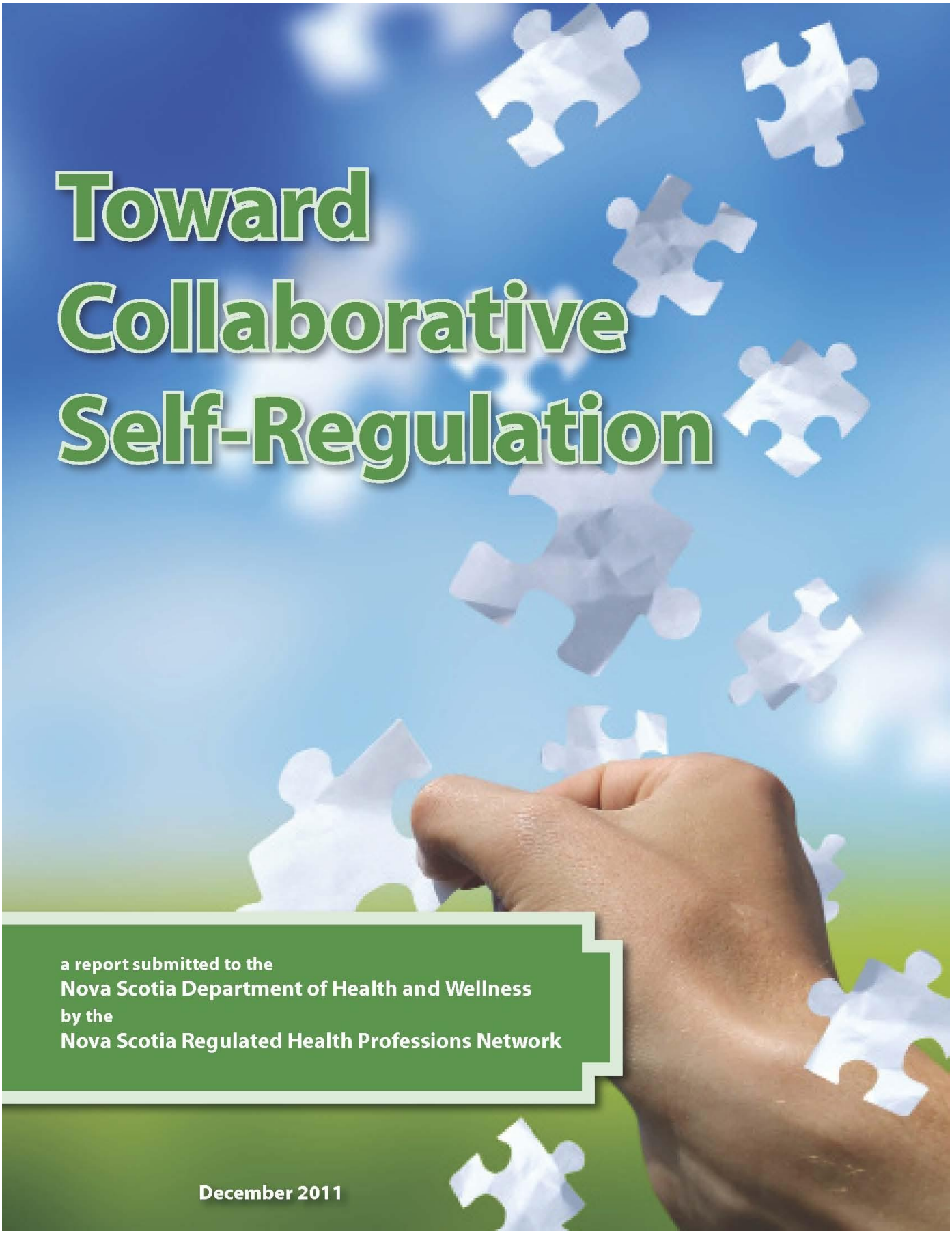
Toward
Collaborative
Self-Regulation
a report submitted to the
Nova Scotia Department of Health and Wellness
by the
Nova Scotia Regulated Health Professions Network
December 2011

INDEX

Executive Summary

Healthcare delivery in Nova Scotia has been evolving toward inter-professional practice, where a variety of healthcare professionals share information and work together to provide better patient care.

This Report explores how the regulation of health professionals in Nova Scotia should concurrently evolve to better reflect the presence of inter-professional practice in the health care system. The conclusion of the Report is that the movement toward collaborative practice should coincide with a movement toward the collaborative self-regulation of the health professions within the Province, which should be formalized through new legislation.

Presently, there are 22 regulated health professions in Nova Scotia, each of which is constituted by a separate statute. Within each statute, the scope of practice of the profession is established; criteria for registration and licensing are set out; mechanisms are created to deal with complaints and hearings; certain titles are protected; and various quality assurance mechanisms are created.

This system of self-regulation is founded upon the principle that members of the profession are best able to regulate themselves, given their knowledge of the profession, the ethos of professionalism engrained in members of the profession, and the value of peer review and peer oversight.

Despite the existence of 22 separate statutes regulating these distinct professions, there has been a strong history of collaboration and cooperation among the various professions in this Province. This collaboration has resulted in informal information sharing, encouragement of best practices, and has led to the creation of an informal network calling itself the Nova Scotia Regulated Health Professions Network (the "Network"). Over the past five years the Network, in addition to sharing information and promoting best practices, has collaborated on collective responses to a number of initiatives such as the *Fair Registration Practices Act*, the Agreement on Internal Trade, and the need for health human resource coordination during the H1N1 outbreak.

This informal Network of regulated health professions has arisen largely as a result of the limitations presented by the formal regulation of these professions in the province. Legislative barriers exist respecting the sharing of competencies among the professions, the collaborative investigations of complaints arising among multiple professions, and the sharing of information with relevant individuals and organizations.

In addition to these limitations, members of the Network have observed that current methods of regulation are not keeping pace with the reality of inter-professional practice in the province. For example, patient complaints often relate to the overall care received in a facility, where services were provided by members of multiple health professions. In order to have this type

of complaint dealt with by regulators, the patient is required to file separate letters of complaint with the colleges of the varying professionals involved. Investigations proceed within their own "silos", with each regulator being statutorily prohibited from sharing information with others.

Similarly, as inter-professional practice grew within different practice environments, there was no effective and timely method by which overlaps in scopes of practice could be properly addressed. This was particularly so when the scope of practice of a particular profession was ingrained in legislation such that any change to that scope of practice had to await the bureaucracy of the legislative process.

In 2007, members of the Network hosted a conference entitled "Regulation in the 21st Century": Inter-disciplinary Team Accountability". As a result of this conference, the concept of different regulated health professions working collaboratively in certain aspects of their regulatory roles was discussed and embraced. Since then, members of the Network have been working toward a regulatory structure that would retain the benefits of self-regulation and the existing informal benefits of the Network, and at the same time would enhance voluntary opportunities for collaboration in a variety of the regulatory processes in which each college is engaged, but where statutory barriers to collaboration existed.

Through project funding from the Nova Scotia Department of Health and Wellness, the Network has been exploring the idea of collaborative legislation, and is now proposing that the concept of collaborative self-regulation become more formalized through legislation. The essence of the proposal is as follows:

- A new statute will be created to incorporate the Network and to establish a governance and decision-making structure for the Network;

- All members of regulated health professions that meet identified criteria will be mandatory members of the newly incorporated Network;

- With a more formalized governance and decision-making structure, the Network will be able to develop common approaches on a variety of matters, will have more opportunities to share information and best practices, and will be able to speak with one voice to government and other relevant organizations. Similarly the Network itself will be a useful structure for other organizations to consult, as it will offer a "one-stop" option by which all regulated health professions may be accessed;

- The proposed statute will provide mechanisms to enable the members of the Network to collaborate on regulatory processes, but will not require them to do so. Each profession will maintain its autonomy as a self-regulated profession, and that autonomy can only be overridden with the agreement of the relevant professions. Where two or more professions agree to do so, the statute will enable them to collaborate on such regulatory matters as:

1. A system of addressing overlapping scopes of practice among the regulated health professions to allow two or more professions with shared competencies to engage in expanded practices without offending another profession's statutory scope of practice;

2. Joint investigation of complaints, where appropriate, and sharing of information arising from such investigations;

3. A common review or appeal process arising from regulatory decisions, such as decisions to deny registration, or decisions to dismiss complaints; and

4. Joint quality assurance processes both for the regulators of professions and for the members of such professions.

The model that is being proposed is an innovative one that the Network believes retains the benefits of self-regulation while at the same time addresses some of the perceived deficiencies of self-regulation. It is an approach initiated by the professions themselves, which Network members believe stands a greater chance of success than an alternate system that may be imposed on them. The Network has examined alternate systems of regulation throughout Canada and in other countries, but none of these systems focus on the connection between collaborative practice and collaborative regulation. While there are advantages and disadvantages to each of the regulatory systems in place around the world, the Network is satisfied that Nova Scotia's system works well, but can be enhanced through the creation of collaborative regulatory processes to be enshrined in new legislation that would work with, and not replace, existing legislation.

