit reporting of complaints. Ontario is the only province to have both a regulatory College and separate provincial professional societies for both medical laboratory technologists and medical radiation technologists. It is not financially viable for smaller provinces to sustain separate organizations. Well-structured regulations/bylaws contribute to good governance and accountability in all organizations.
## Table 5
**Medical Laboratory Technologists**

<table>
<thead>
<tr>
<th>Year</th>
<th>Province</th>
<th># of Complaints</th>
<th># of Discipline cases</th>
<th>Discipline outcomes</th>
</tr>
</thead>
</table>
| 2000 | ON       | 4               | 5                     | - Sexual abuse: registration revoked  
- Failure to maintain standard of practice: 3 weeks suspension $250 fine  
- Incompetent: one week suspension, $100 fine and no longer allowed to practice immunohematology  
- Unprofessional conduct, errors made due to medical condition: required to practice under supervision  
- Theft of money from purse in lab: 1 month suspension and ordered to take an ethics course |
| QC   | 1        | 0               |                       |                     |
| 2001 | ON       | 0               | 4                     | - Transfusion science errors: 1 month suspension, course and $250 hearing costs  
- Lab errors: 3 weeks suspension, courses in histology, immunohematology, specimen collection and ethics required, $1000 fine  
- QA documentation discrepancies: oral reprimand, $100 fine and required to report to the College on the importance of honest member communication with the College  
- Allegation of professional misconduct: adjourned in exchange for member resignation |
| QC   | 0        | 2               |                       | - temporary suspension  
- practice restrictions |
| 2002 | ON       | 0               | 2                     | - Lab errors: One week suspension or completion of courses in specimen collection and problem solving, $100 fine, $400 costs  
- Lab errors: 4 weeks suspension, reduced by a week on completion of a customized competency assessment in Immunohematology and any upgrading recommended, practice limited to supervision, $2,000 costs |
| QC   | 3        | 1               |                       | - suspension and fine |
| 2003 | ON       | 0               | 2                     | - Disgraceful, dishonourable or unprofessional conduct: reprimand, 2 weeks suspension or completion of course on boundaries, $3,000 costs  
- Offence relevant to suitability to practice: reprimand, 3 weeks suspension, 1 remitted on completion of a course on boundaries, $500 fine, $1500 costs |
| QC   | 1        | 0               |                       |                     |
| 2004 | ON       | 0               | 0                     |                     |
| QC   | 7        | 0               |                       |                     |
| NS (new) | 1  | 0               |                       |                     |
| 2000 - 2004 | AB | 13    | 3                     | Reprimands, required courses, fines, costs |
| SK   | 8        | 4               | All found guilty      |                     |
Fitness to practice, which was also addressed under Impact on Public Safety, deals with a professional’s incapacity as a result of injury or illness, either physical or mental. When investigations lead to referral to a panel for a hearing, it is important that this process be conducted in camera, due to the personal nature of the material disclosed. Ontario Colleges have held a limited number of Fitness to Practice hearings since the Regulated Health Professions Act was proclaimed in 1991.

Medical radiation technologists have more interaction with the public and their practice is better understood, resulting in regulatory bodies receiving more complaints. Table 6 shows data for Ontario in the last five years. Information could not be obtained from other provincial regulators of medical radiation technologists. It seems the higher the profile of the profession, and the greater the contact with the public/patient, the more complaints are likely to be received by the regulator, with physicians being at the top of the list.

<table>
<thead>
<tr>
<th>Year</th>
<th>Complaints</th>
<th>Discipline hearings</th>
<th>Discipline outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>2000</td>
<td>6</td>
<td>1</td>
<td>- Professional misconduct, negligence: 2 months suspension, reprimand</td>
</tr>
<tr>
<td>2001</td>
<td>0</td>
<td>1</td>
<td>- Non-compliance with QA program requirements: suspension until compliant, $2,000 costs, member resigned</td>
</tr>
<tr>
<td>2002</td>
<td>9</td>
<td>1</td>
<td>- Payroll record mismanagement: one year suspension, reprimand</td>
</tr>
<tr>
<td>2003</td>
<td>10</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>2004</td>
<td>10</td>
<td>1</td>
<td>Decision issued in 2005</td>
</tr>
</tbody>
</table>

