



May 30, 2008

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Health Professions Regulatory Advisory Council
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Dear Ms. Schiefer:

The Health Professions Appeal and Review Board 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.

Please find enclosed the Board's submission along with a CD copy.

There will also be a copy submitted as an e-mail attachment to the address provided in the HPRAC discussion guide.

Sincerely,

A handwritten signature in black ink, appearing to read "Linda Lamoureux".

Linda Lamoureux
Chair
Health Professions Appeal and Review Board

**RECOMMENDATIONS
TO
HEALTH PROFESSIONS
REGULATORY ADVISORY COUNCIL**

**On behalf of the
HEALTH PROFESSIONS
APPEAL AND REVIEW BOARD**

Dated: May 29, 2008

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SUBMISSION TO HPRAC

EXECUTIVE SUMMARY

The Health Professions Appeal and Review Board (“HPRAB”) fulfills a regulatory responsibility across Ontario to further the governmental objective of ensuring that the health professions are effectively regulated in the public interest.

HPRAB is well positioned to provide HPRAC with insight into potential areas for enhanced collaboration particularly with respect to the complaint review process which, as currently structured, limits the opportunities for the Complaints Committees of the Colleges to work together. In this regard, we note the following:

- Complaints regarding health care may be fractured by a complaints model that operates in a “silo” fashion;
- Reviews conducted by HPRAB reflects the “silo” complaint model;
- As a result, there are limited opportunities to address and collaborate on systemic issues.

Furthermore, because HPRAB is a locus of intersection for oversight of the Colleges in the public interest, it is also well situated to serve as a useful mechanism to enhance and encourage inter-College collaboration with respect to complaint reviews, particularly on a systemic level. In this regard, we propose the following potential solutions:

- The creation of an inter-College Complaints Committee subject to review by HPRAB;
- Permit HPRAB to consolidate, join and/or sever proceedings with respect to complaints that concern members of different colleges;
- Permit HPRAB to initiate its own investigation or inquiry when there is reason to believe that systemic problems exist that affect one or more Colleges of regulated health professionals.

We hope the discussion below is of assistance to HPRAC’s present task of recommending mechanisms to facilitate and support interprofessional collaboration between the Colleges of the regulated health professions.

Introduction

The Health Professions Appeal and Review Board (“HPARB”) is the provincial governmental agency assigned to oversee the Colleges of twenty-two self-governing health professions established or continued under specifically identified health profession statutes.¹ HPARB’s duties and powers are assigned to it under the *Regulated Health Professions Act, 1991* (“RHPA”) which includes as Schedule 2, the *Health Professions Procedural Code* (the “Code”).

In carrying out its role in the public interest, HPARB has three separate functions:²

1. The first function relates to the decisions and conduct of the complaints committee of a College of a regulated health profession pursuant to the *Code*.
2. The second function relates to reviews or hearings in respect of registration orders made by the registration committee of a College of a regulated health profession pursuant to the *Code*.
3. The third function deals with hospital appointments pursuant to the *Public Hospitals Act*.

In exercising its responsibilities to perform reviews, appeals, and hearings HPARB discharges an important oversight responsibility by exercising functions that are primarily regulatory and adjudicative,³ HPARB carries out the governmental objective of ensuring that activities of the health professions are regulated in the public interest.

Although, HPARB is not *per se* an agent of inter-College collaboration, in reviewing the decisions of Complaints Committees and Registration Committees of all of the regulated health professions, and with its additional perspective in addressing appeals under the *Public Hospitals Act*, HPARB is uniquely positioned to offer insight into potential areas for enhancing collaboration between the Colleges.

¹ Amendments are expected to increase the number of colleges in 2009.

² HPARB also hears appeals in respect of matters regarding hospital privileges under the *Public Hospitals Act*, R.S.O. 1990, Charter P.40 but that jurisdiction is not germane to the matters under discussion herein.

³ *Re Ombudsman of Ontario and Health Professions Board of Ontario et al.* (1979) 26 O.R. (2d) 105 at 117 (C.A.).