The system of collaborative regulation proposed in this report harnesses the sense of cooperation that exists among the regulated health professions, and establishes a regulatory platform that mirrors the health system platform of collaborative, inter-professional practice. Its purpose will be to foster and enable collaboration among regulated health professions in a manner that upholds and protects the public interest through enhanced self-regulation of the health professions.

The members of the Network believe that this proposal for the creation of a statute to formalize the creation of the Network will facilitate the development of other strategies and approaches that will enable health profession regulators to respond individually and collectively to regulatory challenges and opportunities.

Through the proposal outlined in this Report, the Network is soliciting the support of the Department of Health and Wellness to work with the Network to give this proposal for collaborative self-regulation the necessary statutory foundation it requires for success.

Introduction

The Nova Scotia Regulated Health Professions Network (the "Network") is an informally created affiliation of regulated health professions in Nova Scotia.[1] The Network traces its beginnings to the 1990's when a small group of Registrars and Executive Directors of various health profession colleges began meeting for lunch to discuss areas of common interest. Over time, as the benefits of these informal meetings became apparent, invitations were extended to more and more of the health professions and in 2007, it was determined that an invitation would be extended to representatives of other health professions to join these informal sessions.

These informal meetings coincided with the expansion of inter-professional practice in the delivery of health care, which lead to discussions among the Network members of the need for a conference to discuss how these changes in practice should impact the regulation of the health professions.

As a result, on November 16, 2007 members of the Network presented a conference entitled "Regulation in the 21st Century: Interdisciplinary Team Accountability". During this conference, the concept of different regulated health professions working together collaboratively in certain aspects of their regulatory roles was discussed. By the end of the conference considerable interest was created in exploring ways to enhance the regulation and accountability of health professions in Nova Scotia through collaboration.

Following the conference in November 2007, the Network formed a Working Group to explore aspects of collaborative regulation ("the Working Group"). The Working Group consisted variously of the following members:

> Dr. Cameron Little, Former Registrar, the College of Physicians and Surgeons of Nova Scotia;[2]
>
> Dr. D.A. (Gus) Grant, Registrar, the College of Physicians and Surgeons of Nova Scotia;[3]
>
> Ms. Donna Denney, Executive Director, College of Registered Nurses of Nova Scotia;[4]
>
> Ms. Linda Hamilton, Former Executive Director, College of Registered Nurses of Nova Scotia;[5]
>
> Ms. Michele Brennan, Director, Policy, Practice and Legislation Services, College of Registered Nurses of Nova Scotia;

[1] A list of all current members of the Network, and their governing statutes, is attached as Appendix 1 to this Paper.
[2] Dr. Little was an active participant in the Working Group until his retirement as Registrar in September, 2011
[3] Dr. Grant joined the Working Group when he replaced Dr. Little as Registrar in September, 2011
[4] Donna Denney was the Nursing Policy Advisor with the Department of Health until June, 2009, and then replaced Linda Hamilton as Executive Director of the College of Registered Nurses of Nova Scotia
[5] Linda Hamilton, former Executive Director of the College of Registered Nurses of Nova Scotia, was an initial member of the Working Group and actively contributed to its work until her retirement in 2009.

Ms. Bev Zwicker, Deputy Registrar, Nova Scotia College of Pharmacists;

Ms. Ann Mann, Executive Director–Registrar, College of Licensed Practical Nurses of Nova Scotia;

Ms. Gayle Salsman, Registrar, College of Occupational Therapists of Nova Scotia;

Mr. Dennis Holland, Senior Director, Legislative Policy, NS Department of Health and Wellness;

Ms. Michelle MacDonald, Senior Legislative Policy Analyst, NS Department of Health and Wellness).

To facilitate and support the Working Group, the NS Department of Health and Wellness (DHW)[6] provided initial project funding to the Dalhousie Health Law Institute (HLI), pursuant to a Memorandum of Agreement between DHW and Dalhousie HLI under which HLI provides DHW policy advice with respect to health system legislation. This support was provided under a Project Charter approved in January of 2010.

Professor William Lahey has provided ongoing advice and research support to the Working Group from the beginning, and throughout the submission of this Report.[7]

In addition, legal advice has been provided to the Working Group from Marjorie Hickey, Q.C., a lawyer at McInnes Cooper who provides advice to many regulated health professions in the province.[8]

In August, 2009 the HLI prepared a report for the Working Group on "Collaborative Self-Regulation and Professional Accountability in Nova Scotia's Health Care System".[9] This 2009 report outlined the Working Group's analysis, conclusions and recommendations with respect to the development of a collaborative regulation model for improving the functionality of Nova Scotia's system of health professions regulation in the area of professional accountability, specifically in relation to the investigation of patient complaints.

Following the submission of the 2009 report, the Network formulated a Project Charter outlining a proposal for the DHW to contribute toward the funding of a system of regulation of

[6] There was a name change from the Department of Health to the Department of Health and Wellness in January, 2011

[7] Initial assistance was also obtained from Leah Hutt, HLI Research Associate, and from law students, Alison Hopkins and Tracy Hobson.

[8] Throughout this paper, the above-mentioned members of the Working Group together with William Lahey and Marjorie Hickey will be collectively referred to as the "Working Group".

[9] Collaborative Self-Regulation and Professional Accountability in Nova Scotia's Health Care System – A Report from the Working Group on Collaborative Regulation of the Nova Scotia Health Professions Regulatory Network to the Nova Scotia Health Professions Regulatory Network and the Nova Scotia Department of Health, prepared by William Lahey, Director, Dalhousie Health Law Institute with Assistance of Leah Hutt and Alison Hopkins, and Tracy Hobson, August, 2009

health professions that would enhance and reflect the collaborative regulation of health professionals. The description of the project contained in the Project Charter reads, in part, as follows:

> The (Network) has identified a range of challenges and opportunities facing the health care system that call for greater collaboration among health professions regulators. Issues include the growing reliance of the system on inter-professional teams to deliver patient-centered care as well as the priority that is being placed on improved quality of care and better protection of patient safety.
>
> Members of (the Network) have agreed to explore the concept of "collaborative self-regulation" as a framework for the identification and development of options that will enable them to respond, individually and collectively, to these challenges and opportunities.

The true nature of collaborative self-regulation, as the term is used in this Report, can really be described very simply as follows:

- Each health profession retains self-regulatory status through their respective enabling statutes;
- While maintaining their autonomy, the health professions collectively become members of a formalized network that identifies and promotes best practices, speaks with a unified voice on behalf of the health professions, and works toward inter-professional accountability in addition to the accountability of each individual profession;
- Each profession may voluntarily collaborate with other professions in various regulatory matters such as appeals arising from dismissals of complaints, investigative processes, procedures authorizing the sharing of competencies among professions, and others.

Funding for the Project Charter was approved by the DHW in June 2010, and since that time, the Working Group and the Network as a whole have explored how collaborative self-regulation may work within both the health care context and the statutory framework of health professions in Nova Scotia. This Report represents the results of the discussions and analysis by the Network. It explores the reasons and the potential for a new legislative framework to co-exist with the existing statutory framework that preserves the autonomy of each health profession within the province.