**6.2 Alternative Dispute Resolution**

Discipline hearings are quasi-legal proceedings and very expensive for the Colleges. Hearings are open to the public and findings of guilt are made public, together with details of the penalty. If a matter can be resolved by other means it is preferable for everyone. In recent years there has been a focus on the use of
Alternate Dispute Resolution (ADR) techniques, to broker resolutions to matters of professional misconduct or negligence. The Alberta legislation allows the Colleges to use ADR in complaint resolution. A paper published in Australia in 2003 examined the use of ADR techniques within health regulatory authorities both within Australia and New Zealand and internationally. The recommendations made for amendments to health professions legislation were to use the term “case management processes” rather than ADR which has a number of definitions; to allow for the inclusion a broader range of case management processes at the conclusion of preliminary investigations and during the formal hearing process; and to educate regulators on the use of a variety of case management processes. Regulators must be seen to behave consistently, fairly and transparently and to act in the public interest.

6.3 Accountability
Accountability is fundamental to any complaints and discipline process. The regulator must expect to be held accountable by government, by its members, by patients receiving service from members and by the public at large. A very good discussion paper entitled Rhetoric, Fallacy or Dream? Examining the Accountability of Canadian Health Care to Citizens was published in 2004. There is an assumption of a relationship between the parties for an accountability requirement to exist. There are different types of accountability and regulation focuses on professional accountability. This is defined as the responsibility for demonstrating the maintenance of professional standards and relates to the quality of service provided. Regulators are responsible for policy development, regulation and redress. The conclusions drawn in the paper are that efforts are underway to improve system accountability and can be further enhanced by engaging citizens in the process. Involving citizens in discussions about the way in which information is reported and how to make it more useful is recommended. This is an interesting concept when applied to health professions such as medical laboratory technologists that have little direct interaction with the public.
Faced with growing demand for increased public accountability on the part of self-governing professional bodies, innovative ideas should be welcomed.

7. QUALITY ASSURANCE

All of the many dimensions of quality are widely discussed in the literature and the debate continues on how best to ensure ongoing competence of practitioners. In the past, many professions relied primarily on discipline proceedings to monitor member competence. This approach assumes that from the time of licensing or registering, the regulator does not need to take positive steps to foster or monitor quality. This has the potential to harm both the public and the profession’s reputation. Today, most regulatory bodies have a quality assurance requirement in the legislation. The components of a quality assurance program vary considerably and may include:

- Continuing education, either mandatory or voluntary
- Required hours of practice
- Specialist or advanced certification
- Random practice review
- Focused practice review, targeting those identified as being in need of remediation
- Reflective practice and self-assessment tools
- Publication of standards and guidelines for practice
- Peer activities, e.g. mentoring
- Re-examination

A definition of competence used in nursing can be edited and applied to technologist professions: “a competent technologist is one who is able to integrate and apply the knowledge, skills and judgment required to practice safely and ethically in a designated role and practice setting”. A variety of tools have been developed by health professions to measure clinical competence, but
there is no one standardized tool that can be considered valid, consistent and cost-effective. A best practices paper published by the College of Registered Nurses of Nova Scotia suggests a “triangulation” approach; a mix or variety of competence assessment tools and strategies would be employed such as paper-based examinations, standardized clinical assessments and supervisor evaluations.

A Review of British Columbia Health Professions’ Quality Assurance Programs, by David Logan, published March 2003, provides a review of current practices and recommends changes going forward. The response from the BC regulatory Colleges was published in February 2005 with some conflicting opinions. Logan looked at the US where the Pew Commission has recommended periodic re-examination as a way to address competency concerns. New Zealand legislation provides a legislative model that provides authority and evidentiary protection for QA activities. The UK has proposed assuring quality of medical practice using a “re-validation” model. The Ontario Regulated Health Professions Act requires the Colleges to implement quality assurance programs that include a practice competence component. The recommendations for changes to the Health Professions Act made by Logan are:

- The functions of the Quality Assurance Committee should be articulated, including: overall responsibility for recommending QA policy to the board; approving specific QA or continuing competency programs; identifying outcome measurements for these programs and evaluation methods; and proposing a timetable for implementing these measures and evaluations;
- The college should make renewal of registration contingent on completion of a QA program it chooses; government should not stipulate a particular program, but the bylaws should demonstrate that the college has addressed this linkage;
- Subject to adequate legislative authority and to colleges identifying the desirability of such an approach, the bylaws should create and empower assessors in a QA context;
The annual reports of the college should include information relating to QA, including reporting on the timetable for implementing, measuring and evaluating QA programs.

