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Submission to HPRAC on Interprofessional Collaboration Among Health Colleges and Professionals

INTRODUCTION

The Ontario Podiatric Medical Association (OPMA) is pleased to have this opportunity to respond to HPRAC's Consultation Discussion Guide.

Before responding to the Questions listed in the Discussion Guide, we would like to make several overarching comments for HPRAC's consideration:

Inequality Among Professions and Regulatory Colleges: Despite the promise that was both implicit and explicit when the *Regulated Health Professions Act* was originally drafted that there would be equality among the regulatory Colleges, some Colleges and professions continue to be more equal than others (to paraphrase George Orwell). There is still a hierarchy among the regulated professions and their Colleges that is due to more than their relative sizes. (Size should be irrelevant in any event.) That hierarchy presents a considerable obstacle to interprofessional collaboration, because the hierarchical approach trickles down and influences the perceptions and behaviour of front line practitioners. Some examples by way of illustration:

- The drug regulation of the College of Chiropractors, which has been under development for nearly 15 years, was held up by the Ministry pending comment from the Ontario Medical Association and the College of Physicians and Surgeons of Ontario. In both cases, neither organization had commented during the consultation period. Nevertheless, the Ministry apparently felt obligated to hold the draft regulation in abeyance pending feedback from the two organizations.



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- The Ontario government allows physicians and dentists to have family members as nonvoting shareholders in their professional corporations, but denies this ability to every other regulated health care profession. It's difficult to imagine a public policy rationale for this discriminatory treatment.

Obstacles Created by Varying Funding Models: Podiatry is both pleased and honoured not to have gone through the OHIP delisting process experienced by other "allied" health care professions, namely chiropractic, optometry and physiotherapy. Being able to bill OHIP does constitute a clear benefit to our patients and a competitive advantage, but it also makes working with other professions more difficult. For example, any Podiatrist would think twice about referring a patient to a health care practitioner where the patient would have to pay out of his or her own pocket. Archaic OHIP rules, such as the Podiatrist having to personally deliver the services billed to OHIP, also detract from interprofessional collaboration. Insurance companies have been known to discourage referrals to Podiatrists because of legislative barriers against co-billing. In short, differences in funding models create delivery silos that constitute huge barriers to interprofessional coordination.

The Ministry's Role: The Discussion Guide appears to ignore, or at least undervalue, the role that the Ministry could play in promoting interprofessional collaboration. The Ministry of Health and Long-Term Care has been anything but activist in pushing for the removal or amendment of regulations, standards of practice, policies, guidelines, etc. that inhibit interprofessional collaboration. For example, the Ministry did not take up the cudgel with the Ministry of Finance to allow interprofessional ownership of professional corporations. Neither has the Ministry taken any action against those Colleges whose conflict of interest regulations contravene Ministry guidelines. Ministry policy excludes Podiatrists (and other professions) from direct involvement in the Family Health Teams. The Ministry has also done a poor job in "orienting" public appointees to College Councils. Part of that orientation could and should be about what other Colleges and professions do and the need to collaborate with other Colleges and professions. Public members should be outward looking, rather than inward-looking members of Council, seeing the bigger picture and identifying opportunities for inter-College coordination and collaboration in the public interest.

Inter-Professional Awareness: In our experience, one of the principal barriers to interprofessional collaboration is the lack of knowledge of professions (primarily the "referring" professions) about the competencies, scopes of practice and authorized acts of other professions. Put more simply, members of one profession rarely have anything but the most cursory knowledge of what members of another profession can contribute in terms of diagnosing and treating patients.

Legislating Collaboration: There's an implicit assumption or theme in the Discussion Guide that interprofessional collaboration can be mandated by legislation, or by College standards of practice, guidelines, policies and so on. While removing legislative and regulatory barriers to collaboration is a worthwhile exercise, it's difficult to see how collaboration could be legally mandated and, if legally mandated, how monitored and enforced.