History of HPARB

HPARB's historical evolution is critical to an understanding of HPARB's role in serving the public interest by overseeing the regulated health professions. HPARB's public interest focus has developed and expanded over the past thirty-four years evolving from its roots in the Royal Commission of Inquiry into Civil Rights, the Committee on the Healing Arts, the Guiding Principles Report, and the *Health Disciplines Act*.⁴

McRuer Report, 1968

In 1968, the Honourable James Chalmers McRuer completed his Royal Commission of Inquiry into Civil Rights (the "McRuer Report"). The McRuer Report emphasized the fundamental need to ensure that the interests of the public are met by the self-governing professions. McRuer surmised that the self-regulated professions had no inherent right to self-government; however, with appropriate regulation, this was the best method of protecting the public interest. The concept of establishing a layperson oversight body such as HPARB grew out of the political application of the public interest principles enunciated in the McRuer Report.

Healing Arts Report and the Guiding Principles Report

The second key historical pillar for the creation of HPARB is the report of the Committee on the Healing Arts tabled by the government on April 28, 1970 (the "*Healing Arts Report*"). Based upon the input from various stakeholders who had commented on the blueprint *Healing Arts Report*, the Minister of Health, the Honourable Thomas L. Wells, developed and presented the "*Guiding Principles for the Regulation and Education of the Health Disciplines*" ("*Guiding Principles Report*")

The *Guiding Principles Report* included a number of recommendations relevant to HPARB's evolution, including:

- The primacy of the public interest is the basic principle underlying the regulation of the health disciplines;
- An independent, regulatory body should be established for the health disciplines;
- The role of the public in the regulation of the health disciplines is best recognized by ensuring that the regulatory oversight body is composed of laypersons independent from the health professions.

⁴ See Appendix "A" for a detailed discussion on the HPARB's historical background.

Health Disciplines Act

On April 2, 1974, Bill 22, entitled the *Health Disciplines Act*, had first reading in the Ontario legislature. All three parties represented in the Legislature broadly supported the establishment of an independent Board with lay participation to oversee the governance of the health professions. Furthermore, there was all party support for the principles enunciated in the McRuer Report, and for the expansion of lay oversight of the traditionally insular self-governing health professions.

HPARB Today

As noted in the introduction, HPARB, as presently constituted, is a quasi-judicial adjudicative tribunal that conducts reviews and performs the duties that are assigned to it under *RHPA* with respect to the oversight of the twenty-two regulated health professions in Ontario.

HPARB is composed of public members appointed by the Lieutenant Governor in Council on the recommendation of the Minister of Health and Long-Term Care.

As a locus of intersection for oversight of the Colleges in the public interest, HPARB is able to provide insight regarding inter-College collaboration. The following is our response to the Health Professions Regulatory Advisory Council's Consultation Discussion Guide on Issues Related to the Ministerial Referral on Interprofessional Collaboration among Health Colleges and Professionals.

The Current Complaint Model

SUMMARY

In response to questions 2, 4, & 9 posed by HPRAC in its discussion guide, we note the following limitations on inter-College collaboration:

- Complaints regarding health care may be fractured by a complaints model that operates in a “silo” fashion;
- Reviews conducted by HPARB reflect the “silo” complaint model;
- As a result, there are limited opportunities to address and collaborate on systemic issues that arise.

DISCUSSION

Providing a mechanism for complaints is a key area in which oversight of the health professions in the public interest is ensured. In addition, an effective complaints mechanism can provide both the public and health professionals with an alternative to courts for resolving disputes that may arise. Indeed, the Gilmour Report on *Patient Safety, Medical Error and Tort Law* (“Gilmour Report”), noted that there should be an expansion of complaints mechanisms as an alternative to litigation. A complaints mechanism is a valuable alternative to litigation because it can provide information, explanations, apologies, and assurances whereas litigation is mainly geared to a disposition in terms of faultfinding and damages.⁵

However, the current structure of the *RHPA* and the *Code* may limit opportunities for collaboration between the Colleges with respect to the manner in which complaints from members of the public are addressed.

For example, a complaint about a member of a College of a regulated health profession is dealt with at first instance by the Complaints Committee of that member’s College. The Complaints Committee’s primary responsibility is to consider complaints about health professionals from the public and determine the appropriate action to be taken.

