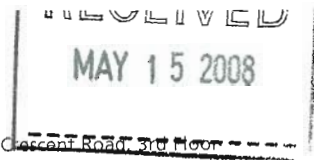




Royal College of
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Ensuring Continued Trust



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May 14, 2008

VIA COURIER

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

This College is pleased to respond to the HPRAC Consultation Discussion Guide on Issues Related to the Ministerial Referral on Interprofessional Collaboration among Health Colleges and Professionals.

We welcome the opportunity to assist HPRAC and the Minister of Health, and commend HPRAC for yet again adopting a consultative approach that is rooted in inclusiveness and transparency.

In preparing our response, special meetings of the Executive Committee and of our governing Council were held to deal specifically with this submission.

This College, in existence since 1869, has seen many different forms of legislation up until now when the *Health System Improvements Act* received third reading in the Legislature on June 4, 2007.

During the consultation process for this Act, our College was very supportive of the commitment to change and we commend both HPRAC and the Minister for their foresight.

The legislative changes were many; however, clearly one of the most significant was the mandatory provision for interprofessional collaboration among health regulatory colleges and professionals.

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We are proud and delighted to report to you that, in the less than a year that has passed since the legislation received Royal Assent, we have already made interprofessional collaboration a priority and absorbed these values into the culture of our organization.

Our list of activities is impressive, notwithstanding the very brief period we have had to work with the new amendments. Let me demonstrate this with an outline of some of the major collaborative activities that we and others have embarked on already.

1. Electronic Prescribing

There appears to be an inconsistency in approaches taken by various health-care professionals around the area of e-prescriptions and, in addition, federal legislation limits its use.

Consequently, the College of Physicians and Surgeons of Ontario, the College of Nurses of Ontario, the Ontario College of Pharmacists, and the Royal College of Dental Surgeons of Ontario have created a collaborative working group to develop joint policies around e-prescribing. It will assist government in developing uniform and acceptable standards.

Our intended goal is to provide the public with easier access to prescription drugs and to increase public safety and protection.

2. Toxic/Carcinogenic Materials Manufactured Internationally

Oral health-care professionals – dentists, dental laboratory technologists, denturists, dental hygienists – use significant amounts of materials for the prevention and cure of oral health-related diseases.

Information has emerged recently from Health Canada that indicates some of these products may contain toxic/carcinogenic materials. In the United States, just last week the Food and Drug Administration put this matter under review as lead had been found in crowns and bridges made offshore.

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I am pleased to report that here in Ontario the regulators have already taken action. Our College organized and hosted two meetings with my colleagues, the Registrars from the College of Dental Hygienists of Ontario, the College of Dental Technologists of Ontario, and the College of Denturists of Ontario.

With agreement that there is a significant problem, we were pleased to host a meeting with senior Health Canada officials. The Chief Dental Officer of Canada, Dr. Peter Cooney, plus Health Canada staff responsible for regulating dental materials came from Ottawa to attend.

It was a very productive meeting and we are now working collaboratively with Health Canada to develop information for oral health-care professionals to increase their awareness of the role of Health Canada in the approval of products for use in Canada.

In addition, these same four colleges are in discussions about the development of common standards around this topic.

Because of the potential for public harm, we have also had discussions on organizing a national symposium. This symposium would involve the active participation of the four regulatory groups from all provinces. Our aim is to attempt to develop an across-Canada approach and to create regulatory consistency in our advice and standards for our respective members.

As you can imagine, there are indeed a number of challenges to holding a national meeting of this scale, not the least of which is cost. However, the important thing to note is that we are able and willing to work in collaboration to responsibly address a potentially serious public health issue.

3. Infective Endocarditis

In April 2007, the American Heart Association published a new guideline around antibiotic prophylaxis with respect to infective endocarditis. These

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recommendations centred on whether or not patients with certain heart conditions should take antibiotics shortly before dental treatment. This was the first change in treatment advice for a decade.

Here in Ontario, the problem was that health-care practitioners, who have prescription privileges from different colleges, have varying protocols and guidelines around prescribing.

