



College of Dental Hygienists of Ontario
L'Ordre des hygiénistes dentaires de l'Ontario

May 23, 2008

Sent via email

Ms. Annie Schiefer, Project Manager
Health Professions Regulatory Advisory Council
55 St. Clair Avenue West,
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Toronto ON M4V 2Y7

Dear Ms. Schiefer:

Please find attached the response from the College of Dental Hygienists of Ontario (CDHO) to the Health Professions Regulatory Advisory Council (HPRAC) February 2008 document *Consultation Discussion Guide on Issues Related to the Ministerial Referral on Interprofessional Collaboration among Health Colleges and Professionals*.

The College trusts that HPRAC will take into account the history of the CDHO when reading the attached document.

If CDHO can be of further assistance in HPRAC's deliberations, please do not hesitate to contact our Registrar, Fran Richardson at [redacted] or by email at [redacted]

Sincerely,

Cathie Mazal-Kuula, President
College of Dental Hygienists of Ontario

CMK:jc
Enclosures

HPRAC/collaboration 08 ltr

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**Response to HPRAC's Consultation Discussion on Issues Related to the Ministerial
Referral on Interprofessional Collaboration among Health Colleges and
Professionals**

Introduction

The College of Dental Hygienists of Ontario (CDHO) has been an active participant in the process to develop the Federation of Health Regulatory Colleges of Ontario's (FHRCO) response. Accordingly, the College will restrict its comments to areas directly or uniquely related to the CDHO.

The CDHO accepts the main premise of the statement (Q1) that HPRAC has used to focus this discussion and initiatives. Nevertheless, HPRAC may wish also to consider ways in which regulated health practitioners can utilize their competencies in the public interest without the hindrance of outdated legislation such as the restrictions under the *Healing Arts Radiation Protection Act (HARP)* that restricts which professions may order radiographs, or the requirement for delegation of a controlled act without a mechanism to facilitate such delegation, or even allow delegation to happen.

Eliminating Barriers and Enabling Collaboration

HPRAC has asked if there are barriers in the *Regulated Health Professions Act* or in profession specific *Acts*, their accompanying regulations, policy or professional cultural issues that restrict or prohibit interprofessional collaboration. CDHO is hopeful that the new provisions within the amended *RHPA* will facilitate increased collaboration among the *RHPA* Colleges and ultimately enhance the confidence that the public has in the regulated health professions' ability to govern themselves effectively in the public interest. Nevertheless, there are additional areas that require attention.

The individual scopes of practice in the profession specific *Acts* certainly permit collaboration, but it is often in the regulations or the interpretation of those regulations that barriers are raised. History has had both a positive and a negative effect on the relationships among a number of the Colleges that are now governed under the *RHPA*. Many of the barriers that exist today were erected long before the *RHPA* was enacted and, while there may have been some public policy justification or rationale at the time of their creation, they are out of place in the modern, ever-evolving world of health care delivery. A primary example is the **non-association regulation** that still exists under both the *Dentistry Act* and the *Optometry Act*. These regulations place unnecessary restrictions on the registrants of those respective Colleges and negate their and other health professionals' ability to choose with whom they wish to associate in their healthcare practices. The restrictions in the (*Ontario*) *Business Corporations Act* against

multidisciplinary shareholders in professional corporations have the same affect. While some may argue that this is a professional association concern, it is very much within the regulatory framework, as non-association clauses have the effect of imposing often untenable employment relationships that ultimately impact on the public if the employer attempts to direct treatment that is inconsistent with the practitioner's standards of practice. In 2005, the MOHLTC produced conflict of interest guidelines but did not enforce their application. It is also noteworthy that the (federal) Competition Bureau has urged the dentistry and optometry professions to do away with such restrictive practices in order to benefit consumers.

Another example is regulations that prohibit **delegation of controlled acts** or impose undue restrictions on delegation. Some Colleges have regulations prohibiting delegation in the absence of regulations that authorize delegation and have not put any of the authorizing regulations in place. It should also be noted, in this regard, that OHIP regulations applying to some professions prohibit payment for any treatment that is delegated or assigned. These sorts of restrictions obviously militate against interprofessional collaboration, but they also create perverse incentives that make health care delivery more expensive and less accessible.

Problems have arisen for the CDHO **when the professional associations are permitted or encouraged by the Ministry to interfere in matters that clearly fall within the jurisdiction of the regulatory Colleges.** In Ontario, membership in nearly all professional associations in the healthcare sector is currently voluntary. The voluntary associations rarely represent all or even nearly all of the profession and some represent less than half. Some professions are represented by multiple associations. Giving voluntary association de facto regulatory roles not only intrudes on the prerogatives of the regulatory Colleges, it also allows a component of the profession to have sway over the entire profession. While the CDHO understands the rationale for consulting with the association and will continue to do so, regulatory bodies should never have to consult face-to-face unless there is a desire by both parties to do so and professional associations should never be given veto power over regulatory matters.