The model that is being proposed is an innovative one that the Network believes retains the benefits of self regulation while at the same time addresses some of the perceived deficiencies of self regulation. It is a responsive approach both to changes in our evolving health system and changes in regulatory frameworks for health professions.

What is being proposed and why?

To answer this question, it is helpful to answer each of the following in turn:

- What is the current system of regulation of health professions in Nova Scotia?
- What is the Network's proposal in a nutshell?
- What is the current and potential contribution of collaboration in health professions' regulation in Nova Scotia?
- Why should expanded collaboration be pursued through an enabling statute?
- Why not a more fundamental restructuring of the legislative framework?

What is the current system of regulation of health professions in Nova Scotia?

In Nova Scotia, the formal system of regulation is set within a framework of 22 health professions created through 22 separate statutes. In addition to this formal system of regulation, an informal system has grown organically, largely because of the limitations of the formal system. The creation of the Network has arisen because the formal statutes regulating health professions create limitations that impede effective collaboration.

Within each of the formal statutes for the 22 health professions, common features generally include a statement of the scope of practice for the particular profession, the criteria for initial registration in the profession, criteria for maintaining and renewing licences, the setting of standards of practice and code of ethics, the establishment of a complaints process and a process for adjudicating matters. In addition, the statutes usually create some protections to allow members of the profession to use designated titles, and to prohibit non-members from using such titles.

This system of self-regulation has worked relatively well, and continues to improve. For example, more recently amended statutes include public representatives as members of the governing board for each college, and as members of key regulatory committees such as Complaints Committees and Hearing Committees. The inclusion of public representatives assists in ensuring that self-regulated professions continue to focus on their primary mandate, the protection of the public.

While the presence of public representatives on the governing entities and committees of health professions in Nova Scotia assists in achieving public protection, ultimately the key underpinning of public protection lies within the culture of self-responsibility and accountability that are the hallmarks of professionalism. Nova Scotia's system of self-regulation is founded on

this sense of professionalism, and is built on concepts of peer governance and peer review, aided by the presence of public representatives.

There is recognition by these professionals of the need to be accountable through their statute to government and to the public, placing the public interest at all times at the forefront of regulation.

A broad array of health services are provided through these regulated health professions. The professions range in size from 12 members of the Midwifery Regulatory Council to more than 10,100 members of the College of Registered Nurses of Nova Scotia, with many variations in between.

Given the range in size and accompanying resources of the various professions, the capacity of each profession to engage in and enhance their regulatory processes varies.

The Network has become a critical tool in Nova Scotia to assist with the capacity building of each regulated profession. Through sharing of best practices and in some instances through a coordination of training efforts, the regulatory strength of each health profession has continued to grow.

While the informal cooperation among the health professions in Nova Scotia has been of tremendous assistance, it is clear that the present system of regulation with 22 separate statutes creates limitations to the amount of cooperation and collaboration that can occur.

With a few exceptions, there are no mechanisms within the statutes in Nova Scotia to allow for sharing of competencies among the professions, and to recognize overlaps in scopes of practice. Rather, each profession defines its own scope of practice in isolation. During the recent H1N1 outbreak in Nova Scotia, where a need was identified to have multiple health care professionals in a position to administer vaccines, the restrictive nature of these statutory scopes of practice became problematic. The defined scopes of practice for a variety of health professionals prohibited them from engaging in this activity, without statutory amendments.

Network members understand that inter-professional collaboration in all aspects of professional governance and practice is crucial to the future of the health care system in Nova Scotia and in Canada more generally.

Another limitation is found in the statutory provisions requiring each profession to maintain the confidentiality of information acquired throughout their registration, investigative and hearing processes. There is no direct sharing of information permitted with the other health professions, unless a specific disciplinary decision directs this to be the case.

In instances where information comes to the attention of one profession that raises heath systems issues or issues respecting the practices of other health professionals, there is no straightforward way of sharing this information with others without violating the confidentiality provisions of the particular profession that holds the information.

Similarly, there are provisions in each statute that set out how complaints are to be investigated. Where complaints involve members of more than one profession, there is no system in place to allow for a sharing of the investigative function where it would both expedite the process and assist in a more thorough and witness-friendly investigation.

It is anticipated that with the increase in inter-professional care, the colleges will be dealing with larger numbers of multiple profession complaints. While the health care system is becoming more collaborative, the system of health care professions regulation remains focused on the individual actions of one or more members of a specific profession.

In summary, while the regulatory system in Nova Scotia based on individual self regulation for each health profession works well in many instances and is rooted in a culture of cooperation and collaboration among the different regulators, there is room for improvement to take into account the shift toward inter-professional practice.

What is the Network's Proposal in a Nutshell?

What is the Network's Proposal in a Nutshell?

The Network is proposing that a new statute be developed that will allow it to:

a. ensure better sharing of information and best practices among network members;

b. address statutory barriers in the present legislation that impede effective collaboration and information sharing;

c. facilitate collaboration among network members on a continuing basis; and

d. enable individual regulatory bodies to work together on various regulatory processes that call for or are amenable to collaborative action but that current legislation requires each regulatory body to manage in isolation.

This proposal for new legislation arises from the Network's consideration of the following question:

> **How can health professional regulation in Nova Scotia be enhanced through wider and more formally structured collaboration among Network members?**

The Network has concluded that expanded collaboration will enhance the ability of Network members to individually and collectively protect the public interest in multiple ways. However, it has also determined that the current legislative framework for health professions regulation makes it difficult or impossible for Network members to take full advantage of many of the positive opportunities for greater collaboration that have been identified.

The basic problem is not that each regulated profession is governed by its own legislation. Rather, it is that these statutes (with some limited exceptions) do not expressly authorize collaborative activity with other regulatory bodies. The consequence is that the current legislative framework creates unnecessary barriers to collaboration that could improve regulation and public protection. To remedy this problem and to enable and empower Network members to build more collaboration into their regulatory processes, the Network is proposing a new statute that would complement and work with the existing statutes of each of the self-regulating health professions.

What is the Current and Potential Contribution of Collaboration to Health Professions Regulation in Nova Scotia?

The Network believes that one of the current strengths of health professions regulation in Nova Scotia is the collaboration that happens between the regulators of the various professions. One example of this is the contribution of representatives of the College of Physicians and Surgeons and of the College of Pharmacists to the work of the Prescription Drug Monitoring Board. Another is the collaborative approach that the College of Physicians and Surgeons and the College of Registered Nurses have taken to the establishment and administration of a regulatory framework for collaborative partnerships between physicians and nurse practitioners. A further and more intangible but equally important example is the positive support and assistance that has been provided to new colleges (once they have been created by legislation) by the established regulatory bodies.

The formation of the Network has both expanded and elevated the collaborative features of health professions regulation in Nova Scotia. It has given regulatory bodies a forum in which to discuss common issues and to learn from each others' experiences, knowledge and perspectives. It has given regulatory bodies and the Department a forum in which to discuss and resolve policy issues that pertain to health professions regulation as a whole and to facilitate the collective contribution of the regulatory bodies to health system priorities. An example of the former is the role played by the Network in the drafting and implementation of the *Fair Registration Practices Act*. An example of the latter is the role that the Network played in contributing to Nova Scotia's response to the H1N1 pandemic.

Since 2007, the Network, with the support of the Department, has been actively at work in exploring how health professions' regulation can be further enhanced through wider collaboration. More specifically, it has been actively exploring the role that collaboration could play in the carrying out of the core regulatory functions that are central to the mandate of the self-regulating professions in public protection, like the investigation of patient complaints. The Network has undertaken this work and moved it forward because Network members understand that inter-professional collaboration in all aspects of professions' governance and practice is crucial to the future of the health care system in Nova Scotia, and in Canada more generally. This is reflected in the emphasis that was placed on inter-professional collaboration

(or on multi-disciplinary teams) in the report of the Romanow Commission and in the Health Accords of 2003 and 2004.[10] It is also reflected in major health reform initiatives in Nova Scotia, including the Models of Care initiative[11], the Ross Report[12] and the emphasis placed on collaborative teams in the response to the Ross Report.