To address this matter, our College, the College of Physicians and Surgeons of Ontario, the College of Nurses of Ontario, and the Ontario College of Pharmacists have formed a working group with the goal of achieving consistency in Ontario for prescribing advice about prophylaxis antibiotics for patients to prevent infective endocarditis.

4. Dental Office Protocol Issues and Self-Initiation

With the advent of self-initiation for dental hygienists, several questions have arisen about how this might or might not impact professional relationships among the different regulated professionals in the dental office environment.

Consequently, at our invitation, the Ontario Dental Association, the Ontario Dental Hygienists' Association and the College of Dental Hygienists of Ontario met several times to develop consistent advice to our memberships.

We jointly developed an article entitled "With a Common Voice" that is being published in our respective membership magazines. It was also posted simultaneously on the website of each organization on March 26 at 10:30 am.

The preamble speaks volumes to interprofessional collaboration as it states, "Our four organizations would like to speak with one voice and ...". You will note the article was signed by the presidents of each of these four dental organizations.

I have attached a copy of the most recent issue of our magazine, *Dispatch*, for you to read the full joint statement that appears on page 5.

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We hope that this first “With A Common Voice” statement is the beginning of a periodic series that shares information about issues of common concern with our members and has the weight of a collaborative statement under the name of all four organizations.

5. Supervision of Commercial Laboratories

The College of Dental Technologists of Ontario (CDTO) has raised some issues around the supervision of commercial laboratories. Current legislation regulates dental technologists but not the laboratories.

Consequently, at the invitation of CDTO, we have had a series of meetings to discuss how the public can be better protected. We anticipate that the end result will see CDTO develop a position paper and invite us to join with them.

Clearly, this is an issue of public safety and public interest protection and we welcome the opportunity to work collaboratively with our CDTO colleagues.

6. Educational Collaboration Among Health-Care Regulatory Colleges

There are numerous examples of the health colleges sharing skills and information that even predate the legislative changes.

More recently, many of us participated in an educational session at a recent College of Dental Hygienists of Ontario (CDHO) Council meeting. CDHO had invited Dr. Rocco Gerace, Registrar of the College of Physicians and Surgeons of Ontario, and me to discuss some issues around the composition of the Discipline Committee and, in particular, the use of independent counsel.

The Ontario Dental Hygienists’ Association has invited me to speak about collaborative business practices between dentists and registered dental hygienists at their bi-annual general meeting this September.

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Many of us have developed CD-based educational packages and manuals on topics, such as how to conduct a Discipline Committee hearing, how to conduct a pre-hearing conference, and how to use alternate dispute resolution in the complaints process. We unreservedly share this educational material among the health colleges so that we can learn from each other.

7. Patient Relations Committee

Another creative example of interprofessional collaboration is the invitation extended by this College's Patient Relations Committee to our colleague, Anne Coghlan, Executive Director of the College of Nurses of Ontario, to participate in a working group to develop a mission statement and strategic plan for us.

8. Sexual Abuse Prevention

At our March 6, 2008 Council meeting, we created an educational program for our Council and non-Council committee members focusing on sexual abuse prevention and boundary violations in professional practice.

Lectures and workshops were given by Dr. Philip Klassen, Acting Clinical Director of the Law and Mental Health Program at Toronto's Centre for Addiction and Mental Health, and Margaret Bogue, prominent psychotherapist and social worker who specializes in the treatment of sexual abuse victims.

We extended an open invitation to our colleagues at all the other health-care regulatory colleges to attend. Sixteen of them sent either their staff or elected representatives to join us in these sessions.

9. Regular Registrar Meetings for Dentists/Pharmacists/Physicians/Nurses

The Registrars of these four colleges meet approximately once every two months to discuss common approaches and share information on issues, such as access to care and other matters.

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10. Long-Term Care Access to Oral Health Care Summit

Our College, together with the Ontario Dental Hygienists' Association and the Ontario Dental Association, planned and organized a one-day summit on access to oral health care in the long-term care sector that took place in Toronto on April 9.