Oral health, and by default dental hygiene, are largely ignored by the broader health care delivery system, especially by those components that are publicly-funded. The major **defect of the publicly funded system** is that it pays professions, rather than paying for assessments and treatments. This anachronistic approach restricts accessibility, patient choice, injects huge inflexibility into health care delivery and reinforces a hierarchical approach in health care delivery.

Many of the professions that are within the publicly funded system are reluctant to collaborate with professions that are outside the system because of complications with respect to payment, including patients having to pay out of their own pockets. In addition, the MOHLTC appears to be discouraging, (no doubt inadvertently) interprofessional collaboration at the clinical level by the omission of any mention of oral care in the *Long-Term Care Act*, in the *Long Term Care Homes Act* that obtained Royal Assent last June and in Family Health Teams. By inference, it appears that the Ministry

does not fully appreciate the value of registrants of the oral health Colleges in their own right, but also collaborating with registrants of the medical Colleges. While the CDHO understands that this may have been driven by funding considerations, the omission of the oral health care sector reinforces the impression that the health policymakers view the “mouth” as a separate and distinct component of the body and don't recognize that the presence of oral disease may lead to significant debilitating effects, especially in vulnerable populations.

The traditional approach to public funding of healthcare perpetuates the myth that some components of health care are more important ("medically necessary") than others, thus creating a situation where other *RHPA* registrants may not appreciate the interconnectedness of the oral health/systemic link. In addition to the anomalies created by funding silos, the emphasis within the health care system on the provision of treatment, with the accompanying reliance on a professional hierarchy, rather than on the prevention of disease and the promotion of health, have also created **challenges for interprofessional collaboration since some health professionals are viewed as more important than others** based on their positioning with respect to the publicly funded system. The creation of the Ministry of Health Promotion and a commitment from Minister Best [personal communication March 5, 2008] has given the CDHO hope that this barrier is slowly being eradicated and that there will be increased government support for public education on the prevention of disease.

There is no doubt that there is a **culture of hierarchy** despite the original intentions behind the *RHPA*. Some of this is related to professionals' education, some to history, but most of it has to do with the inherent inequities built into the *RHPA*. The controlled acts model, while innovative at its inception, and the MOHLTC by declining to ensure common understanding of terms and terminology that are fundamental to the *RHPA* (e.g., "assessment", "diagnosis", "communicating a diagnosis"), have encouraged and reinforced the hierarchy by allowing materially different interpretations across the Colleges and by allowing certain Colleges more latitude than others in interpreting the controlled acts.

Scientific advancements have moved faster than changes to the legislation and the promised flexibility of the *RHPA* has been largely unrealized. The CDHO had understood that as the newly regulated professions evolved, amendments would be made within the *RHPA* to accommodate their growing body of knowledge and any increases in the enhancements in the skills required in response to public demand. Yet, the experience by some Colleges has been that amendment requests based on new clinical evidence, or the advent of new skill sets, have resulted in the more dominant Colleges asserting that only they have the requisite competencies, or that the public is only well served by their ability to act as gatekeepers. An example of this is the need to amend the *Healing Arts Radiation Protection Act (HARP)* to permit additional regulated health practitioners to be radiation protection officers and to determine when to take radiographs within their scope of practice.

Professional elitism is definitely a barrier to collaborative practice. This can be modified over time by **emphasizing competence** within the scope of practice rather than controlled acts and by introducing a circular model of collaboration rather than a top down system. The CDHO has long promoted a flatter interprofessional system built on the competencies of the individual practitioner, rather than on title or an employment status. HPRAC may choose to be a champion of a different focus. In essence, it may be necessary to turn the system on its side and view optimal wellness counselling and health promotion as the ultimate goal, rather than placing the emphasis on who does what when. This approach would mean a major culture shift that may garner great resistance from traditionalists, but it would be future oriented and the public, in general, would be better served by having the tools to manage their own health care.

In addition, the **inequality of the treatment of specific professions by various Ministries has encouraged elitism and worked against the establishment of true partnerships**. For example, it's difficult to find any legitimate public policy rationale behind the Ministry of Finance's decision to allow physicians and dentists to be able to have family members as nonvoting shareholders of their professional corporations, while prohibiting every other regulated healthcare profession from doing so.