More specifically, the Network understands that collaborative inter-professional approaches can have multiple advantages when pursued in health professions regulation. They preserve the core strength of Nova Scotia's current regulatory model – the acceptance of each regulated profession and its membership of the statutory accountability to the Minister of Health and the public for their own self-regulation in the public interest. At the same time, collaboration allows consistent approaches to be taken to common problems and opportunities. It allows coordinated approaches to be taken to shared problems or opportunities that are beyond the capacity of individual regulators to address by individual effort. Such problems and opportunities are becoming more common as the health care system continues to evolve towards greater and more complex levels of integration.

In addition, collaborative approaches allow regulatory bodies to benefit from each other's experience, knowledge and specialized skill. They facilitate applied learning and the sharing of tangible resources, such as policies, standards, training materials and techniques and procedural manuals. These benefits avoid duplication of effort and the wasting of resources. They help to ensure a consistently high standard of regulatory practice and public protection in each of Nova Scotia's self-regulating health professions.

Such benefits of collaboration are particularly important in a small province like Nova Scotia, where regulatory resources are limited, especially for self-regulating professions that have a relatively small number of members and that have less experience under self-regulation than the professions that have been self-regulating for many years or decades. Viewed from this perspective, the Network believes that collaboration among regulatory bodies can be an additional reason for confidence on the part of Nova Scotians that health professions' self-regulation will continue to live up to its responsibility of public protection.

The alignment between health professional regulation and the health care system is necessary to ensure that health professional regulation does not become an impediment to the collaborative delivery of health care.

[10] Romanow, Roy J., *Building on Values: The Future of Health Care in Canada – Final Report*. (Ottawa: Commission on the Future of Health Care in Canada, 2002), at 93, 106, 107, 113, 119, and 151-152; First Ministers Meeting. 2003. *First Ministers' Meeting on Health Care Renewal, February 5, 2003, Doc. 800-039*. Ottawa: First Ministers Meeting. First Ministers' Meeting. 2004. *A Ten-Year Plan to Strengthen Health Care, September 16, 2004, Doc. 800-042*. Ottawa: First Ministers' Meeting.

[11] Rob Alder *et al*. of the Dalhousie University/World Health Organization Collaborating Centre on Health Workforce Planning & Research, *Model of Care Initiative in Nova Scotia (MOCINS): Final Evaluation Report*, (October 21, 2010) online: <http://www.gov.ns.ca/health/MOCINS/docs/MOCINS-evaluation-report.pdf>

[12] Dr. John Ross, *The Patient Journey through Emergency Care in Nova Scotia – A Prescription for New Medicine*, (October 2010) online: <http://www.gov.ns.ca/health/emergencycarereport/docs/Dr-Ross-The-Patient-Journey-Through-Emergency-Care-in-Nova-Scotia.pdf>

Further, the Network believes that the benefits to be gained from expanded collaboration in health professions' regulation will escalate as the health care system continues to move towards collaborative team-based care. A parallel shift to inter-professional collaboration in the regulation of professional practice will help to ensure that alignment between health professions' regulation and the health care system is maintained and enhanced. This alignment is necessary to ensure that health professions' regulation does not become an unnecessary barrier or impediment to collaborative team-based approaches to the delivery of health care services. Indeed, it can help to ensure that health professions' regulation plays a role as one of the enablers of team-based delivery of health care services. Meanwhile, expanded inter-professional collaboration in health professions' regulation will also help to ensure that the accountability of health professionals to Nova Scotians and to their peers through professional regulation keeps pace with how the delivery of health care services is organized and carried out.

The relationship between inter-professional collaboration in health professions' regulation and inter-professional collaboration in the delivery of health care services has been stressed by others. For example, in 2006, Ontario's Health Professions Regulatory Advisory Council concluded that the emergence and growing prevalence of what it called "multidisciplinary and collaborative care" was one of the most significant health system changes confronting health professional regulation.[13] It therefore also concluded that "the health professions regulatory environment should be structured to encourage and support this kind of positive development and innovation in the delivery of health care in Ontario". Similarly, in 2007, the Conference Board of Canada concluded that inter-professional regulatory collaboration could assist inter-professional clinical collaboration in multiple ways. These contributions included the development of a new "regulatory paradigm", called "collaborative self-regulation" that would be based on a "regulatory culture … measured by its success in the creation, continuing development and support of collaborative, interdisciplinary, patient-centered health-care team practices". [14]

Why should collaboration be pursued through an enabling statute?

The statute being proposed would not require regulatory bodies to collaborate. It would enable them to collaborate. It would leave the choice of when to collaborate and the design of collaboration to be determined by the regulatory bodies themselves on the basis of the choice that each makes, as a self-regulating body, to collaborate.

The Network is aware that Ontario has taken a more regulatory approach to inter-professional collaboration. It has amended the *Health Professions Regulation Act* to make collaboration

[13] Health Professions Regulatory Advisory Council, *Regulation of Health Professions in Ontario: New Directions*. (Toronto: Province of Ontario, 2006) at 7, 13 and 25

[14] Conference Board of Canada, *Achieving Public Protection through Collaborative Self-Regulation: Reflections for a New Paradigm*. (Ottawa: Conference Board of Canada, 2007), at 15-16

with other regulatory colleges part of the statutory mandate of each regulatory college. The same Act has also been amended to give Ontario's Minister of Health and Long-Term Care broad powers of oversight over all of the regulatory colleges of Ontario's self-regulating health professions. This oversight encompasses the mandate of the colleges to collaborate with each other. British Columbia has also put a duty of collaboration among regulators into the *Health Professions Act* of that province.

The Network recognizes that these legislative changes have been made in part, because public policy is being shaped in Ontario by an understanding of the need for and the benefits of collaboration in health professional regulation that is similar to that shared by Network members. Despite that, the Network believes that the Ontario approach is not the right approach for Nova Scotia. It is likely to produce resistance to collaboration and/or "for show" or begrudging collaboration that discharges the accountability to collaborate but does not actually enhance regulation and public protection. Indeed, such an approach is likely to become more dependent on oversight and enforcement with time. This could actually weaken professional regulation and public protection, especially by smaller regulatory bodies, by diverting limited resources to collaboration that is carried out for the sake of collaboration.

In contrast, the Network believes that an approach that focuses on removing the barriers to collaboration and on otherwise enabling but not mandating collaboration is more likely to foster genuine collaboration that produces tangible benefits. Under such an approach, collaboration will happen because it is determined in the course of regulatory decision-making to be the appropriate approach for effectively dealing with a particular problem. The experience of collaborating in such circumstances and the benefits which such collaboration is more likely to yield, will become a stronger and more compelling rationale than regulatory oversight ever could be for further collaboration in like circumstances and for the application of collaborative approaches to other kinds of problems and opportunities.

A statute creating a more unified entity of the regulated health professions:

- gives recognition to the reality that health professions are inter-dependent
- allows government to have a single point of access for communications on issues that impact all health professions;
- allows the health professions to have a formalized collective voice to speak on issues impacting all health professions;
- breaks down legislative barriers that impede information sharing.

In addition, the Network believes that Nova Scotia has an opportunity to move forward on the basis of an existing and growing openness to collaboration among regulatory bodies and between regulatory bodies and government that may be unique in Canada. It is the members of the Network who are coming forward to government asking for expanded statutory authority for wider and more operational collaboration. They do not need legislation that tells them they must collaborate because they already understand they need to collaborate. In such a context, legislation that assumes the reverse runs the risk of being counterproductive. The Network believes that Nova Scotia should instead adopt an approach to legislative change that builds on existing strengths.

The suggested approach to legislative change would see the retention of the existing discrete statutes for each of the regulated health professions in the Province, and in addition to these 22 statutes, a new statute would be created to facilitate collaboration among the professions. Such legislation will have the following benefits:

- The existence of a statute creates a more unified entity of all the regulated health professions in the Province.