⁵ *Patient Safety, Medical Error and Tort Law: An International Comparison*, Gilmour, Joan M., Health Canada HPRP Project Number 6795-15-203/5760003, May 2006 at p. 35.

Pursuant to subsection 26(2) of the *Code*, after investigating a complaint regarding the conduct or actions of a member, and after considering the submissions of the member and considering or making reasonable efforts to consider all records and documents relevant to the complaint, a panel of the Complaints Committee may do any one or more of the following:

1. Refer a specified allegation of the member's professional misconduct or incompetence to the Discipline Committee.
2. Refer the member to the Executive Committee for incapacity proceedings.
3. Require the member to appear before the panel or another panel of the Complaints Committee to be cautioned.
4. Take action it considers appropriate that is not inconsistent with the *RHPA*, the *Code*, the regulations, or by-laws.

However, a member of the public may have a complaint about health care provided by a team of regulated health professionals whose members are governed by different Colleges. Similarly, from the perspective of the health care professional, the care given to a member of the public may be inextricably linked to the care provided by other members of the "team". The current structure militates against consolidation of complaints involving different Colleges (and there are issues about the propriety of combining complaints against more than one member of the same College) resulting in a fragmentation of an individual's complaint into a number of separate complaints before different Complaints Committees. The current complaint model creates, in effect, "silos" of investigation that can result in different and potentially conflicting dispositions arising from a complaint made by member of the public.

Similarly, although a complaint may give rise to investigations by different Complaints Committees of different Colleges, HPARB does not have a practice of consolidating reviews of Complaints Committee decisions of different Colleges at the review stage (to the extent to which such decisions may be before HPARB for review). Instead, the "silo" model extends into the review process conducted by HPARB, which again gives rise to the potential for disparate conclusions about the adequacy of an investigation and/or the reasonableness of a Complaints Committee's decision.

While different recommendations and results may be appropriate in certain circumstances, the current complaint model makes it cumbersome for complaints to be dealt with across "silos". Similarly, health care professionals may have their conduct reviewed out of its institutional context and without reference to other members of the

“team” or health care system itself. It also prevents HPARB from conducting a global review of the manner in which each Complaints Committee conducts its investigation.⁶ Instead, a complaint is fragmented across the various Colleges which govern the health professionals involved in a complaint with each investigation by each relevant Complaints Committee and potential review by HPARB performed in isolation one from the other.

The situation is further complicated by timing. A complaint which implicates a “team” of health professionals raises the following problems under the existing scheme:

- a) The complaints against the various team members may not be filed with all of the relevant Colleges simultaneously, leading to investigations being undertaken at disparate times, and conceivably months or years apart from each other.
- b) The complainant may not know who all of the relevant team members may be, resulting in an incomplete series of complaints. At present, it is up to the various Colleges to decide whether to identify and include in the complaint proceedings, other team members who were involved in the event giving rise to the complaint.
- c) Even if the complaints are filed against all team members simultaneously, there is no guarantee that each College will process the complaints at the same pace or with the same investigative techniques.
- d) Although there is now no impediment to the Colleges pooling their resources or sharing information in respect of the parallel investigations, this process may be rendered difficult by, among other matters, different standards of practice for different health professions, variations in professional culture and the modus of investigations, confidentiality issues, etc.
- e) The practices of the various Colleges as to complaints by a complainant against more than one member are inconsistent – some Colleges render one decision per complaint which encompasses all of the members involved; while others render a separate decision for each member who is the subject of the complaint.
- f) Assuming that all of the complaints committees involved in all of the “team” complaints render decisions simultaneously, there is no guarantee that the complainant will seek review of all of the decisions, or if the complainant does seek review of all decisions, that he or she will do so simultaneously. Thus there

⁶ See, for example, the decision of the Divisional Court in *Moreau and Andrea Wynia Meilun v. The Health Professions Appeal and Review Board* (Divisional Court, February 14, 2003, unreported).

is no guarantee that HPARB will have before it all of the “team” complaint decisions to consolidate or join together, assuming HPARB has such powers.