The health-care regulatory colleges whose members also care for patients/clients in that sector were among the 120 invited participants. The morning session featured a series of panel discussions, with both dentists and registered dental hygienists as participants. Then in the afternoon, everyone broke into workgroups to identify barriers and challenges and potential approaches to problem solving.

The final report is now in production and will be delivered to the Minister of Health. It will also be sent to all the participants and be accessible to any other interested parties and individuals.

It is interesting to note that one of the major obstacles identified at the summit is the lack of coordination and interprofessional collaboration among the various oral health-care providers and other regulated professionals, such as dietitians, physicians, nurses, physiotherapists and psychologists.

11. Joint Quality Assurance Committee Meetings

We have invited the Quality Assurance (QA) Committee of the College of Dental Hygienists of Ontario to meet with our QA Committee to develop an agenda for discussions over the next couple of years.

We believe that there is much to be gained by working towards some common approaches in areas such as guidelines, transfer of records, infection control, and access to care.

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While this list of collaborative efforts is not exhaustive, we are confident that it is impressive. It clearly demonstrates that interprofessional collaboration is already alive and well, and our Council would go so far as to say that it is thriving.

If we have been able to accomplish so much with the ink barely dry on the amendments to the *Regulated Health Professions Act* and with many of the provisions not even implemented yet, just imagine what is possible in the near future.

There is now a clear legislative mandate to allow health professionals and their regulators to work together. We believe that our 11 examples are proof that even though health-care regulation is a complex area that cuts across many professions, regulators have already demonstrated they are ready and willing to support interdisciplinary collaboration.

Our Council believes that government and the Minister of Health should take comfort in and even be encouraged by the immediate and substantive efforts of the health colleges to respond to the intent and the spirit of these legislative changes.

It is the unanimous view of our Council that the current legislation offers much opportunity to foster, promote and implement further efforts in interprofessional collaboration.

However, we respectfully suggest that some fine tuning would significantly assist and encourage regulators to make even more significant strides forward and accelerate the entrenchment of interprofessional collaboration.

Recommendation #1

Our Council believes that it is important that all regulators are accountable to the Minister not only for their commitment to interprofessional collaboration, but also for their results.

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We propose a formal audit process to ensure colleges are accountable for their performance achievements towards the overall goal of interprofessional collaboration. The Ministry would set specific benchmarks against which colleges would be measured.

This audit process would give the Ministry a formal mechanism and uniform standards to evaluate the efforts of colleges as they become more familiar with the changes in the statute and learn to use it more effectively.

As a side benefit, this process of evaluation and measurement could well add to our knowledge about best practices in the regulatory environment.

Recommendation #2

Staff of the Quality Assurance programs meet on a regular basis to share information. However, to date, committees do not. We recommend that QA Committees and perhaps even governing councils of colleges with similar activities (for example, all the teeth colleges) would periodically and regularly have joint meetings. This would include regular joint meetings of the Quality Assurance (QA) Committee from each college.

These meetings would focus on the creation of a blueprint to encourage the growth of interprofessional collaboration, the integration of interprofessional care into existing strategies, and the development of concrete plans to identify and overcome the obstacles to a collaborative, team-based approach to care.

For example, joint meetings of the QA Committees are an ideal avenue to develop joint guidelines and directives, organize interprofessional educational opportunities, and promote the sharing of tools and templates that could be used to facilitate collaboration between/among the colleges.

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They also would provide an excellent avenue for the professions to explore and recognize the cultural differences of each profession, to reconcile any differences through open dialogue and consensus, and to broaden our understanding of each other.

They would also encourage colleges to pool resources; and perhaps, most important of all, they would send a clear message to the colleges' members about the importance and value of collaboration.

While the amended RHPA does not appear to contemplate committee interprofessional collaboration, our experience has already shown that great things are possible with goodwill and a firm grasp on our mandate of public safety and public interest protection.

Recommendation #3

Colleges with similar activities (for example, all the teeth colleges) could take a proactive approach to interprofessional collaboration by conducting joint investigations to handle interdisciplinary complaints.