The Health Regulatory Organizations of British Columbia (HROBC) responded with a Philosophical Approach, Principles and Assumptions, citing quality gurus and the principles of self-governance. The paper has a section on the Difficulties in Clarifying the Relationship Between Quality Assurance and Health Professional Regulation, noting that there is an overall lack of compelling and objective evidence that quality management systems actually lead to improvements in patient care and outcomes. It is apparent to the reader that the professions are not supportive of making the changes suggested by Logan. They refer to limited resources, resistance of members, committee membership turnover, changes occurring in the health care environment and the time delay apparently inherent in moving from identification to remedial action. Mandatory continuing education is dismissed as having no conclusive evidence of any appreciable impact on competence or changes in practice. The HROBC puts forward four principles to guide promotion of a quality assurance approach in the “coming years”.

(i) Registrants understand and value self-regulation. Health professional regulatory colleges share accountability and responsibility for quality assurance with their registrants.

(ii) Quality assurance is embedded across the continuum of key roles for which health professional colleges are responsible: from entry to practice, to supporting the maintenance of competent practice, through to remediation, and intervening when practice is below expected standards.

(iii) Quality assurance initiatives are more likely to be accepted by the profession and thus to succeed when there are collaborative partnerships between health professional regulatory colleges,
employers, membership-driven associations, educational institutions, and other stakeholders.

(iv) Colleges are obligated to continue to provide support to registrants in pursuit of quality assurance, including continuing competence programs. The nature of this support will vary by college and may include existing continuing competence programs.

Clearly the colleges do not support any kind of mandatory quality assurance activities, arguing for the status quo. This would seem to be contrary to the whole quality management systems movement, risk management and the public expectation of accountability. It is no surprise then that the Ombudsman of British Columbia has expressed concerns about possible self-interest on the part of health professionals compromising effective regulation of the professions in the public interest.

How do quality assurance programs contribute to public safety? When administered with rigor and supported by legislated authority, a regulatory agency can audit for compliance and conduct practice audits, both randomly and for cause. Employers become partners in the process, supporting professional development and continuing education and reporting incompetence. Practitioners take responsibility for self-assessment and recognizing any limitations to their ability to practice competently. Although there are not yet any published studies with evidence of improved public safety, this is surely only a matter of time, given that a number of jurisdictions have moved to implement programs of this type. Ontario is one example: the Regulated Health Professions Act mandates employer reporting; Colleges mandate participation in quality assurance programs that have a mix of continuing professional development, practice audits and linked to renewal of registration. There have been a number of discipline cases with charges of non-compliance to QA programs.
8. COST AND SUSTAINABILITY

A key principle of professional self-regulation is that professional fees fund the operation. This may become a limitation for a regulatory body with a small membership. Provinces with over-arching legislation expect the same scope of activities and diligence from all professions, regardless of numbers. One of the criteria for application to be considered a regulated profession in Ontario is the ability to sustain the cost of regulation.

Cost is the primary reason why the regulatory and professional advocacy functions remain combined in smaller provinces. However the effectiveness of the regulatory process can be called to question. The most recent published financial statements for the two professional Colleges in Ontario show expenses of $2.2M for CMRTO and $1.4M for CMLTO. Alberta CMLT is estimating expenses of $927,000 for 2005. Alberta has the highest fees for medical laboratory technologists in Canada at $390 per year for 2006. British Columbia should expect operating costs for regulation similar to those in Alberta, given the respective numbers. Table 7 shows the professional fees for the respective provinces that were available. Fees for national society membership are in addition to those shown.

