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May 5, 2008

Ms. Annie Schiefer, Project Manager  
Health Professionals Regulatory Advisory Council  
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Dear Ms. Schiefer:

The Ontario Medical Association would like to thank you for the opportunity to provide input on the HPRAC consultation that is taking place regarding the Ministerial Referral on Interprofessional Collaboration among Health Colleges and Professionals.

Please find enclosed the Ontario Medical Association's submission outlining our views on this important matter. We will also be submitting a copy as an e-mail attachment to the address provided in the HPRAC discussion guide.

We look forward to continued participation in the HPRAC consultation process to assist in providing the best advice to the Minister on matters of interprofessional care.

Sincerely,

Ken Arnold MB BCh  
President



## **ONTARIO MEDICAL ASSOCIATION**

Submission to the Health Professions Regulatory  
Advisory Council

Respecting

The Consultation Discussion Guide on Issues Related to the  
Ministerial Referral on Interprofessional Collaboration among  
Health Colleges and Professionals

May 2008

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## ***Introduction***

The Ontario Medical Association (OMA) appreciates the opportunity afforded by the Health Professions Regulatory Advisory Council (HPRAC) to respond to the "Consultation Discussion on Issues Related to the Ministerial Referral on Interprofessional Collaboration among Health Colleges and Professionals". Although the contribution to interprofessional care that can be made directly by the regulatory colleges is relatively modest compared with other possible system enablers, it is important to consider opportunities for improvement at all levels of the system.

The OMA has prepared the following response to the questions raised in the HPRAC Discussion Guide (Guide). While we have attempted to consider each question individually, we have grouped our responses based on general themes in some instances.

## ***Defining Interprofessional Collaboration***

In general, the OMA agrees with the purposes set out for IPC initiatives at the regulatory college level, however, we feel that undue emphasis has been placed on expanding scopes of practice within the context of IPC. In addition, we believe that some of the specific issues surrounding college objectives, complaint processes, investigations and joint quality assurance programs have already been addressed with the enactment of Bill 171 and question what HPRAC hopes to accomplish in these areas.

While discussion around appropriate scopes of practice is an important component of the IPC model, the expansion of scopes of practice is only tangential to IPC. The more pressing task is a clear delineation of professional roles within teams. As we develop a clear understanding of the roles of each professional, we will also cultivate mutual confidence in the competence of team members in the provision of care within their respective roles.

As a general point, it is imperative that HPRAC emphasizes the need for *collaboration and not competition* between health care professionals in the interprofessional context. In addition, HPRAC should help to better distinguish leadership from supervision – physicians will often take a clinical leadership role but this does not necessarily imply a direct supervisory role over all the clinical services provided by a team.

A final preliminary point, it is important to bear in mind that the members who are “regulated” by each Colleges are represented by corresponding professional associations. Therefore, it is imperative that each professional association participates in this discussion surrounding IPC. By-passing the professional associations is akin to by-passing the voice of the profession. In fact, it is likely that greater mobilization for meaningful collaborative care will be made through the associations and not the professional colleges.

### ***Eliminating Barriers to Collaboration among the Colleges***

#### *Fees to Support IPC*

The Guide asks whether there are any obstacles in the *Regulated Health Professions Act* (RHPA) or other legislation that could restrict or prevent collaboration among colleges or providers. We would point to the *Health Insurance Act (HIA)* and the Fee Code model therein, which provides little incentive for physicians to collaborate with other health professionals. The OMA wishes to emphasize that the fee-for-service payment model is not inherently inconsistent with IPC; it simply needs some adjustments to support indirect services and team participation.

#### *Internal College Policies*

There are other systemic and administrative barriers that may interfere with IPC. Each college may be required to relinquish some of their administrative power to allow enhanced practical application of the collaborative model. For example, there are many

potential advantages to physicians delegating responsibility of controlled acts to other health professions: this will decrease demands on doctors and offer an efficient alternative in access to care. However, the internal policy surrounding delegation developed by the FMRAC is onerous for physicians and demands extensive follow up and attention to procedure. While these types of policies have patient safety as their intended focus, they make delegation less administratively efficient. The OMA is troubled by the fact that the some of the very colleges that insisted upon these complex rules now point to them as evidence that delegation is not a viable tool to support IPC. HPRAC may need to engage in open discussion with colleges to encourage removing complex administrative hurdles that may dissuade physicians from delegating acts.