- g) The current model is firmly based in the architecture of professional misconduct or incompetence. It is about reforming or punishing the conduct of an individual member based on all of the attributes well known to law: fault, mitigation, propensity for rehabilitation, seriousness of the offence, etc. At the complaints stage, the complaints committee and HPARB do not even make conclusive findings in their determinations – their job is once removed from fact finding – it is to screen complaints as to whether allegations therein should be referred to a Discipline Committee hearing or whether non-punitive or no remedies are applicable. The complaints process is ill suited to a broad investigation which may or may not end up in allegations being directed to another body for determinations of individual misconduct or incompetence.

The individual complaint/complaint review process as now constituted contains a number of barriers to a determination of issues which arise out of the conduct or actions of a team of health professionals who are members of various Colleges. The fragmentation of complaints is a concern reflected in other jurisdictions as well. For example, the Health Service Ombudsman for England recently concluded that “fragmentation in complaints systems, combined with shortcomings in complaints handling capacity and leadership, and a failure to focus on patients’ needs resulted in “just remedies not being secured for just complaints.””⁷

As discussed further in the next section, HPARB may be a bridge to the facilitation of inter-College collaboration to better serve the public interest by addressing the fragmentation of complaints and providing a mechanism, where necessary, for a more systemic approach.⁸

⁷ *Gilmour Report*, *supra* note 5 at p.128.

⁸ For examples where the Board has made recommendations to address complaints involving inter-disciplinary care and complaints involving multiple members of a single college please see, respectively: *Burstyn* and *Groh et. al.* decision of Health Professions Appeal and Review Board, (unreported) at Appendix “B” and *Savard* and *Malvern* decision of Health Professions Appeal and Review Board (unreported) at Appendix “C”

Areas for Enhancement

SUMMARY

Having previously noted some of the limitations on inter-college collaboration imposed by the current complaints model, HPARB has identified three potential areas for enhancement, namely:

- The creation of an inter-College Complaints Committee subject to review by HPARB;
- Permit HPARB to consolidate, join and/or sever proceedings with respect to complaints that touch upon members of differing Colleges;
- Permit HPARB to initiate its own investigation or inquiry when there is reason to believe that systemic problems exist that affect the one or more Colleges of regulated health professionals.

DISCUSSION

To enhance inter-College collaboration, HPARB is well positioned to act as an independent arm's length organization to facilitate and support collaboration between the Colleges with respect to developing common standards for the investigation of complaints by members of the public, as well as common issues in registration applications. To this end, we note the following three potential means to enhance inter-College collaboration:⁹

- a) One possibility would be the statutory creation of an inter-College joint complaints committee that would have the ability to investigate complaints with respect to a "team" of health care providers. To respect the self-regulatory nature of the individual Colleges, such a joint complaints committee could provide an intake and investigatory function and then refer its recommendations to the College that governs the each health care provider that was the subject of a complaint. HPARB, with

⁹ We note that to fulfill this role, some changes to the current legislation would be required to facilitate the proposed potential solutions for enhancing collaboration between the colleges.

necessary statutory amendments, may then be entrusted with the task of reviewing the decisions of a joint complaints committee in much the same way it currently performs this function *vis a vis* the Complaints Committee of an individual College.

- b) Alternatively, if the current complaint and review model is maintained, it may facilitate inter-College collaboration to empower HPARB to consolidate, join and/or sever proceedings at the review level and amend the relevant timelines as needed to better serve the public interest by ensuring that consistent results are reached.

One way to achieve this would be to amend section 34(2) of the *Code* to include the following provisions of the *Statutory Powers Procedure Act* (“*SPPA*”) with necessary modification in addition to those *SPPA* powers already conferred under section 34(2) of the *Code*:

- Section 5.4 (Disclosure) – This would allow HPARB to order the exchange of documents between parties.
 - Section 9.1 (Similar Questions) – This would allow proceedings involving similar questions of fact, law or policy to be combined (on consent of the parties).
 - Section 25.0.1 (Control Process) – This would allow HPARB to determine its own procedures and practice.
- c) As a further alternative, it may be advantageous to allow HPARB to conduct its own investigation or inquiry when there is reason to believe that a systemic problem exists in the context of a complaint or review, possibly as an extension to HPARB’s existing authority under section 28 of the *Code* (which presently permits HPARB to take over an investigation in the case of unreasonable delay in the investigation conducted by a College’s Complaints Committee).

