

Submission Details:

NAME: Thayalan Paramalingam _____

ORGANIZATION, IF ANY: [REDACTED] _____

TITLE: Management Consultant _____

ADDRESS: [REDACTED] _____

CITY: [REDACTED] PROVINCE: Ontario POSTAL CODE: [REDACTED] _____

E-MAIL ADDRESS: [REDACTED] _____

PHONE: [REDACTED] DATE OF SUBMISSION: May 29, 2008 _____

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My contribution to the inter-professional collaboration is based on my personal experience working to start a dental hygiene practice for a newly allowed self-initiated dental hygiene professional. The difficulties and challenges that I faced are the ones that can be prevented by having the larger concept of inter-professional care. I have had no past expertise in this field but have extensively researched the subject matter under discussion and feel I can contribute positively for the patient care and professional development.

I am a project management professional with over 20 years of experience. I have a B.Sc. in computer science, a project management professional (PMP) designation and currently following part-time MBA studies with Schulich School of Business at York University.

Defining Interprofessional Collaboration

1. Please comment on the above statement that HPRAC has used to focus this discussion and initiatives. Are there elements that should be added or removed? If so, what are they?

Allow delegation of controlled acts to qualified professional who share the same scope of practice. This can be further refined to professional who have had some years of experience performing the controlled act under supervision.

Eliminating the Barriers to Collaboration among the Colleges

2. Are there barriers in the RHPA, the health profession acts or their regulations that restrict or prevent collaboration among the Colleges? If so, what are they? Should they be eliminated? If so, how? (For example, do existing scopes of practice restrict or prevent collaboration among health professionals?)

First and foremost barrier is the attempt by regulation to stop health professionals who share the same scope of practice from practicing together. Specifically, under Dentistry Act 1991, Ontario Regulation 853-93, Professional Misconduct, Section 5, Sub Section 4, Item (I), specifies that a dentist can only practice dentistry with another dentist only. This is a severe restriction that stops a newly allowed self-initiating dental hygiene professional to work collaboratively with a dentist.

The restricting currently is:

- (i) engages in the practice of dentistry by employment, association, partnership or otherwise with any person or corporation other than,
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And should be changed to:

- (i) engages in the practice of dentistry by employment, association, partnership or otherwise with any person or corporation other than,
 - (i) a member who is engaged in the practice of dentistry, or
 - (ii) a member who belongs to another regulated health profession or

3. Are there barriers in other Acts or regulations that restrict or prevent collaboration among the Colleges? If so, what are they? Should they be eliminated? If so, how?

I believe good cooperation at the health professional level will filter-up to the colleges and vice-versa. The removal of section 36 of the RHPA (the so-called “secrecy clause”) allowed colleges to work together, but at the health professional level, there remains restriction in sharing patient files. For example a dentist is not allowed by RCDSO to transfer/sell patient files to a hygienist but can so to a dentist. Both practitioners use the same file to treat the patients. The law that is referred in not allowing the transfer is PIPEDA (The Personal Information Protection and Electronic Documents Act).

Again, this will not be an issue for collaboration, if the restrictions in law, not allowing health professional who share the same scope of practice to work together (referred in Q2).

4. Are there other policy and/or systems issues that act as barriers to collaboration among the Colleges? If so, what are they? Should they be eliminated? If so, how?

The main problem is the dual nature most of the colleges are tasked with. One is public protection and the other being the development of its member's profession. The colleges must be refrained from taking position against other health professional colleges based purely on turf or power position protection. The college should present its opinion based on public protection only.

The second issue is of professional misconduct. As the colleges are tasked with enforcing the rules, they wield a significant power over their members. As the colleges are currently assuming the mandate to protect the interest of their members, this power is being used to stop wayward members from looking for independent patient centric care solutions. For example a member being warned that their may be potential for conflict of interest in working with another health professional in the same scope of practice. This effectively shuts the door as the power relationship with the college and its members are one sided.

A first right step has been taken in specifying that the colleges must work together in RHPA, section 3 under "object of college", item (9) "To promote inter-professional collaboration with other health profession colleges". An essential second step is to restrict colleges from advising their members on issues that are not related to college's objective. This can be achieved constructively by asking colleges that all advice given to its members are in the spirit of inter-professional care. The legislation can specify in addition to the above that the colleges will follow the same with "To promote inter-professional collaboration with their members and other health professionals".