### ***Developing Enablers for Collaboration among the Colleges***

#### *Enablers and the RHPA*

HPRAC asks what collaborative policies or initiatives will be required to ensure support for new colleges. The OMA believes that it is completely inappropriate to mandate existing colleges to "support" new colleges as they are being established. The establishment of new colleges is strictly a political decision and is completely outside of the duty of **self**-regulation for any existing profession that is funded by membership dues.

The development and implementation of IPC cannot erode the autonomy of each profession. Existing colleges can support and promote IPC without being required to do so. It should also be noted that IPC will continue to occur between providers whether they are regulated or not.

#### *"Related Colleges"*

HPRAC emphasizes collaborative care and shared administrative tasks between "related colleges", is linked to having same or similar scopes of practice. HPRAC needs to clarify what is meant by the term "related colleges". This term may have a shifting

definition depending on the context of the care being provided. We question the criteria that will be used in assessing whether or not colleges are “related” and doubt the usefulness of categorizing colleges based on a loose association of scopes of practice.

The OMA would discourage the merging of various colleges’ powers and procedures. Each professional college maintains a distinct character which includes rules and protocols that respond to the clinical realities and regulatory needs of each profession. If the colleges or college procedures are over-zealously amalgamated, not only will each profession’s regulatory structure be compromised, professional autonomy – which is embodied through self-regulating colleges - will also be eroded.

Instead, we propose a focus on "courses of care", which acknowledges the full range of professionals involved in specific types of care and allows the various professions that are involved in identified courses of care to discuss their respective roles and develop protocols for quality management. We do not believe that any legislative change is required to meet that objective.

### ***Structural Mechanisms as part of IPC***

#### *Joint Body for Complaints and Investigations*

The OMA believes that there is merit in the idea of exploring a common *framework* for addressing complaints and investigations related to team-based services provided by health professionals. We are less certain about the idea of a conjoint *process or body* for dealing with complaints and investigations between regulatory colleges. It may be sufficient, at present, for the colleges to avail themselves of their new right to share information relating to investigations before taking any further steps in terms of new regulatory processes.

The OMA does not believe that a conjoint process is appropriate for addressing disciplinary matters. We are concerned that such multi-disciplinary hearings would

simply result in less diversion from discipline to QA, because the process will become more adversarial as the parties try to deflect blame from themselves to one another. It is important for HPRAC to recognize that the college disciplinary process does not use the Patient Safety approach of 'no blame' – it is a quasi-judicial process that is very much engaged in the finding of wrong-doing.

The OMA believes that legislative changes authorizing joint investigation and/or disciplinary processes will not improve patient safety but will in fact increase interprofessional turbulence and interfere with collegial multidisciplinary care.

### *Joint Practice Standards*

The OMA supports the exploration of shared standards of practice in certain areas. There are four areas where this type of joint model might be explored:

1. *Administrative tasks*, such as record-keeping;
2. *Business matters*, including advertising, conflict of interest and managing incorporation of professional practices;
3. *Communications*, including team-building; and
4. *Ethics*, including such as creating consistent policies around conflict of interest.

The OMA does not believe that collaborative or joint development practice standards are appropriate for establishing clinical practice standards. The College of Physicians and Surgeons of Ontario has traditionally avoided articulating specific standards for clinical practice (although there are a few exceptions to this rule). This convention recognizes the fact that clinical practice standards are context-specific and change as new information is disseminated throughout the profession. The CPSO has always recognized that it is the **profession** and not the College that sets standards for clinical practice. This is the essence of self-regulation and must be protected if physicians are to continue to stand behind it.

### *Shared Quality Assurance Programs*

For the purposes of this discussion, we recognize that college Quality Assurance (QA) programs consist of two somewhat separate parts: proactive (educational) QA and reactive (remedial) programs.