Complaints about the conduct or actions of individual members or a team of members of the health professions are from time-to-time indicative of larger systemic issues within the health professions. In this regard, the current systems focus on the individual health care professional may be

misplaced, and ultimately, contrary to the public interest. Indeed, it is noted that,

[P]atient safety advocates urge the adoption of a systems approach to patient safety, “based on the understanding that the individual practitioner is not a potential culprit to be blamed and punished, but rather that he or she is one participant interacting with many others in a highly complex environment. Adverse events are generally viewed as a consequence of the system; the goal is to improve the structure and/or process so the event is less likely to occur.”¹⁰

Similar systemic problems may emerge with individual application for registration within the health professions. While serious public interest concerns may be indicated, the individual complaint review or registration process does not equip HPARB to suitably investigate, assess, or make remedial recommendations with regard to systemic concerns, as adverted to above. Allowing HPARB to consider and address public interest matters that are brought to its attention is one possible solution to this issue.

¹⁰ *Gilmour Report, supra* at note 5 p.7

Conclusion

For over 30 years, HPARB has played an evolving role in the oversight of the regulated health profession in the public interest. HPARB respectfully draws the following conclusion to HPRAC's attention for consideration:

- Complaints regarding health care may be fractured by a complaints model that operates in a "silo" fashion through Complaints Committees of the separate health-professions Colleges;
- Reviews conducted by HPARB reflects the "silo" complaint model;
- As a result, there are limited opportunities to address and collaborate on systemic issues that arise.

Because HPARB is a locus of intersection for oversight of the Colleges in the public interest, it is also well situated to serve as a useful mechanism to enhance and encourage inter-College collaboration with respect to complaint reviews, particularly on a systemic level. In this regard, we propose the following potential solutions:

- The creation of an inter-College Complaints Committee subject to review by HPARB;
- Permit HPARB to consolidate, join and/or sever proceedings with respect to complaints that touch upon members of differing Colleges;
- Permit HPARB to initiate its own investigation or inquiry when there is reason to believe that systemic problems exist that affect the one or more Colleges of regulated health professionals.

We hope the comments and suggestions we have provided assist HPRAC with its Ministerial referral on Interprofessional Collaboration among Health Colleges and Professionals.

APPENDIX “A”

Historical Background To HPARB

HPARB’s role in the exercise of governmental oversight of the regulated health professions finds its roots in the Royal Commission of Inquiry into Civil Rights, the Committee on the Healing Arts, and the *Health Disciplines Act*.

McRuer Report, 1968

In 1968, the Honourable James Chalmers McRuer completed his Royal Commission Inquiry into Civil Rights (the “McRuer Report”). It was a massive undertaking, and comprised several volumes. Report Number One, Volume 3, Section 4 is titled “*Self-Governing Professions and Occupations*”¹. The McRuer Report emphasized the fundamental need to ensure that the interests of the public are met by the self-governing professions. Chapter 79 of the McRuer Report commenced with an overview of the purpose of self-regulation:

The granting of self-government is a delegation of legislative and judicial functions and can only be justified as a safeguard to the public interest. The power is not conferred to give or reinforce a professional or occupational status. The relevant question is not, “do the practitioners of this occupation desire the power of self-government?”, but “is self-government necessary for the protection of the public?” No right of self-government should be claimed merely because the term “profession” has been attached to the occupation. The power of self-government should not be extended beyond the present limitations, unless it is clearly established that the public interest demands it.²

McRuer concluded that there was a tension between the needs of the members of the profession and the public interest:

The traditional justification for giving powers of self-regulation to any body is that the members of the body are best qualified to ensure that proper standards of competence and ethics are set and maintained. There is a clear public interest in the creation and observance of such standards. This public interest may have been well-served by the respective bodies which have brought to their task an awareness of their responsibility to the