5. Are there professional cultural issues that act as barriers to collaboration among the Colleges? What steps should be taken to minimize these barriers? Who should provide the leadership to eliminate them? What role can health care associations, including associations whose members are regulated professionals, play in this process?

Colleges will reflect society's attitude towards professions that they represent. The medical profession has a very respectable position within the society. The medical doctors being at the top of the ladder and others in lower stratus below, based on the length of education and financial consideration .The way to overcome this is by giving health professionals in all levels, a way to be promoted into more responsibility based on experience and education.

The leadership must come from the government, colleges and educational institutions. The colleges can recommended a career blue print that takes into consideration the work experience and further educational training.

Developing Enablers for Collaboration among the Colleges

9. What changes to the RHPA, the health profession acts or their regulations are needed to encourage, require, facilitate and enable collaboration among the Colleges?

The best way to get the colleges to work together is by getting its members to work together. To this end health regulation need to be changed to allow for regulated health professional to work in partnership. (Please refer to Q2)

The responsibility for discipline the membership should be moved to another common board, made up from colleges that participate in similar care to patients or have an input/output relationship with a related profession.

10. What changes to other Acts or regulations are needed to encourage, require, facilitate and enable collaboration among the Colleges?

Same as in Q9.

11. What collaborative policy or program initiatives are needed to ensure support is provided to new Colleges as they are being established?

12. Are there administrative responsibilities within Colleges that could be shared with related Colleges? What barriers exist to shared administration services?

Structural Mechanisms

Complaints, Investigation and Discipline

13. Should Ontario introduce a common framework, consisting of common structures and processes, for all regulated health professions to address complaints, investigations or disciplinary matters arising in an interprofessional care setting?

Yes. The responsibility for disciplining the membership should be moved to another common board made up from colleges that participate in similar care to patients or have an input/output relationship with a related profession. This should be applicable in all professional care settings. This will allow the college to be involved in public health promotion and member professional development, not enforcement. This will remove the college from its dual responsibility action for public protection and as the same promoting the profession. As well, this will allow the colleges to concentrate more on improving their health profession and inter-professional care.

14. If so, what should and should not be included in the common framework?

Anything that is not related to complaint and discipline should not be included in the common framework. The rehabilitation of the member should be excluded from the common framework. This should be the task of an educational institute or can be that of the respective college the member belongs.

15. If not, should the RHPA, nonetheless, be amended to give individual Colleges greater flexibility to deal with complaints, investigations and discipline arising in an interprofessional care setting within their own already-established structures?

No, this will lead to more conflict as the colleges may be more interested in turf and power protection or in finding fault with the other health professional.

16. If so, what should and should not be addressed in an amendment to the statute? For example, should the RHPA be amended to enable Colleges to establish joint committees to deal with complaints, investigations and discipline in respect of issues arising in an interprofessional care setting?

This will not help as the relationship currently is not based on constructive foundation. Some colleges are more powerful due to history and financial resource reasons. This also makes it difficult for colleges to interact in a level playing field.

17. Considering reforms in other jurisdictions, what would be the merits of a single complaints model in Ontario? How should such a 'model' be funded?

All colleges should contribute based on usage by their members.

18. Would the authority to conduct joint investigations following complaints or reports relating to professionals who work in a multidisciplinary setting or practice provide more efficient investigations of such cases?

I have recommended a different board for this purpose, separate from the colleges. The common board will not be biased and will be mandated only on public health protection. As well this new board may not be interested in its protection of image and when a mistake is made it can look to other means of coming to an agreement with the accused and the defendant.

19. Should Colleges have further authority to collaborate in the disposition of complaints and reports relating to professionals in a multidisciplinary setting or practice?

Obviously the colleges will be able to represent their members on the common board. This will give the colleges more constructive relationship with their membership base.

20. Could such authority contribute to patient safety in interprofessional care?

Yes. As the new authority will not have any existing biases it will be more effective in dealing with issues in different light.

21. *Is legislative change required to accomplish these goals?*

Yes, most of the interaction, relationship and responsibilities are defined in the law, such that only legislative changes will be effective.