Table 7
Professional Fees

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<tr>
<th>Province</th>
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</thead>
<tbody>
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<td></td>
</tr>
<tr>
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</tr>
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<td>Nova Scotia</td>
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<td>Not applicable</td>
</tr>
<tr>
<td>British Columbia</td>
<td>Not applicable</td>
<td>$90</td>
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</table>
There is no record of a profession de-regulating for financial reasons. De-regulation usually only occurs when government decides it is no longer necessary. The alternative of government intercession in professional regulation would not only be more costly, but infinitely less effective. The quest should be to continue to demand accountability from the regulators and continuously improve the regulatory process.

Cost could be a strong argument in favour of a combined regulatory structure for the two professions that would be able to share some administrative costs.

9. MODELS FOR HEALTH PROFESSIONS REGULATION

Earlier in 2005, the Ontario Health Professions Regulatory Advisory Council (HPRAC) was asked by the Minister to review a number of items pertaining to professional regulation, including whether there are any impediments in the RHPA or the profession specific acts to a shared service business model for new professions for whom the financial demands of regulation are onerous, but where the public interest would be served by regulation. This follows a report in 2003 on Regulating, De-Regulating and Changing Scopes of Practice in the Health Professions, A Jurisdictional Review, by Douglas Alderson and Deanne Montesano for HPRAC. In the review three modes of regulation are identified: Licensure, Certification and Registration, representing a scale of regulation. Licensure creates a professional monopoly, giving the practitioner exclusive right to practice in addition to title protection. Certification is achieved through title protection Acts, is less restrictive and recognizes individuals who have met predetermined qualifications set by a regulatory agency. Registration is the least

<table>
<thead>
<tr>
<th>Medical Radiation Technologists</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Alberta</td>
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</table>
restrictive and does little more than provide a roster of practitioners. The Review concludes that public interest is the only justification for regulation. Protection from harm and the advancement of the public’s health, safety and welfare are paramount considerations. The determination of those considerations remains a political judgment in the opinion of the authors.

There are two well recognized models for professional self-regulation that bring together disparate health disciplines within an overall coordinating self-regulating Council, to maximize the establishment of common processes, structures and terminology, and to provide a reputable and well resourced body for the public and government to interact with. The two models differ quite significantly.

**Health Professions Council – United Kingdom**

The Health Profession Act, 2001, created the Health Professions Council in the UK. The role of the Council is to protect the health and well being of anyone using or needing the services of the 13 health professions regulated under the Act. The Council administers the registration of all of the professionals and is currently planning the implementation of a continuing professional development program in July 2006, following consultation with the registrants and other stakeholders. A random number of professionals will be audited each year for compliance to the program. The Council also sets standards of professional training, performance and conduct. A register of health professionals is maintained and action is taken if registered health professionals do not meet defined standards. Both medical laboratory technologists (Biomedical Scientists) and medical radiation technologists (Radiographers) are regulated under the Act. All professions pay the same fee of £60 (approx $150) per year, collected every two years.

This model regulates all professions under a single regulatory framework, presumably yielding economies of scale in the regulatory process. There is no information available on the effectiveness of this model.
Health Professions Regulatory Council – Ontario

The Health Professions Regulatory Council (HPRAC) is an “arms length” agency of the Minister of Health and Long-Term Care and provides independent policy advice to the Minister on matters related to the regulation of health professions in Ontario. The mandate of the Council is defined in the Regulated Health Professions Act (RHPA 1991) that applies to 23 professions in Ontario. HPRAC advises the Minister on whether to regulate or de-regulate health professions and can suggest amendments to the RHPA and related profession specific Acts and regulations. The council may also be directed by the Minister to investigate and report on any matter pertaining to regulation of health professions. HPRAC has a duty to evaluate and report on the effectiveness of each College’s programs related to: Patient Relations, Quality Assurance and Complaints and Discipline procedures with respect to professional misconduct of a sexual nature. The 7 members of HPRAC are appointed by government and may not be past or present members of the regulated health professions or public servants.

HPRAC essentially serves as an overseer of the individual regulatory Colleges, each of which functions independently. There is however a voluntary Federation of Health Regulatory Colleges of Ontario that provides a collective voice on behalf of the regulators and is a communication channel for HPRAC when matters affecting all Colleges need to be addressed.