Role for Associations: As a voluntary professional association itself, the OPMA found it remarkable that the Discussion Guide made no reference to the role that the associations can play in interprofessional collaboration. There is considerable scope for associations to work together on non-regulatory matters to enhance collaboration among the professionals they represent. For example, there could be interassociation collaboration on the insurance associations provide to their members. There could be interassociation collaboration on education, particularly those elements designed to improve interprofessional awareness. There is considerable scope for associations to educate other professions on what their members do.

Principles Governing Collaboration: The OPMA suggests that a starting point for any discussion of interprofessional collaboration should be the articulation of some fundamental principles. We propose:

- The objective of interprofessional collaboration is to make health care more accessible, more efficient and to otherwise benefit the public.
- Interprofessional collaboration should in no way detract from patients' ability to obtain their health care services from their regulated practitioner of choice
- Colleges are equal and the professions they regulate are equal when their scopes of practice and authorized acts overlap or intersect.
- Any mechanisms to enhance collaboration should not inhibit, or be used to frustrate or delay regulatory or legislative evolution, or be used by one College to interfere with the affairs of another College, or the ability of another College to regulate its registrants.
- Independent, professional self-governance is a hallmark of the RHPA and must be preserved within any interprofessional collaborative models.
- Approaches to inter College collaboration must recognize that the primary obligation of each College is to regulate the profession in the public interest.

SELECTIVE RESPONSES TO HPRAC QUESTIONS

Question #1: The reference in this statement viz "Assist health regulatory Colleges and their members to work collaboratively, rather than competitively..... (emphasis added) is concerning. The Discussion Guide mentions "competition among health professionals" as being a challenge in enhancing interprofessional care. The OPMA would like to make the point that interprofessional competition isn't necessarily bad and should not necessarily be discouraged. Intra and interprofessional competition enhances quality of care, accessibility, consumer choice and can also restrain prices charged to consumers and payers. The need to be able to compete can also prompt members of multiple professions to join together in interprofessional clinics to provide seamless care and maximize economies of scale. It should be noted, in this regard, that the (federal) Competition Bureau has indicated concern from a competition point of view of the restrictive practices of certain professions. It is important, therefore, that in the quest for collaboration Colleges and professions do not unnecessarily inhibit competition, or inhibit competition to the disadvantage of patients or engage in collaborative efforts that amount to interprofessional anticompetitive collusion.

Questions #2-5: Legislation other than the RHPA that presents obstacles to collaboration:

- The provisions in the (*Ontario*) *Business Corporations Act* that prohibit professional corporations from having shareholders from more than one profession;
- Antiquated conflict of interest and misconduct regulations by some Colleges that limit or prohibit members of one profession being employed by, or having any form of commercial or business association with, members of another profession;
- The *Public Hospitals Act* and regulations that restrict hospital privileges to a very few professions and thereby establish a very rigid professional hierarchy in terms of service delivery in hospitals and severely restrict patient choice.
- Restrictions under the (*Ontario*) *Health Insurance Act* that restrict the ability of professions to collaborate on the services that are billed to OHIP and, inter alia, prohibit Podiatrists from billing for services that they have delegated or assigned to others. Restrictions under OHIP also prohibit Podiatrists from referring their patients to specialists with whom there should be a close relationship, such as dermatologists and orthopedic surgeons. Podiatrists must refer their patients to a physician who then refers onward to a specialist. Aside from consuming unnecessary time and resources, and aside from the particular problems faced by podiatric patients who do not have a family physician, this convoluted referral chain unnecessarily complicates communications between the Podiatrist and the specialist.

- Privacy legislation that inhibits the sharing of patient records and patient information among health care professionals.

Professional cultural issues that act as barriers to collaboration:

- Preferences for professions that are educated in an Ontario program.
- The haphazard allocation of access to the "Dr." title.

Questions # 6-8: The OPMA has no evidence that liability issues are a barrier to interprofessional care. Having said that, we would emphatically endorse a legal obligation that all regulated health professionals hold minimum professional liability insurance coverage.

Questions #13 & 14: There is probably some scope for a common framework for complaints, investigations and disciplinary matters within the independent, professional self-governing model. Having a single clearinghouse, or single window for the public, relating to complaints, would probably be a good idea, at least from the public's perspective, because of public confusion as to which College to register a complaint. Joint training on the conduct of complaints and disciplinary hearings might also be worthwhile. There is probably also some scope for the small or medium-sized Colleges to share common administrative services. Beyond that any commonality begins to erode the independent, professional self-governance principle. In particular, the OPMA is opposed to a "single complaints model".