Quality Assurance

22. *Would a joint quality assurance program among relevant Colleges enable the Colleges to develop common standards of practice or professional practice guidelines where the same or similar Controlled Acts are shared?*

Yes. Having common standard will allow for responsibilities to be shared in a well understood way with the patient care at the center.

23. *Would a joint quality assurance program among Colleges whose members have similar scopes of practice, share the same or similar Controlled Acts, or provide closely related services often involving the same areas of the body, provide opportunities for enhanced continuing competence and exposure to best practices? If yes, how should program standards be jointly set and measured?*

As I have discussed in other points, it is important there be a graduated way of assigning responsibilities to participants in the same scope of care. A blueprint for all health care professional that perform control acts under direct or indirect supervision must be allowed to do the control act without supervision when sufficient experience and additional education has been completed.

24. *Is legislative change required to accomplish these goals?*

Yes. The legislation can layout what graduated experience and qualification needed to perform controlled acts, what acts can be delegated and an expedited way to accomplish these changes

Standards of Practice and Professional Practice Guidelines

25. *Should an independent arm's-length organization facilitate and support collaboration among the Colleges, particularly with a view to the development of common standards of practice and professional practice guidelines?*

There are 2 options depending on how other recommendation gets implemented.

1. If the single complain model is implemented then the colleges will have the time and resources to study and work on inter-professional collaboration.
2. If single complain model is not implemented then it will best to have an independent organization with legislated power to allow for cooperation between health professions that share common scope of practice.

26. *If so, what should its specific mandate include or not include? For example:*

- *Educate the Colleges, professions and the public on the regulatory model, the health professions and everyone's role within the regulatory system;*
- *Create common resource repositories (e.g., a data warehouse to track regulatory indicators, such as the level and nature of quality assurance activities, complaints and disciplinary actions and the cost of regulation);*
- *Research and develop standards of practice and professional practice guidelines, and disseminate best practices;*
- *Resolve disagreements among professions that share overlapping scopes of practice and the same or similar Controlled Acts;*
- *Address issues arising from conflicting legislation, and*
- *Have an oversight function over regulatory bodies, as in the United Kingdom.*

There are 2 large issues that negatively affect the relationship between health professionals. One is overlapping scope of practice issues and the other is on compensation for the work performed.

To resolve and mediate on these issues, the mandate of the new board can include:

1. Power to mediate and recommend actions that can be implemented immediately while the matter is referred to the legislator and other interested parties for further studies. The decision will be taken with patient care as the ultimate consideration.
2. The board can have power to determine what area under a scope of practice can be performed with experience and additional education. The compensation can follow the levels of scope by having graduating levels in each health profession.

27. *Are there any existing bodies that could take on responsibilities in this area? If so, what are they?*

28. *If not, should a new and independent oversight body be formed? If so, how should it be funded?*

The funding for the new board must come from the provincial government. The savings that will result from its activities should more than pay for itself. The issue will be to quantify the savings.

29. *Should the Minister direct the Colleges, using his existing powers under the RHPA, to engage in specific collaborative initiatives (e.g., to develop instruments to support interprofessional care)? Why or why not?*

The college's dual role in protecting the public and promoting their profession has to be separated. Then the minister can use the powers under RHPA to promote inter-professional care.

30. *If so, should the Minister provide financial or other incentives to the Colleges to undertake these activities?*

No. The colleges should be motivated by their objectives as specified by the legislation.

31. Should the Colleges be required to report to the Minister and/or the public on their collaborative activities on a regular basis? Why or why not?

Yes. This can be used as a measurement of accomplishments.

32. Should minimum guidelines, standards and policies concerning matters such as conflict of interest, advertising, record keeping and the consent process be consistent across all Colleges? If yes, what guidelines, standards and policies could effectively be applied to all regulated health professions? If not, why not?

Background: When closely related professions are regulated by the same

Yes. This is being done by all colleges currently.

33. What kinds of structures and processes could facilitate collaboration among Colleges to address issues related to standards of practice and professional practice guidelines for those professions that deal with closely related activities (e.g. dental hygiene, dental technology, dentistry and denturism; or opticianry, optometry and ophthalmology)? (For example, joint colleges, collaborative Councils or independent bodies such as the Council for Healthcare Regulatory Excellence in the UK.)