10. SCOPE OF PRACTICE AND JOINT REGULATION

As health professions continue to evolve and expand their scope of practice, it becomes increasingly difficult to carve out professional territories. A century ago the practice of medicine was all encompassing, over the ensuing years other
professions have emerged and assumed responsibility for tasks previously the exclusive domain of the physician. The regulatory models have evolved similarly. Title protection is the most common form of regulation today, combined with some form of assigning responsibility for tasks that present a particular risk of harm to the public. These restricted, reserved or controlled acts (terminology varies according to the specific statutes) have generally replaced the former delegated acts, reflecting the independence of the various health professionals. The delegation model was based on physician control of all invasive procedures.

Title protection models allow a profession to articulate its scope of practice and the standards required for practice. Practice may include acts that present a risk of harm and this is usually specified in legislation. The emphasis of any professional legislation should be on the accountability of the professional. Health professionals are expected to meet and maintain standards of practice and it is the job of the regulator to ensure this happens. This is achieved by a number of means:

- Practice restrictions e.g. MLTs practicing in one specialty only
- Assigning controlled or reserved acts to a profession or to individual practitioners
- Quality assurance programs for continuing professional development
- Mandatory reporting of incompetence or professional misconduct by employers
- Complaints, discipline and fitness to practice processes
- Public reporting of compliance to the various requirements

There is a group of practitioners in Canada who have an overlapping scope of practice; the Certified Laboratory and X-Ray Technicians (CLXT). There are education programs in Alberta and Saskatchewan and in Alberta there is a regulatory College exclusively for this group of practitioners. They are employed
in Western Canada in more rural locations. Legislation in Ontario and Quebec prevents them from practicing in those provinces.

In addition to the CLXTs who have completed a program of education and certification, there are also practitioners from both professions who have undergone additional training to allow them to expand their scope of practice in either laboratory or radiography areas. The challenge in British Columbia lies in designing a regulatory framework that encompasses the need for public protection, without having three separate regulatory agencies, as is the case in Alberta. The title protection and accountability model may be the solution. A CLXT may be registered by one or other of the professions of medical laboratory technologists or medical radiation technologists and subsequently held accountable for their actions. However, the two professions should jointly develop standards of practice for this group of practitioners. The same standards could then be administered by a joint College or by individual Colleges. It would not be in the public interest to ignore these practitioners in BC.

As far back as the 1940s, there is a record of consideration being given by the Ontario medical radiation technicians to the inclusion of lab people in their association. This did not come to fruition. In the process leading to the Regulated Health Professions Act, 1991 in Ontario, the Ontario Society for Medical Technologists proposed an umbrella College to regulated medical laboratory technologists, medical radiation technologists and respiratory therapists. The proposal followed discussions among and between the respective professions, about the feasibility of such a structure, the benefits and barriers. The concept was abandoned when each profession decided to place individual professional regulation as the first priority, with the umbrella proposal as a fall back position. A decade or more later, a number of the Ontario Colleges embarked on discussions about the possibility of sharing some administrative functions, once again failing to a consensus.
When the RHPA was enacted in Ontario technologists working in the in vitro section of nuclear medicine had the option to register with either the College of Medical Radiation Technologists or the College of Medical Laboratory Technologists, according to their qualifications and experience. Those who did not have the required qualifications were registered under a grandparent clause in the first year.

For a shared regulatory structure to be effective within a self-regulatory model, the consent of the professions is essential. While a survey has shown 73% of medical radiation technologists in British Columbia support professional regulation, the BC Association of Medical Radiation Technologists’ web site response on the idea of a combined College states “This is unacceptable to us, as our voice with government would be weakened and our ability to guarantee title protection for our members and the services we provide would be made more difficult. As well, there is no guarantee that fees for a combined college would be any less than for an autonomous college of Medical Radiation Technologists.” There is no further information to support the statement, dated April 2000. The purpose of a College is not usually to “have a voice with government”, but rather to regulate the profession in the public interest.

There is an opportunity for the diagnostic services professions in British Columbia to be pioneers in working together to develop a regulatory model that acknowledges the overlapping scopes of practice and regulates practitioners in the public interest.
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APPENDIX A

Mutual Recognition Agreement for Labour Mobility of Medical Laboratory Technologists in Canada

May 2002