Questions #22-24: The OPMA would like to see consistency in standards of practice or professional practice guidelines where the same or similar controlled acts are shared. For example, the OPMA has for some time advocated for a joint, or consistent, standard of practice among Colleges relating to the prescription and dispensing of orthotics.

Questions #25-28: The OPMA is opposed to the creation of an additional body to facilitate and support collaboration among the Colleges. We are concerned about the creation of yet another bureaucratic layer in the regulation of health care professions. The Federation of Regulated Health Colleges should already be performing this role and the Ministry could and should do much more in this regard. For example, when the RHPA was going through the legislative process the Ministry made undertakings that it would play a prominent role in educating the public on the regulatory model and everyone's role within the regulatory system. Nothing, or very little, has been done.



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Questions #29-31: If the Minister is going to direct the Colleges to engage in specific collaborative initiatives, then the Ministry has to be engaged in forging or facilitating the solution. Situations where the Minister gives a direction and then washes his hands of any further involvement are untenable. If the Minister directs Colleges to engage in collaborative activities, the Ministry should compensate the Colleges for the actual and reasonable costs of doing so. The costs of collaboration mandated by the Ministry should not be borne by registrants.

Question #32: Yes, there should be minimum guidelines, standards and policies concerning matters such as conflict of interest, advertising, recordkeeping and the consent process across all Colleges. Furthermore, the Ministry should more effectively enforce them when they exist.

Question #33: The Podiatry profession has ample experience with being a minority class of members within a larger College and that experience has not been happy. In the final analysis, the will of the majority profession will almost always overrule the minority profession. Too much College time and resources are taken up by arbitrating interprofessional disputes within the College. Interprofessional frictions between Podiatrists and Chiropractors have actually militated against collaboration between the two professions. Although, as indicated above, there is probably scope for the sharing of common services that are strictly administrative, joint Colleges would be perceived by the OPMA as a seriously regressive step.

About the OPMA and the Podiatry Profession in Ontario

The OPMA is the voluntary professional association that represents Podiatrists who are registered to practise in Ontario. The OPMA is affiliated with the Canadian Podiatric Medical Association.

In Ontario, Podiatrists are registered to practise by the College of Chiropodists of Ontario under the Chiropody Act, 1991. Podiatrists form a separate class of members regulated by the College. In order to have been registered to practise as a Podiatrist in Ontario, applicants must have received a Doctor of Podiatric Medical Degree/DPM from one of the accredited US programs. The DPM is a four year, postbaccalaureate program, usually followed by one or two years of internship or residency.

Podiatrists in Ontario share the same statutory scope of practice as Chiropodists, but have two additional authorized acts: "Communicating a diagnosis" and performing bone surgery on the foot. Podiatrists may also take x-rays and may bill OHIP for the services they render. Nevertheless, the Podiatry scope of practice in Ontario is much more limited and limiting than the scope of practice for DPM's in most other North American jurisdictions.

In order to promote the development of the chiropody profession in Ontario, the registration of new Podiatrists was actively discouraged from 1982 and the Chiropody Act, 1991 took the unprecedented step of banning the registration of new Podiatrists after July 31, 1993. DPM graduates who returned to Ontario to practise since 1993 have been registered to practise as Chiropodists and do not have access to the additional authorized acts of Podiatry, nor may they bill OHIP for the services they render.

The majority of North American jurisdictions have moved towards a Podiatry model of foot care delivery. Ontario is the last jurisdiction to have a "chiropody" model.

The Minister's last referral letter of June, 2007 has asked HPRAC to examine the need to move the direction of foot care delivery in Ontario towards a Podiatry model of practice. The OPMA looks forward to participating actively in the HPRAC review.

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The foregoing completes our response to the Discussion Guide. We trust that our comments and suggestions are helpful and we would be happy to provide whatever additional information or clarification is required.

We look forward to the issuance of HPRAC's report on this very important subject.


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