1. Remove barriers in regulation to stop health professionals who share the same scope of practice from practicing together. Specifically, under Dentistry Act 1991, Ontario Regulation 853-93, Professional Misconduct, Section 5, Sub Section 4, Item (I), specifies that a dentist can only practice dentistry with another dentist only. This is a severe restriction that stops a newly allowed self-initiating dental hygiene professional to work collaboratively with a dentist.

2. Allowing for innovation and entrepreneurship in the health care field by removing power barriers between health professions. This will be any place in the legislation that requires supervision without promotional opportunities to the person being supervised.

Tools and Templates

34. Would the development of a Collaboration Toolkit, containing some or all of the elements suggested above, serve to facilitate and support collaboration among the Colleges?

35. If so, what should be included in a Collaboration Toolkit and who should be responsible for developing it?

College Autonomy, Authority and Accountability

36. Should the standards of practice and professional practice guidelines that the Colleges adopt be legally enforceable? Why or why not?

No. The colleges like any other organization have a need for self preservation. The status quo is always preferable. There needs to be debate on any guidelines, from all perspectives, before it can be made a legally enforceable act.

37. If so, should the Colleges be given statutory rule-making powers (as in New Brunswick) allowing them to enforce the standards of practice and professional practice guidelines that they adopt? Why or why not?

Following the same line of argument from Q36, the by-laws proposed by the colleges can be made in such a way as to hinder inter-professional collaboration.

Taking as an example, RCDSO's past presentation to the legislature of Ontario on allowing dental technologists to be independent and the subsequent presentation, several years later on the dental hygienist to be independent practitioners, speaks volumes of the conflict most colleges find themselves in promoting the memberships interests and that of the patient care and inter-professional care. Here the issue was not on conflict in scope but to allow for a health professional to work independently without supervision, which in reality did not exist in a practice environment. Both professions can now independently work on their own.

38. What kinds of enforceable rules should the Colleges be able to make without needing Ministerial or legislative approval?

On educational qualification, quality control, practice specific regulation like safe disposal of waste, can be an area that colleges can make rules that increase the level of patient care, environment and standard of practice.

39. What accountability must accompany any rule-making authority?

Critical area that needs to be accountable for will be due diligence that the proposed law will not hinder inter-professional care and does not have unintended effect of turf protection or power protection.

Interprofessional Care at the Clinical Level

The Role of Colleges in Promoting Interprofessional Care at the Clinical Level

40. How will greater collaboration among the Colleges serve to enhance interprofessional care at the clinical level?

In my experience, a greater collaboration between the colleges will translate into better working arrangement among health care professionals.

41. Are any changes to the RHPA, the health profession acts or their regulations needed to encourage, require, facilitate and enable interprofessional care at the clinical level? If so, what are they?

Again speaking from my experience, essential steps are needed in the legislative front. All health professionals are now highly trained with modern technologies that give access to information and support when required. The patients are more knowledgeable on available alternatives and look for higher level of service. The colleges need to be brought into the new reality of inter-professional care without the power projection. An employer employee relationship is defined in law, but the new realities require allowing for equal partnerships when it is in the interest of the patient care.

From Q1:

(1) First and foremost barrier is the attempt by regulation to stop health professionals who share the same scope of practice from practicing together. Specifically, under Dentistry Act 1991, Ontario Regulation 853-93, Professional Misconduct, Section 5, Sub Section 4, Item (I), specifies that a dentist can only practice dentistry with another dentist only. This is a severe restriction that stops a newly allowed self-initiating dental hygiene professional to work collaboratively with a dentist.

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 - (ii) a member who belongs to another regulated health profession or

(2) Allow for income sharing between health professional based on competitive market forces.

(3) A blueprint for all health care professional that perform control acts under direct or indirect supervision must be allowed to do the control act without supervision when sufficient experience and additional education has been completed.

All above 3 points are essential for inter-professional care at clinical level to prosper and for patient to get quality care.

42. Should Ontario law have a requirement similar to the one in New Zealand?

43. If so, what should the requirement look like and should there be consequences for a failure to meet the requirement?