Professional Liability

With respect to liability insurance as a barrier, the only context in which the CDHO has found that liability issues have been obstacles to interprofessional care has been in the attitudes of some employers of CDHO registrants. They either do not recognize that dental hygienists are required to carry errors and omissions insurance, or fail to recognize that under the *RHPA*, CDHO registrants are responsible for their own actions, when performed within their scope of practice and authorized acts. This mistaken perception of liability is definitely a barrier to collaboration, because collaboration implies equal input and joint decision making. Perhaps this misperception arises in the confusion of employment law concept of vicarious liability of employers with the autonomy of independently regulated health professionals. While collaboration cannot be mandated, statutorily or otherwise, it can be encouraged and facilitated. Education of the roles and responsibilities of other professions regulated under the *RHPA* is certainly deficient.

Complaints, Investigation and Discipline

Conducting joint investigations where there are complaints involving an interdisciplinary structure consisting of various *RHPA* registrants makes eminent good sense in this era of scarce resources. In fact, the *RHPA* should be amended to require such practices. This would also send a message to the public that *RHPA* registrants can and do work together to protect the public interest. Nevertheless, the basic tenets of self-regulation must be preserved and registrants must have the ability to be judged by their peers. Thus profession-specific screening and hearing committees should be retained (even if they are permitted to share information or consult with each other on cases of shared interest).

Creating a pool of dedicated, well-trained public members available to sit on complaints and discipline panels would help to further ensure consistency of process and reduce the

need for constant training of new public members who, depending on their College appointments, might never sit on a hearing panel.

Quality Assurance

Joint quality assurance initiatives between Colleges would be beneficial especially in light of the multidisciplinary focus now evident in healthcare delivery. On-site assessments for all practitioners within a unit or office, happening at the same time, would be less disruptive for clients and beneficial for all concerned. The assessors would be able to see a true snap-shot in time and to assess the interconnectedness of the *RHPA* registrants within the practice. This would be especially true if Colleges could adapt the *RHPA* to reflect a more competency based model. Nevertheless, it must be emphasized again that collaboration cannot be legislated and that in the case of the oral health Colleges, for example, all voices would have to be at the table and be heard equally in order to make a truly collaborative system work. If each individual College has a different philosophy as to the merits and methods of Quality Assurance, then the shift will be more difficult. Standards and the interpretations of regulations require clarity among Colleges whose registrants share the same controlled acts. Often, lack of clarity within the *RHPA* causes confusion for the public and the practitioners.

A major area of discrepancy within the present model is the “communication of a diagnosis”. There are different interpretations of the controlled act and the logic of allowing healthcare practitioners to formulate a diagnosis but not communicate it is questionable. All regulated health care practitioners must perform an assessment, within their scope of practice, prior to any intervention. It is unrealistic that patients may not, for reasons unrelated to competency, be told of the outcomes of that assessment. Doing so reduces the confidence the public has in the person who performed the assessment and maintains the elitism that is counterproductive to an efficiently run health system. It is also impossible to obtain the patient's informed consent for treatment if the practitioner is unable to communicate what is being treated, why and the options for treatment.

Collective Initiatives

As previously stated, the CDHO believes that it is a contradiction in terms to legislate collaboration. The place for collaboration to begin is within the educational setting such as the George Brown College Interprofessional clinic where a variety of students in the health professions truly work together for the benefit of the client. Providing financial incentives to the educational institutions for such multidisciplinary endeavours would enable the schools to teach and integrate the concept of interprofessional collaboration from the ground up thus ensuring the formation of positive partnerships among several professions but also among the relevant Ministries.

Structural Considerations

The CDHO appreciates that economies of scale could be realized in the sharing of joint administrative functions among more than one College. Nevertheless, we should not forget the Health Professions Legislation Review's conclusion that the regulation of dental hygiene by the dominant employer group (i.e., dentistry) constituted a clear conflict of interest and for this and other reasons dental hygiene should become a self-

governing profession in its own right. This rationale may apply to other professions as well.

HPRAC has cited a number of jurisdictions where similar professions are regulated together and has specifically noted dentistry and dental hygiene as examples. Unfortunately, the jurisdictions cited could not be called progressive and the dental hygienists in those jurisdictions have indicated a desire to move to the self-regulation model similar to the one currently in place in Ontario. In response to the examples cited, HPRAC may wish to consider that:

- In BC, dental hygiene was previously regulated by dentistry and due to irreconcilable differences dental hygienists successfully petitioned the BC government for their own College.
- There are no dental hygiene self-regulating jurisdictions in the USA, but there has been considerable movement in various states toward self-regulation due to the under-representation of dental hygienists on the dental governing bodies. Yet, the well-funded dental lobby has managed to block each initiative in the various State legislatures.
- In the UK, dental hygienists are looking for more autonomy within the British Dental Council as they have noted that dentistry continues to dominate the agenda. They are also looking to Canada as a leader in dental hygiene regulation.