The OMA believes that there are opportunities for the colleges to play an important role in enhancing IPC through their proactive QA programs. We do not believe that we should be moving to interprofessional remediation at this stage, although it may be something that could be considered at a later time.

It is through QA that our proposal to use a Course of Care approach rather than Scopes of Practice is best illustrated. We suggest that the regulatory colleges work together using a course of care approach to bring together the various professions that must work together in certain areas. The process would include such things as:

- describing in detail the role of each profession in contributing to the course of care;
- identifying areas where experience demonstrates that improvements in care might be sought. (This step might include the identification of roles/tasks that professionals feel they are able to play, but cannot/do not in the existing system.);
- developing communications/tools that would be promoted by all of the affected colleges and disseminated for continuing professional development (CPD) purposes. This might include some shared CPD across disciplines.

As discussed earlier, defining “related colleges” requires us to defer to scopes of practice, and forces us to maintain a static definition of scope. A correct understanding of related controlled acts is entirely context specific and requires an understanding not only of the technical acts, but of the context in which they occur, including the cultural milieu of the professions involved. For example, an examination of maternal and newborn care that is focused exclusively on scope of practice will fail entirely to capture the very significant

differences in the approach taken by obstetricians (and other physicians) working with obstetrical nurses from that taken by midwives.

There are several benefits to adopting a Course of Care approach. First, it offers a more comprehensive record of all the professionals involved in the care of an individual at any given point in time. It puts a greater emphasis on competencies and collaboration as it focuses on each profession's capabilities. A course of care model is more empirically based, as it considers all the factors at play along a continuum of care.

Professionals may collaborate more effectively if they know that their college has worked with all the relevant colleges whose members are engaged in the various phases of the course of care to identify opportunities to improve care using 'care maps'. These tools should provide information to support practice teams and professional judgment; they should not be mandatory and must be able to be modified to suit the circumstances.

### ***Collaborative Toolkits***

The Discussion Guide asks whether “toolkits” to promote IPC are useful. There may be some value to educative documents like a “Collaboration Toolkit” if it is tightly focused and provides administrative supports in areas such as team-building and communication.

### ***Standards of Practice and Professional Practice Guidelines***

#### ***Arm's Length Oversight Body***

The Discussion Guide proposes an independent arm's-length organization to facilitate and support collaboration, including collaboration among colleges. It is the OMA's position that a new administrative body is not necessary. It seems that a more efficient approach would be for the Ministry's Interprofessional Care Implementation Committee to facilitate and support collaboration among colleges. If the IPC Implementation

Committee takes on this role, we feel that its scope should be clearly defined. The committee should not be an oversight body.

### *Practice Guidelines*

The Discussion Guide refers to the fact that Denmark has established a Secretariat for Clinical Guidelines and queries whether something similar might be useful here. The OMA wishes to note that the government, in partnership with the OMA, established a body called the Guidelines Advisory Committee (GAC) in 1997, but has recently withdrawn funding for this arms-length body.

### *Ministerial Powers*

HPRAC has asked whether the Minister should be proactive in directing the colleges, using his existing powers under the *RHPA* to engage in specific collaborative initiatives.

Section 5 of the *RHPA* provides that:

5. (1) The Minister may,
  - (d) require a Council to do anything that, in the opinion of the Minister, is necessary or advisable to carry out the intent of this Act, the health profession Acts or the Drug and Pharmacies Regulation Act.

While the Minister enjoys broad discretion in directing the colleges to adopt policies, we do not believe that the Minister should mandate specific collaborative initiatives. The Minister should identify key areas of interest, signal the presence of political will and commit to assisting in the implementation of collaborative initiatives. At most, the Minister might require the colleges, either individually or collectively, to report upon their IPC initiatives on a regular basis. Reports to the Minister might cover issues like ongoing and foreseeable obstacles to IPC and requests for assistance from the Minister in facilitating specific IPC initiatives.