- A new statute will focus on greater accountability, better practices, more training and more consistency in decision making, as a result of which public confidence in the self-regulation of health professions will be increased.

- Under the current statutory structure for health professions in Nova Scotia, legislative amendments are required when the scope of practice of one profession requires change to take into account the overlapping scopes of practice with other professions. Under new legislation, a simpler mechanism for revising scopes of practice can be achieved without the necessity of specific statutory change for the affected professions.

- Most current statutes for regulated health professions contain confidentiality provisions that disallow sharing of information among the professions. A new statute will remove these legislative barriers. A new statute will assist health care quality issues by allowing information sharing when "systems" issues are identified. This enhances the protection of the public.

- The creation of new legislation shows responsiveness to what is happening in the health care system regarding the increase in inter-professional practice. It assists in the public understanding that each profession is not a silo unto itself, but one piece of the total system that works collaboratively with others. By enabling voluntary collaborative processes for regulatory matters such as investigations and reviews of internal decisions, more effective processes will be in place for the public, and efficiencies will be created for the participating professions. For example, when using a collaborative investigatory process for complaints that impact members of more than one profession, multiple investigations can be reduced to one investigative process where witnesses will only be interviewed on one occasion for purposes of the multiple complaints.

In short, the creation of new legislation is considered essential in order to maximize the benefits of collaborative self-regulation.

Why not a more fundamental restructuring of the legislative framework?

The Network is aware that its proposal for an enabling statute that complements the statute of each self-regulating profession comes forward at a time when the Nova Scotia model for health profession regulation, under which each regulated profession is governed exclusively by its own

statute, is becoming an anomaly within Canada. In the provinces of Quebec, Ontario, Alberta, British Columbia and Manitoba each regulated health profession is subject to its own statute or regulations, but all are also subject to an umbrella statute that deals with matters in which common legislative provisions are deemed appropriate for all professions.

Outside of Canada, other legislative models for professional regulation in health care have been evolving. A more detailed discussion of these models is found in the discussion paper prepared by the Dalhousie Health Law Institute on behalf of the Working Group in Phase 1 of the Network's consideration of collaborative interprofessional regulation.[15]

The Network believes that discussion of the merits of these alternative models of legislation for health professional regulation is a distinct matter that should not be confused with the proposal for collaborative legislation outlined in this Report. The Network is not proposing to replace the system of existing regulation of health professions in Nova Scotia. It is proposing to enhance it through legislation that will complement existing legislation by enabling collaborative regulatory processes and eliminating legislative barriers to such collaboration. The Network is of the view that the systems of regulation in place in other jurisdictions do not achieve the benefits of collaboration that are being proposed in this Report. Accordingly, the discussion outlined in this Report that centres on the benefits to be achieved through collaborative legislation should proceed independently of any discussion about the fundamental structure of health professions in this Province.

The Network notes that one of the original objectives of umbrella legislation was to reduce or eliminate the barriers that health professional regulation could pose for flexible and integrated delivery of health care. Yet more than twenty years after adopting umbrella legislation, Ontario undertook an extensive exploration of options for expanding interprofessional collaboration in health care and in the regulation of health professions. The Network believes that the proposed collaborative model is a preferable and more immediate way to achieve the objectives that might also be pursued either through umbrella legislation or through the more dramatic changes being adopted beyond Canada. It builds on existing structures and strengths, including the collaboration that is already happening among members of the Network and between the Network and the Department. More fundamentally, the collaborative model being proposed can address the structural limitations that regulators face in a system of regulation based on self-regulation by each regulated profession. At the same time, it will ensure that health professions' regulation continues to be strongly based on self-regulation and therefore on the ethos of professionalism that self-regulation underpins and nurtures among regulated professionals. In turn, this will help to ensure that the regulation of health professionals that is authorized by statute continues to support and reinforce the self-regulation that members of

[15] *Collaborative Self-Regulation and Professional Accountability in Nova Scotia's Health Care System – A Report from the Working Group on Collaborative Regulation of the Nova Scotia Health Professions Regulatory Network to the Nova Scotia Health Professions Regulatory Network and the Nova Scotia Department of Health*, prepared by William Lahey, Director, Dalhousie Health Law Institute with Assistance of Leah Hutt and Alison Hopkins, and Tracy Hobson, August, 2009

professions must be expected to practice on their own if the public interest is to be truly served.

The Network believes that any discussions relating to a fundamental restructuring of the regulation of health professions in Nova Scotia would be divisive, and perhaps more importantly, such discussions would take many years to achieve a conclusion. The proposal outlined in this Report is a solution that can be implemented readily; it is a proposal that is an organic one rather than an imposed one; it allows the professions to retain control over their own costs; and it achieves an outcome that is not achievable under the legislative frameworks in place in other jurisdictions.

In addition, the Network believes that the enabling legislation being proposed in this Report should be reviewed five years after its adoption. The lessons learned from the implementation of this legislation over a five- year period will better position Nova Scotia to consider whether a more fundamental restructuring of the legislative framework for health professions regulation in necessary to accomplish that the objectives that the Network believes can be accomplished through collaboration and continued reliance on the core principle of self-regulation.

Foundational Principles:

While members of the Network support the development of new legislation that will enable collaborative self-regulation and develop the existing benefits of the informal Network, they wish to ensure that under such new legislation their existing legislative structure and processes will continue unless voluntary choices are made to participate in collaborative regulatory processes. Because of the advantages of a self-regulation model as outlined in the previous section, they wish to enhance self-regulation; not replace it.

The emphasis throughout the new statute should be on its **enabling** objectives, which will allow each profession to continue as a self-regulated profession, but with the ability to choose different collaborative regulatory processes that will assist a specific profession in meeting its legislated mandate.

In any legislation that is developed to embody the principles of collaborative self-regulation, members of the Network maintain that the following foundational principles need to be borne in mind:

- The autonomy of each health profession and its enabling statute needs to be maintained. This ensures that the positive benefits arising from a system of self regulation, based on the professional ethos of its members, will continue;

- Given the benefits of autonomy, the new statute should enable collaborative regulatory processes, but not require them;

- The new statute should allow the current benefits of the informal Network to continue through sharing of best practices and sharing of information;
- The new statute should also enhance the benefits of membership by removing barriers to information sharing and by removing existing barriers found in current regulatory processes;
- The new statute should allow the health professions to do legislatively what they are now doing as a work-around.

Key Concepts for Inclusion in New Statute:

This Report to government is not intended to be a legislative drafting exercise. Rather, it is intended to put forward the key concepts for inclusion in a new statute.

The following key concepts will be discussed more fully below:

1. Name of statute;
2. Incorporation of Network;
3. Regulation and By-Law making authority;
4. Transitional section to establish governance on proclamation of new statute;
5. Objects clause – purpose of Network;
6. Membership in the Network;
7. Governance and decision making structure;
8. Voluntary collaborative regulatory options such as :
    - A mechanism for addressing overlapping scopes of practice;
    - A collaborative investigative process;
    - A collaborative review or appeal process for regulatory decisions;
    - A joint quality assurance processes.
9. Relationship of current statute to Network statute;
10. Five year mandatory review clause;

11. General immunity/indemnity provisions;

Name of Statute

One of the objectives of new legislation will be the formalization of the existence of the Network as an incorporated legal entity. By having a clearly established governance and decision-making framework set out in the legislation, the Network will be enabled to speak in a unified manner on behalf of its membership.

As the focus of the new legislation is on the formalization of the Network and the voluntary opportunities it provides to its members, it is appropriate to call the statute: *An Act Respecting the Collaborative Self-Regulation of Health Professions.* The short name of the statute would be *The Regulated Health Professions Network Act.*

Incorporation of Network

The statute will become the mechanism by which the Network will be formally incorporated. As a result, the statute will need to contain a provision constituting the Regulated Health Professions Network as a statutory entity. It should include the standard statutory provisions indicating it has the capacity, rights, powers and privileges of a natural person; and perpetual succession and a common seal, with power to acquire, hold, lease, mortgage and otherwise dispose of real and personal property, and may sue and be sued.