¹ Great Library citation, KF 4483 .C5 O5846 1968, v.3 c.1 ST

² McRuer Report, chapter 79, p. 1162.

public they serve, but there is a real risk that the power may be exercised in the interests of the profession or occupation rather than in that of the public. This risk requires adequate safeguards to ensure that injury to the public interest does not arise.³

A self-governing profession exercises powers in three areas: administration, policy and discipline.⁴ McRuer's view was that the areas of policy and discipline give rise to the most concerns as to whether self-government meets the public interest. The McRuer Report recommended that all rule-making power of the professional regulators should be clearly prescribed. By-laws should only deal with administrative affairs, while rules dealing with adjudication and discipline should be contained in regulations approved by the Lieutenant Governor in Council.⁵

McRuer took the view that a decision to remove a member of the profession from the register should be an adjudicative decision, subject to the same safeguards as a parallel procedure before a quasi-judicial tribunal which adjudicated similar matters.⁶

The McRuer Report found that the system then extant was unsatisfactory in respect of the administration of member discipline. McRuer wrote that "disciplinary powers are penal powers", and that permitting a self-regulatory body to engage such penal powers is anachronistic and "can only be justified if all the interests concerned are better protected by this method than they could be by an other".⁷

McRuer concluded that the self-regulated professions had no inherent right to self-government – rather, they were permitted to continue an otherwise anachronistic system because this was the best method of protecting the public interest.

The Royal Commission focused on mechanisms for creating effective supervision of "truly professional bodies". Given that the purpose of self-regulation was not (only or at all) to preserve the profession's monopolistic powers or commercial interests, McRuer distinguished between the licensing and disciplining of professionals "*who have had many years of education and specialized training*" and the licensing of bodies "*whose members are trained technicians engaged largely in quasi-commercial activities*". McRuer concluded that the latter should not fall within the scope of professional self-regulation because in many cases, the "*technical competence of its members can be*

³ *Ibid.*, p. 1166.

⁴ *Ibid.*, p. 1164.

⁵ *Ibid.*, p. 1171.

⁶ *Ibid.*, p. 1180.

⁷ *Ibid.*, p. 1182.

controlled by licensing, without extending to them the monopolistic attributes of self-government."⁸

The supervisory mechanisms contemplated by McRuer included judicial fairness doctrines,⁹ such as the presumption of the innocence of the member,¹⁰ proper disclosure of evidence to the 'accused' member,¹¹ the disclosure of all legal advice obtained by the tribunal,¹² the opportunity to present full legal argument and to know what legal arguments to meet,¹³ proper notice,¹⁴ right to counsel,¹⁵ a full range of sanctions available to the disciplinary body to ensure proportionate results,¹⁶ and appropriate limitation periods that serve the public rather than protect the profession.¹⁷

The concept of establishing a layperson oversight body appears to have grown out of the political application of the public interest principles enunciated in the McRuer Report. The influence of the McRuer Report was expressly acknowledged by the then-Minister of Health in 1974 as the foundation of the proposed *Health Disciplines Act*:¹⁸

We've leaned very heavily on the McRuer principles. I often wonder how we spell McRuer and if it begins with the letter G, because we certainly put very heavy emphasis on any of the principles that have been enunciated by this gentleman, who has had a very profound effect upon Ontario law.

The Healing Arts Report and the Guiding Principles Report

The second key historical pillar which girds the foundations for the creation of HPARB is the report of the Committee on the Healing Arts tabled by the government on April 28, 1970 (the "*Healing Arts Report*").

Based upon the input from various stakeholders who had commented on the blueprint *Healing Arts Report*, the Minister of Health, the Honourable Thomas L. Wells, developed

⁸ *Ibid.*, p.1186.

⁹ *Ibid.* p.1183.

¹⁰ *Ibid.* p.1183.

¹¹ *Ibid.* p.1184.

¹² *Ibid.* p. 1187.

¹³ *Ibid.* p. 1188-9.

¹⁴ *Ibid.* p. 1193.

¹⁵ *Ibid.* p. 1194.

¹⁶ *Ibid.* p. 1195.

¹⁷ *Ibid.* p. 1206.