Given the history between dental hygiene and dentistry and the primary reason for self-regulation being the protection of the public, it would indeed be a regressive step for the primary employer (dentistry) to resume the regulation of dental hygiene. There is no evidence that the RCDSO is interested in such an arrangement and has indicated support for self-regulation of dental hygiene.

CDHO is, and always has been, open to discussions on collaborating or sharing with other Colleges; our history provides ample evidence of just such initiatives. In fact, the CDHO is of the opinion that Colleges with similar philosophies, and not “body parts” could and should partner. Colleges that regulate health care practitioners who practice primarily in the area of health promotion and the prevention of disease would be better placed to share administrative functions, rather than Colleges where employee/employer relations dominate.

If HPRAC is concerned with the number of Colleges regulating oral health practitioners, especially with the possible advent of dental assisting as a self-regulated profession, and if HPRAC is of a mind to recommend joint ventures, then it may be prudent to consider facilitating a partnership between dental hygiene and dental assisting, or denturism and dental technology, or placing all under one umbrella *Act* where competence and not title are the deciding factors in a collaborative model. Such a model would require that those at the decision-making table have equal voice.

The CDHO is unaware of any public interest of public policy initiative that would make such a consideration viable in Ontario.

If the joint administrative model were to be recommended to the Minister by HPRAC, then it may be wise to include the concept of binding arbitration and the requirement for neutrally facilitated meetings between the various professions encompassed within the model.

Accountability

It is worth considering the proposition that the *RHPA* is overly cumbersome and that the professions may be over-regulated. This is not to say that there should not be accountability; quite the contrary. Statutory self-governance recognizes practitioners as health care professionals who must be accountable to the public, both individually and through their respective Colleges. Colleges could effectively regulate with generic regulations and College specific bylaws, standards of practice and guidelines, similar to the situation in BC if these instruments were legally enforceable for complaints, discipline and quality assurance. Part of the appeal of having the ability to make legally enforceable standards and guidelines, is that currently the CDHO is reluctant to make regulations on professional or clinical matters because the approval **process is so slow** and the **changes in health care so rapid**, that obsolescence quickly occurs. Out-of-date regulations can actually hinder the evolution of health care, including injuring interprofessional collaboration.

The CDHO understood that the *RHPA* was instituted to provide flexibility and to foster the evolution of professions as the health care environment changes. The experience in the last 15 years has instead been that the *RHPA* has hindered such advancements due to the excessive bureaucratization of the regulatory and other processes needed to implement the legislation. However, the CDHO is confident that the current study of the problem by HPRAC will address this persistent and frustrating problem.

Other than the timeliness of guidelines as opposed to regulations, there are significant advantages and disadvantages to having legally enforceable guidelines. On the plus side, Colleges would no longer have to rely solely on expert witnesses to prove that certain conduct, not currently outlined in regulation, is improper or unprofessional. Discipline hearings would be shorter and less costly, and hopefully, less frequent as registrants would have clearer guidance as to the content of professional expectations. On the negative side, there is always the potential that unwise rules may be made since the scrutiny from the Ministerial process will be less rigorous and the making of rules could become politically charged both within the College and external to the organization should stakeholders chose to exert their influence. There will likely be more legal involvement in the drafting of the rules since they will have the effect of law.

Nevertheless, the CDHO does believe that the positive advantages outweigh the negatives, provided that certain safeguards are instituted that are enforced for all Colleges. These would include the requirement for formal consultation and posting on the College's web site the required sixty (60) days in advance followed by Council debate centered on all stakeholder responses. There should also be clear direction that one College may not make rules that affect registrants of another College without the approval of the other College involved. Since the Ministry would be considered a major

stakeholder in the rule making process, the Ministry would also have to voice any concerns or objections within the 60 day period. Silence would constitute assent as it does with other stakeholders.

Interprofessional Care

HPRAC has asked if Colleges should have a mechanism to enhance interprofessional care. As stated earlier, it is very difficult to mandate cooperation. The CDHO has long advocated for interprofessional care and interprofessional respect for all of the professions within the health field and especially within the oral health community. Colleges could use the enforceable standards and guidelines to denote the acceptable behaviour towards clients and colleagues. However, this will only work if there is a willingness to develop the standards and guidelines and then to enforce them.

In conclusion, the CDHO Council would like to go on record that its members believe in a more flexible *RHPA* with an emphasis on competencies within a scope of practice rather than on titles or controlled acts.