Regulation and By-Law Making Authority

It is proposed that the new legislation be structured in a similar manner to the statutes of currently regulated health professions. In that regard, the statute itself would deal with key issues such as the eleven matters identified above, but then would enable the passage of Regulations and By-laws to deal respectively with the operational aspects of collaborative regulatory processes, and internal organizational issues such as the election of the Executive, conduct and quorum for meetings, etc..

Objects Clause – Purpose of Network

While this Report is not intended to provide specific suggestions for legislative drafting, an exception is made in the context of the proposed objects clause for the statute, where it is proposed to read as follows:

Objects of the Network

1. The purpose of the Network is to foster and enable collaboration among regulated health professions in a manner that upholds and protects the public interest through enhanced self-regulation of the health professions.

2. In pursuing its purpose, the Network will:

   (a) Establish a forum to share resources, information, trends and issues in health professions legislation among regulated health professions;

   (b) Promote best practices in health professions regulation while preserving the regulatory autonomy of each regulated health profession;

   (c) Enable health professions to build capacity for their regulatory functions by facilitating collaboration with other regulated health professions and others;

   (d) Enable voluntary processes to allow members of the Network to collaboratively address:

      (i) Scopes of practice among regulated health professions;

      (ii) Joint investigation and resolution of complaints;

      (iii) Review and appeal processes for regulatory decisions;

      (iv) Joint quality assurance processes; and

      (v) Any area of common interest among the regulated health professions that may benefit from voluntary, collaborative processes.

   (e) Provide a single point of contact for discussion and consultation on matters with government and others that may impact the regulation of health professions or the objects of health professional regulatory bodies; and

   (f) Facilitate the development of other strategies and approaches that will enable health profession regulators to respond individually and collectively to regulatory challenges and opportunities.

Membership in the Network

It is the view of the members of the Network that mandatory membership of statutorily regulated health professions is required to maximize the benefits of the new legislation.

As earlier outlined, the proposed legislation is designed to **enable** members to collaborate **but not require** them to collaborate. As a result, there will be no loss of regulatory autonomy.

The added credibility and authority of all regulated health professions speaking with one voice is thought to lead to more engagement of all health professions in the Province, particularly as the benefits of the legislated Network are realized.

In any statutory provision requiring mandatory membership, there is naturally a concern about the costs of membership. Members of the Network recognize and accept that because of the different sizes and resources of the various health professions in the province, there may need to be a fee structure that reflects the differences among the various health professions. It is anticipated that this type of detail would be included in the By-laws of the Network, rather than in the statute itself. The bigger question of funding outside of the resources of the organizations themselves will be dealt with later in this Report under the section entitled "Funding".

Having considered the various issues of voluntary versus mandatory membership, it is the view of the Network that all health professions with statutes meeting the following criteria should be required to become members in the Network.

(a) The scope of practice of the profession is defined;

(b) The profession is guided by written standards of practice and a code of ethics;

(c) The statute establishes a body that regulates the practice of the profession in Nova Scotia in the public interest;

(d) The statute provides the detailed criteria for membership in the profession;

(e) The statute provides a detailed process for the resolution of complaints, the investigation of complaints, and the adjudication of matters that are referred to a hearing;

(f) The statute provides that members outside those admitted to membership in the profession cannot engage in the scope of practice defined in the Act, unless specific statutory exemptions apply;

(g) Statutory immunity and indemnity is provided to the governing entity of the health profession, its employees and committee members in the conduct of their work.[16]

[16] Attached as Appendix 1 is a list of all health professions in the province and their governing statutes, that currently meet these criteria. All of these statutes fall within the jurisdiction of the Minister of Health and Wellness with the one exception of the *Social Workers Act*, which is administered through the Department of Community Services. Given the close and collaborative working relationship of social workers with various other health professionals, however, it is important that social workers be included in collaborative regulation legislation.

In addition to the issue of mandatory versus voluntary membership of the health professions, the question remains as to whether there should be other members of the Network. Currently, representatives of government sit as *ex officio* members of the present Network. These members add significant value to the discussions that take place at the Network table.

It is recognized, however, that the new Network is intended to emphasize the need for the maintenance of the self-regulatory status of each of the health professions in the province. Since one of the underpinnings of self regulation is self-governance of the members of the profession without direct government oversight, it is proposed that membership in the new Network be confined to the health professions themselves. The intent is that government representatives will continue to be invited to attend the meetings and to contribute to the discussions, but they would have no role in voting on matters to be determined by the membership and would be considered to be at arm's length from the Network itself.

As a result, it is proposed that the only members of the Network will be the members of the regulated health professions that meet the criteria outlined above.

Transitional Section re Governance

It is anticipated that prior to the passage of the new legislation, the current Working Group members will be constituted as the Executive of the existing Nova Scotia Regulated Health Professions Network (NSRHPN). The new Act would then indicate that on proclamation, the current Executive of the NSRHPN will continue as the Executive of the newly incorporated Network.

Governance and Decision Making Structure

It is anticipated that a position of Administrator will be created under the new legislation. The administrator will have a variety of functions to be set out in the By-laws, some of which would include acting as the point of contact for the Network; and carrying out such duties as assigned by the Executive of the Network.

It is proposed that within twelve months of the proclamation of the legislation, the new Network would be governed by a five person Executive Committee that is broadly representative of the members of the Network as a whole. The details with respect to the composition of the Executive Committee, and their manner of election or appointment would be set out in the By-laws. The By-laws would not restrict the re-appointment of current Executive members, and would allow flexibility with respect to the number of terms that could be served. The detailed role of the Executive would be set out in the By-laws, but is intended to include such items as:

1. The setting of agendas;

2. Establishing a process for chairing meetings; and

3. Engaging in planning and follow-up for the various functions to be performed by the Network.

It is intended that the Executive's role would be a limited one, with key questions respecting the direction of the Network and the availability of collaborative regulatory processes to be determined by the membership as a whole. The voting on any issues would take place by a representative member of each of the member health professions. In most instances, that representative member will be the Executive Director or Registrar of the profession, but in the absence of that individual, the Executive Director or Registrar will name a delegate to attend a meeting to exercise voting rights.

The By-laws may also set out some guidelines for the attendance of observers at the meeting, as some health professions may want to bring more than one representative member to each meeting, depending on the item to be discussed. Because membership in the Network is relatively large however, it is anticipated that some parameters around attendance will need to be established in the By-laws.

A key concept for the new legislation will be the decision-making structure where each profession is entitled to one equal vote on all matters. It is imperative that the legislation not distinguish the size or resources of the varying health professions, as effective collaboration will require a foundation of equal responsibility for the actions of the Network by all members.

It is also anticipated that the new legislation will require a provision allowing for the establishment of committees to take on work that may be delegated by the Executive. It will not be necessary to name the committees in the statute itself, but provisions should be established to create such committees and their terms of reference, in the By-laws.

Voluntary Regulatory Options

As referenced throughout this Report, a key underlying principle of the new legislation is that it will **enable** members to pick and choose among a menu of collaborative regulation options. There will be no obligation for any member to participate in any collaborative regulation processes.

It is anticipated that there will be many types of issues that may lend themselves to collaborative regulation. It is intended that the new legislation will not be prescriptive in setting out an exhaustive list of those processes which may involve collaborative regulation. Rather, it is intended that the proposed legislation will set out the availability of certain collaborative regulation processes (the details of which will be spelled out in the Regulations), and will then provide regulation-making authority to enable further collaborative regulatory processes to develop over time.

The following types of collaborative regulatory processes have been reviewed by the Network to date for general reference in the statute, with the details of how these processes will be implemented to be included in the Regulations:

Mechanism for Addressing Overlapping Scopes of Practice

Under the current method of regulation of health professions in Nova Scotia, the statute for each profession sets out a defined scope of practice for the profession and then generally indicates that only licensed members of that profession may engage in that particular scope of practice. Certain exemptions are then created within the statute that allows designated individuals to engage in a particular practice without offending the legislation.