In establishing practice standards and professional guidelines, we feel that guidelines and policies on matters like conflict of interest, advertising, and record keeping could be consistent across all colleges. Consent to treatment issues, on the other hand, should be handled independently by each college, as they involve the context-specific interpretation of statutory duties assigned to individual practitioners.

### ***Liability Issues***

Physicians perceive liability concerns to be a significant barrier to participation in IPC. The OMA and the Canadian Medical Protective Association (CMPA) have both stated liability issues need not be an impediment to IPC, but that is essential for each health professional to hold adequate liability protection. This point cannot be over-stated: physicians find involvement in legal and regulatory actions extremely stressful and will simply not enter into practice arrangements that they feel will leave them exposed to increased medical-legal risk.

### ***College Autonomy, Authority and Accountability***

HPRAC has queried whether or not the standards of practice and professional practice guidelines that the colleges adopt should be legally enforceable. We feel that the two levels of institutional enforcement that currently exist – the regulatory colleges and the courts - are appropriate and sufficient mechanisms for enforcing standards of practice among colleges.

It is essential that each college, including the CPSO, maintain their ability to provide peer-based guidance and advice to their members. At the same time, there is an important balance that is achieved when colleges must seek government approval before implementing certain rules and processes. This governmental oversight mechanism is important to maintaining a system of “checks and balances”. It also ensures transparency

in the process of self-regulation. There have been instances in recent years where errors were made with respect to requested drug lists and it was only at the government review stage that they were acknowledged and the regulation was sent back to the college for correction.

The OMA believes that the current arrangement whereby certain college policies and rules are "enforceable" and others are not is completely appropriate. It is sometimes by introducing non-enforceable policies that the colleges are able to best move practice along. One can be certain that if all college policies were to be legally enforceable, as the Discussion Guide suggests, a greater number of them would be vigorously resisted, up to and including legal action in the courts.

### ***Interprofessional Care at the Clinical Level***

HPRAC has questioned whether greater collaboration among the colleges will enhance interprofessional care at the clinical level. It then goes on to query whether there should be legislation introduced requiring professions to work and communicate effectively.

The OMA finds it unlikely that greater collaboration at the college level will have a significant impact upon care at the clinical level. That is not to say that there are not some things that might be done, but it is not where we believe the greatest gains are to be had; nor is it where our limited resources should be focused.

The OMA believes that the idea of legislating collegiality is absurd. Interprofessional care will be facilitated by providing teams with a clear understanding of their tasks and roles, and eliminating the economic and medico-legal barriers to shared care. A failure to meet the duty of care, including a failure to take reasonable steps to provide the safest and most effective health care is already required by professional standards through colleges and negligence rules in the common law.

Further, hospitals are beginning to introduce Codes of Conduct and formal processes for addressing behavioural problems in the institutional setting. It is unclear what is to be

gained by such legislation beyond making a political statement at the expense of our hard-working health professionals. The vast majority of collaboration is developed on the ground to meet local needs and the exact nature of the collaboration is highly dependent on the individuals involved. These types of arrangements need to be fostered through the development of practice aids on communication and team-building.

### ***Conclusion***

Overall, the OMA supports collaborative practice between physicians and other regulated and unregulated health care providers. In summary, the OMA would emphasize the following points:

- The HPRAC approach to IPC presented in this consultation document places undue focus on the regulatory colleges' role in developing and promoting IPC. While colleges may have a defined role in the team-based model, they should not be considered the primary enablers of IPC.
- It is the OMA's position that expanding scopes of practice is not critical to the success of IPC. "Scope of practice" is a descriptive phrase; it generally reflects the activities a profession is educated and trained to perform. In many instances, working to one's full *existing* scope of practice will enable IPC without expanding scopes of practice.
- The greatest opportunity to expand IPC rests in shared Quality Assurance between professions. This should be approached by examining best practices within a course of care model.
- Physicians work collaboratively in both hospital and community settings. As a profession, physicians recognize the value of multi-disciplinary, team-based care. To a certain extent, increased acceptance and enthusiasm for IPC will require a

continuing cultural shift and ongoing mutual respect across professions. This must take place organically; collegiality cannot be legislated.