How would these joint investigations work? The colleges involved would agree to the appointment of the same investigator who would report on her or his investigation into the conduct of the members involved in patient care to each college's Inquiries, Complaints and Reports Committee, or one of its panels.

In our view, there is sufficient flexibility in the current amendments to have joint investigations, when warranted, under the legislation. We believe this is a common sense way to effectively and efficiently manage complaints that might arise in an interprofessional setting.

No legislative change is required for this to happen now, as the *Health System Improvements Act* permits sharing of information among colleges and allows for flexibility in joint investigations.

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This shared approach would also be a tangible way to expand the knowledge base of colleges' staff about interprofessional patient care and provide improved public protection.

Recommendation #4

Our Council believes that the public and the professions would be well-served by broadening the understanding and appreciation of collaborative multidisciplinary care in the practice setting at the Discipline Committee component of the regulatory process.

To achieve this, we propose the creation of a roster of public member appointees from which colleges could draw public members to serve on discipline hearings of different colleges. These public members would be in addition to the current appointments to specific colleges.

This cross-pollination of knowledge and experience would enhance an already excellent structure and process. It is also a concrete way to increase public confidence and trust in the interprofessional collaborative approach to patient care.

Recommendation #5

The development and maintenance of positive interprofessional relationships at the college-level have in the past sometimes been blocked by a prolonged disagreement over one or two specific issues.

These isolated instances may have, and could continue to, create barriers to building more positive relationships and nourishing trust and respect. The issue of scopes of practice is an excellent example.

Issues often escalate because there are few options available for resolving these disputes other than the parties looking to the Ministry to become directly involved to broker a resolution.

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These situations often create an unfortunate climate of mistrust which is the antithesis of what is needed to promote a collaborative, team-based approach to care.

Ironically the philosophical approach to deal with these problems is already in place. For example, our long-standing alternate dispute resolution (ADR) program for the complaints process and our pre-hearing conference mechanisms for discipline have provided good benchmarks for preventing disputes and conflict resolution.

Yet, when it comes to dealing with more systemic problems with the statute, government and other regulatory colleges, we all seem to abandon these principles.

We need to expand this model of dispute resolution to address collaborative interdisciplinary issues and provide a formal mechanism to resolve these problems.

So our Council proposes the establishment of a formal third party mechanism to assist colleges to resolve difficult disputes around issues, such as scope of practice, conflict of interest, and practice expectations in interprofessional care environment.

How would this work? It would be similar to what happens in a typical commercial contract: colleges would agree to a predetermination mechanism for conflict resolution and to a roster of facilitators. This independent third party would be funded at the expense of the colleges.

This role could be ably filled by a retired senior judge. Or, other alternatives could be the addition of this new role to the mandate of HPRAC or the creation of another independent third party body.

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In closing, our Council is convinced that the Ontario model, as it is now structured under the *Regulated Health Professions Act*, is without any doubt the best model for the regulation of health-care professionals and for public safety protection.

It actualizes the balance between health-care professions being self-governing and self-disciplining, and the Minister of Health and Long-Term Care retaining significant powers over regulatory affairs, if and when necessary.

In fact, we are no longer surprised to hear from regulatory colleagues in other jurisdictions across North America, Europe and Asia, without the RHPA-style model, that they are envious of us. Ontario has every right to be proud of having an international reputation as a leader in the self-regulation of health professionals.

Our Council believes that, with the amended legislation, there is the flexibility to create new opportunities to promote interprofessional collaboration and to assist members to adapt to changes in the practice environment.

All the major elements are in place for a new exciting partnership to grow among the health regulators, the professions, government and the public.

What is needed now is to ensure regulators have the right tools to implement the changes in our culture and have the opportunity and the time to reflect and build consensus around how to move forward with this new paradigm shift to successfully support effective interprofessional collaboration and expand access to care.

Finally, our Council believes that we are on the right path to continue to build on the principles of public protection to create a better health-care system for all and to enhance the public's trust in health-care regulation in its current form.

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We thank you for the opportunity of providing you with our views and are looking forward to a continuing constructive dialogue.

Yours truly,



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