For example, the "practice of practical nursing" is defined in the *Licensed Practical Nurses Act* in the context of assessing clients, collaborating in the development of nursing plans of care, implementing a nursing plan of care and evaluating the client for the purpose of promoting health, preventing illness, providing palliative and rehabilitative care and assisting clients to achieve an optimal state of health. At the end of this statute, a section then indicates that "Nothing in this Act prohibits … the practice by a person of medicine, dentistry, pharmacy or optometry or, subject to (other clauses) any other health discipline recognized by statute".

The same general structure is used in the statute of every health profession in the province, with the list of specific exemptions varying from one profession to another.

In order to change the scope of practice of a profession, the definition of the profession within the legislation must be changed, thereby requiring the opening of the statute to legislative review. The process for legislative review and revision is a long and expensive one, and does not allow for the rapid evolution that is occurring in the sharing of competencies of various health professions in this Province.

An example may be illustrative.

Discussions took place in recent years between the professions of medicine and dietetics to discuss the potential for registered dietitians to change insulin dosages for diabetics, depending on their blood glucose readings. Dietitians were intimately involved in the nutritional needs of these individuals, and regularly monitored their blood sugar levels. When patients' blood sugar levels indicated a need for variation in the amount of insulin, dietitians were unable to effect the necessary changes without receiving a prescription from a physician.

Both the College of Physicians and Surgeons of Nova Scotia and the Nova Scotia Dietetic Association agreed that it would be appropriate for dietitians to be able to directly effect changes in insulin dosages to accommodate changes in blood sugar readings. However, the variation

The Network's proposed legislation will allow participation in a joint process among the impacted professions to decide issues regarding the sharing of competencies.

of insulin was deemed to fall within the scope of practice of medicine under the *Medical Act*, and outside the scope of practice of dietetics under the *Professional Dietitians Act*. As a result, it would be deemed to be a violation of both statutes for dietitians to engage in this practice.

A new *Dietitians Act* has recently been passed (although not yet proclaimed) that will now authorize dietitians to engage in this practice. These legislative amendments involved cumbersome, time-consuming processes that were not flexible enough to meet the changing realities of the delivery of health care in a responsive and effective way.

Under the new Network legislation, it is proposed that there will be a voluntary mechanism that will allow participation in a joint process to decide issues regarding the sharing of competencies. If the affected professions agree on a change in the scope of practice of one profession, then the added scope of practice will be deemed to become part of the scope of practice of the impacted profession.

Whenever agreements are reached under the new legislation that effect a change in the scope of practice of one profession, there will need to be a formal mechanism to "house" the revised scope of practice to ensure there is public awareness of the entirety of the scope of practice of any particular profession. While there may be varying ways to effect this, one option to consider is the passage of a consequential amendment to all existing statutes of regulated health professions indicating that where an agreement has been reached under the *Regulated Health Professions Network Act* to amend the scope of practice of a profession, such amendment shall constitute a new schedule to the Bylaws of the *Network*, and will be published on the Network's website. In that way, or through some similar mechanism, there will be a transparent linkage established between the current scope of practice contained within the profession-specific legislation, and the additional scope housed under the published By-Laws of the *Regulated Health Professions Network Act*.

It is anticipated that the provisions of the new legislation would include the following:

1. Assuming agreement among the impacted professions regarding a change in the scope of practice for one of the professions, the agreed upon change will be deemed to be a change in the scope of the practice as set out in that profession's own governing statute.

2. Where agreement is reached, the new legislation will provide that the agreement amends the existing scope of practice of the impacted professions.

3. The Department of Health and Wellness will be given the opportunity to comment on the proposed changes and to determine the departmental implications.

4. Notice of any proposed changes must be given to all members of the Network, the public (to a notice to comments section on the Network's website), and other relevant stakeholders. The Network believes that consultation is key to this process, and accordingly, input will be sought before agreement can be finalized among the impacted professions.

5. The new legislation would emphasize this is a voluntary process with no binding outcome in the absence of agreement.

In the event agreement cannot be reached under the above process to effect the change in the scope of practice of a profession, then no change will take place unless the profession seeking the change utilizes the presently-existing processes of statutory amendment to pursue the change in scope of practice.

This proposal for addressing overlapping scopes of practice provides a more fluid system and a more responsive system than the status quo. It is far preferable to the existing legislative processes where so much time is required to effect change that the statutes are often out of date by the time legislative provisions are passed. Scopes of practice are no longer static. They require a flexible system to permit change, that will ensure public protection while at the same time allowing each health care professional to practice to their full scope.

A Collaborative Investigative Process

When the Network first began discussing the concept of collaborative regulation, one of the driving forces was the inability to effectively deal with complaints arising from multiple health care professionals. It is not uncommon for a patient to complain about a series of events creating an adverse impact on a patient, where members of several regulated professions have been involved in the provision of care.

Under Nova Scotia's current system of health professions regulation, separate complaints need to be filed with each impacted profession, and statutory barriers then exist that prevent each profession from collaborating on the investigation of the matter and sharing information gathered during the processes.

This "silo" approach to the investigation of multiple-profession complaints is seen to be problematic. Many witnesses find it a hardship to be involved in multiple regulatory processes. "Witness fatigue" sets in, making some witnesses who are not accustomed to dealing with investigative and hearing processes reluctant and indeed uncooperative with these processes. The thoroughness of investigations can be impeded as a result.

Perhaps most importantly, the silo approach to investigations of complaints often results in decisions that deal with the actions of one professional, and do not deal with the multiple factors that contributed to the development of the issue in the first place, such as the actions of other individuals or deficiencies in health care systems. Statutory duties of confidentiality limit the ability to explore many of these issues with third parties once an investigation is completed.

Key factors impacting the credibility of investigative and adjudicative processes of health professions include the timeliness and thoroughness of the investigation, the need for the issuing of logical reasons for the decision, and consistency in decision making.

Through the availability of a collaborative regulatory system for investigations, these factors can be addressed more effectively for both multiple-profession complaints and complaints arising in professions where there is little experience in dealing with complaints.

Attached as Appendix 2 is a "Health Professions Investigative Model" that sets out in a schematic way how a collaborative investigation could work.

The "silo" approach to the investigation of multiple-profession complaints is problematic.

The basic scheme shows letters of complaints coming in involving members of two different health professions (the scheme can be adapted for however many professions may be involved), and a decision is then made by each of the professions as to whether they wish to engage in the collaborative investigative process. Again it is emphasized that this is a voluntary process. If agreement is not reached by all involved professions, the collaborative investigation does not proceed and each college continues their investigation as they would under the current statutory structure in Nova Scotia.

If there is agreement to engage in a collaborative investigative process, then the colleges themselves make the determination as to who would conduct the investigation and would agree to a sharing of the information gathered during the collaborative investigation. The role of the Network in this process would be to provide resources such as names of investigators, and training for investigators who could then engage in the collaborative investigative process.

Each college would retain their independent adjudicative role, thereby maintaining their own autonomy and control over final decision making. Once decisions are made, however, the information under this statute would then be permitted to be shared with others including the Network itself and third parties such as educational institutions or Quality Assurance offices such as the Health care Quality, Patient Safety and Wait-time Improvement Office of DHW.

In addition to the general benefit to the public arising from sharing information that may lead to health systems improvements, this type of collaborative investigative process will also produce benefits for individual complainants. The matter will be investigated by someone with appropriate training and experience in investigations. It is anticipated that the investigations will be done in a more timely way then could be otherwise be done if each profession were initiating an investigation on its own. Perhaps most importantly complainants would not have to participate in multiple processes at varying times.