¹⁸ *Hansard*, April 30, 1974, p. 1587

and presented the “*Guiding Principles for the Regulation and Education of the Health Disciplines*” (the “*Guiding Principles*”)¹⁹ on January 21, 1971:

...the following guiding principles are endorsed as a basis for discussions in the preparing of new legislation to regulate the health disciplines and arrangements for the education of the health disciplines.²⁰

The *Guiding Principles* contained 53 recommendations regarding regulation of the health disciplines and education of health professionals. The first 11 recommendations are of particular relevance to the history of HPARB. Recommendations 1 to 3 include a general overview of the regulation of the health disciplines:

1. The primacy of the public interest should be the basic principle underlying the regulation of the health disciplines. Since safeguarding the public interest is a primary concern of Government, the Government must take overall responsibility for ensuring that satisfactory arrangements exist for the regulation of the health disciplines. To guarantee the competence of the health practitioner and the quality of service which the public receives, provision must be made for licensing, certifying, registering and disciplining in the overall regulation of practice of the health disciplines.
2. The self-regulatory procedures which have evolved to date should be preserved to the greatest degree possible consistent with and emphasizing the primacy of the public interest and the essential coordination among the varied health disciplines.
3. The rights of individuals to use the services of health practitioners of their choice should be respected. Any limitations on these rights should be those designed specifically to protect the public interest.²¹

Recommendations 4 and 5 were designed to bring consistency to the governance of the health disciplines and to describe the type of quasi-judicial regularity under which such regulators should function (including institutional independence) as follows:

4. There should be regulatory bodies for all established health disciplines. The main concern of the regulatory bodies should be the interest of the

¹⁹ Gerstein Library (University of Toronto) reference RA396.C22 O63.

²⁰ *Guiding Principles*, p. 1.

²¹ *Ibid.*, pp. 1-2.

public. The functions of the regulatory bodies should include the licensing, certifying, regulatory and disciplining of its members.

5. The regulatory body must be independent of any voluntary association established by any health discipline, e.g., professional association, union, or trade association. Even though such voluntary associations have a concern for the public welfare, nevertheless the legal and functional independence must be complete. Under no circumstances should a voluntary association be associated in a corporate way, directly or indirectly, with a regulatory body.²²

Recommendations 6 and 7 address the “Structure and Functions of Regulatory Bodies”. Although not all of the recommendations were adopted: in particular, the proposition that the proposed Health Disciplines Board should have more direct supervision of the Colleges was not adopted; the primacy of the public interest and the focus on public involvement remained:

6. In order to achieve the coordination that is essential for the efficient and proper regulation of the health disciplines, a Health Disciplines Regulation Board should be established by, and be responsible to, the Minister of Health with responsibility for the regulation of each health discipline, and the coordination of all such regulations – based on relevant health policies and health legislation. The Board should report on its activities annually to the Minister of Health, anticipating that the Minister would make the report public.

To carry out the detailed functions of developing, coordinating and applying the regulation of the health disciplines, the Health Disciplines Regulation Board should make use of existing Colleges and create divisions as required, to cover other health disciplines.

- a. The Colleges would have regulatory responsibilities for physicians, dentists, nurses, pharmacists and optometrists. These Colleges would remain essentially self-regulatory but responsive to the main interests of the regulatory structure – the protection of the public interest and the provision of a means of coordination of the regulations among the regulatory bodies of the health disciplines.

²² *Ibid.*, p. 2.

- b. A division would be the regulatory body for one or more related health disciplines. The division would have the responsibility of recommending to the Health Disciplines Regulation Board and, when approved by the Board, implementing regulatory matters relative to their particular disciplines.

The Health Disciplines Regulation Board should provide advice and guidance to the Colleges and provide direction to the divisions, help to devise an appeal procedure and channels of communication between them and the public and coordinate the development and application of the regulations. The Board should be responsible through the Minister of Health for the submission of proposed legislation and regulations under the Acts for both Colleges and divisions.

7. Provision should be made for the appeal of a decision of a College or division to the Health Disciplines Regulation Board. Recourse to the courts is always the prerogative of any citizen.²³

Finally, recommendations 10 and 11 outlined proposed “Membership and Staffing of Regulatory Bodies”. Most of the original recommendations regarding the composition of the proposed Board were ultimately adopted:

10. The Health Disciplines Regulation Board should be a lay Board, small in size (5-7 persons), should be composed of part-time members from outside of government service appointed on a rotating basis for a three-year term, renewable once. It should have its own full-time staff. The Lieutenant Governor in Council should appoint the Chairman and members of the Board.
11. The Health Disciplines Regulation Board should be responsible for determining the general composition and mode of selection of membership of the Colleges and divisions. This should be accomplished in consultation with regulatory bodies now existing or initially with the members of a health discipline if no regulatory body exists.

The role of the public in the regulation of the health disciplines should be recognized by having a significant number of members of

²³ *Ibid.*, p. 2-3.

the Colleges and divisions who are not engaged in the health field. Such members should be appointed by the Lieutenant Governor in Council for a term of office of three years, renewable for a further term of three years.²⁴

Submissions on the *Guiding Principles* were considered, and on June 28, 1972, draft legislation based on the *Guiding Principles* was tabled in the legislature as a discussion document called "*Legislative Proposals for a Health Disciplines Act*". The government described the proposal as follows:²⁵

Of particular interest to the members, I believe, Mr. Speaker, is the establishment of a Health Disciplines Board. It is proposed that this board will be composed of no more than seven lay persons, not members of any of the health disciplines, and it will, of course, represent the public interest. It will be given substantial authority over all the health disciplines and will be responsible for ensuring that the health disciplines are effectively regulated and co-ordinated.

The Board will also act as an appeal board on registration matters. An applicant who has been refused registration by a particular College may appeal this decision to the Health Disciplines Board and the provisions of the Statutory Powers Procedure Act, 1971, would apply to the conduct of these appeals.

The board is also being empowered to review complaints from the public which may not have been dealt with to the complainant's satisfaction by the particular College.

...

An increased emphasis will be placed on the need to ensure continuing competence of practitioners and to maintain high standards of professional practice. We are asking the governing bodies of the various Colleges to assume these responsibilities, consistent with our belief that the health professions should continue to be essentially self-governing as long as they are carrying out their responsibilities in the public interest.

²⁴ *Ibid.*, p. 4.

²⁵ *Hansard*, June 28, 1972, p. 4406-07.

Health Disciplines Act, 1974

On April 2, 1974, Bill 22, entitled the *Health Disciplines Act* had first reading in the Ontario legislature²⁶. The Bill was tabled by the new Minister of Health, Frank S. Miller (Conservative)²⁷. The “Explanatory Note” to the bill stated:

The Bill re-enacts the legislation governing five major health professions:

1. Dentistry.
2. Medicine.
3. Nursing.
4. Optometry.
5. Pharmacy.

The Bill incorporates recommendations of the Committee on the Healing Arts and of the Royal Commission Inquiry into Civil Rights, Vol. 3, Section 4.

The principal changes are:

1. lay representation on the professional governing council;
2. closer supervisory powers in the Minister;
3. the creation of a health disciplines board for the purpose of conducting hearings and review respecting complaints and applications for licensing;
4. a complete system of hearings and review for all matters of licensing and discipline with uniformity of procedures for all professions.

It is important to note that all three parties represented in the Legislature broadly supported the establishment of a Board with lay participation to oversee the governance of the (five) health professions. Although there was disagreement as to the composition of the Board,²⁸ the exclusion of various professions²⁹, and whether the transfer of certain proposed powers to the Minister of Health emasculated the proposed board, there was broad political support for the principles enunciated in the McRuer Report (which was

²⁶ *Hansard*, April 2, 1974, pp 620-25 and 636-37.

²⁷ Frank Stuart Miller, 1927-2000; he joined William Davis’ cabinet as Minister of Health on February 26, 1974.

²⁸ *Hansard*, April 30, 1974, p.1575.

²⁹ *Hansard*, April 30, 1974, pp. 1570-1575 – the NDP apparently voted against the bill on this basis, although the party supported the creation of the lay oversight board.

frequently cited by all parties), and for the expansion of lay oversight of the traditionally insular self-governing health professions.