It is anticipated that the legislation itself would enable this type of investigative model to be implemented, with the detail of the workings of the investigative model to be set out in the regulations. The Act would require the following provisions:

1. the concept of collaborative investigation would need to be enabled in the Act on a voluntary basis by colleges who wish to access it;

2. the collaborative investigative process would need to be defined in a generic way;

3. collaborative investigators, like all college investigators, will need to be given the powers and immunities of commissioners under the *Public Inquiries Act* ;

4. collaborative investigators and their respective colleges will need statutory authority to share the confidential information obtained during the investigation with each other and with identified third parties;

5. a provision will clarify that the sharing of information under the collaborative investigative process does not waive the statutory privilege granted under either the existing statutes of certain health professions, or more generally, under the *Health Professions Disciplinary Proceedings Protection Act*. In other words, if a complaint is made about a dentist and a dental hygienist and these two health professions decide to engage the collaborative investigative process, the sharing of information between these two colleges would not remove the statutory provision under the *Dental Hygienists Act* that requires the maintenance of the confidentiality of information gathered in the investigative process, and does not allow the use of that information in external civil or administrative processes. Information from the collaborative investigation could not be used in a civil suit if the dental hygienist was being sued civilly for negligence. The information could only be used for the joint purposes of the Provincial Dental Board's regulatory investigation and the College of Dental Hygienists regulatory investigation.

A Collaborative Review or Appeal Process for Regulatory Decisions

There are a variety of regulatory processes in each of the health professions that may lend themselves to a collaborative review or appeal process. For example, provisions of the *Fair Registration Practices Act* require all credentials and registration decisions to be open to a review or appeal process. By enabling a review process to take place under the new collaborative legislation, it is possible that one committee could be appointed to conduct the review or appeal process for those health professions who choose to participate in such a collaborative process. The committee established for this purpose could have appropriate training, and would gain expertise through participating in a review or appeal of decisions from a variety of professions that would allow a building of expertise leading toward consistent and logical decision making processes.

The colleges that use the collaborative process would cover the costs of the process – it would be on a user pay basis.

It is anticipated that the details of the review or appeal processes could be set out in the regulations, and they would simply be enabled in the new legislation. The new legislation would also need to provide that if the collaborative review process was engaged, it would be conducted as a replacement for any existing legislated appeal or review mechanisms.

Another example of a collaborative review process arises in the context of a complainant who is dissatisfied with a dismissal of a complaint at the initial stage of a matter. It is the view of the members of the Network that the voluntary availability of a standardized Complaints Resolution Commissioner or Complaints Resolution Committee that is arm's length from the profession in question, may provide objectivity and a consistent approach to dismissals of complaints that may engender greater confidence of the public in the methods used to deal with complaints.

Joint Quality Assurance Processes

At present, many individual statutes for the health professions contain authority to require members to engage in continuing professional development programs as an aspect of quality assurance.

Under a system of legislated voluntary collaborative regulation, it is foreseen that joint processes may be available to assist in expanding quality assurance processes. For example, it is possible to envisage the creation of a Joint Audit Committee that could be called in with the agreement of particular health professions to engage in a quality assurance process. One example that would lend itself to this type of process is a Methodone Clinic, where several types of health professionals work together to assist those with drug addictions. To the extent that a Joint Audit Committee could be authorized to review the practices of the various health professionals to determine if quality improvements could be made, this would be of benefit to the users of the clinic as a whole. Recommendations from such a Joint Audit could potentially benefit the public in general in terms of better treatment of substance abuse

In addition to the potential for quality improvement of professionals and the settings in which they practice, there is also the potential for quality improvement of the regulation of the professions themselves. Through the formal establishment of the Network, common standards and policies can be developed on matters such as Risk Management and Business Continuity.

Relationship of Proposed New Statute to Existing Statutes

In keeping with the key foundational principles, it is imperative that the autonomy of each profession's legislation be maintained under the new legislation. While there would be a mandatory requirement for membership in the newly-constituted Network, there would be no requirement for any particular profession to engage in any of the collaborative regulation processes, without their agreement to do so.

By having mandatory membership but voluntary accessing of collaborative regulatory processes, all professions gain access to the informal benefits of information and resource sharing but are not required to change or "give up" any of their own statutory processes.

In order to enshrine the principle that the separate constituting statute for each health profession is paramount, it is anticipated that the new legislation will need to contain a provision outlining that the current statute of each profession should take precedence in case of conflict with the new legislation.

Some exceptions to this rule will be necessary and should also be set out in the legislation as follows:

1. where agreement is reached on a scope of practice issue;

2. where agreement is reached among professions to override existing statutory regulatory processes;

3. where information is agreed to be shared as a result of voluntary collaborative processes;

4. where the separate statute creates its own override for voluntary collaborative regulatory processes (e.g. the provisions in the new *Medical Act for shared competencies*).

Review Clause

Because the concept of legislated collaborative self-regulation is a new one, it is proposed that the new legislation would include a requirement for a review and assessment of its effectiveness five years after the date of proclamation. The details of the review would be determined by the Department of Health and Wellness, in consultation with the Network.

Immunity and Indemnity Provisions

Each current statute for regulated health professions in Nova Scotia contains provisions providing a general immunity and indemnity to the officers, directors, employees, agents and committee members of the entity engaged in regulation of the profession. It is proposed that the new legislation would need to contain a similar clause for all involved in any of the collaborative regulatory processes that are enabled through the statute.

Funding:

It is not anticipated that the new legislation will deal with the issue of funding for the activities of the Network, except to the extent of providing that the matter of fees for membership in the Network shall be dealt with in the By-laws.

In order to maintain consistency with the principle of autonomy for each regulated health profession and the importance of self-regulation, it is not anticipated that the Network will seek funding on an ongoing basis from the Department of Health and Wellness as a source of revenue for the operation of its collaborative regulatory processes.

While the intent is not to look for long term operational funding, it is nonetheless necessary to have initial funding to ensure that the proposed statute can be tested for a viable period.

Given the anticipated advantages of the proposed legislation and given that a number of initial processes will need to be established as the legislation comes into effect, the Network requests that the Department of Health and Wellness provide an initial grant to the Network to allow for the development of the statute, regulations, By-laws, policies, training programs, a website, the hiring and initial set-up of an Administrator, and an evaluative tool to determine its effectiveness. The Network is also prepared to entertain a model of third party funding, should that become available.

Conclusion:

Inter-professional practice is here to stay.

It is time for the system of regulation of health professions to reflect this.

Regulation works best when those who are impacted by regulation are involved in the design of the system. In the case of the Network, not only have the members been involved – they have initiated the request for change. This presents an opportunity to government to harness the collective thinking of those who are intimately involved in the regulation of health professions in Nova Scotia in a fashion that not only reflects the collaborative nature of health care, but offers creative methods to enhance self-regulation in the public interest.

The Network urges the Department of Health and Wellness to carefully consider the proposals outlined in this Report, and to support the development of legislation that will enable the creative and collaborative regulation of health professions in Nova Scotia.

Appendix "1" - Members of NSRHPN and Statutes under which they are constituted

College of Dental Hygienists of Nova Scotia – *Dental Hygienists Act*, S.N.S. 2007, c. 29, s. 1

College of Licensed Practical Nurses of Nova Scotia – *Licensed Practical Nurses Act*, S.N.S. 2006, c. 17, s. 1

College of Occupational Therapists of Nova Scotia – *Occupational Therapists Act*, S.N.S. 1998, c. 21, s.1

College of Paramedics – *Paramedics Act*, S.N.S. 2005, c. 10, not proclaimed in force

College of Physicians and Surgeons of Nova Scotia – *Medical Act*, S.N.S. 1995-96, c.10, s.1

College of Registered Nurses of Nova Scotia – *Registered Nurses Act*, S.N.S. 2006, c. 21, s. 1

Denturists' Licensing Board of Nova Scotia – *Denturists Act*, S.N.S. 2000, c. 25, s.1

Midwifery Regulatory Council of Nova Scotia – *Midwifery Act*, S.N.S. 2006, c. 18, ss. 15, 18, 19(3)

Nova Scotia Association of Counselling Therapists – *Counselling Therapists Act*, S.N.S. 2008, c. 37

Nova Scotia Association of Medical Radiation Technologists – *Medical Radiation Technologists Act*, R.S., c. 280, s.1

Nova Scotia Association of Social Workers – *Social Workers Act*, S.N.S. 1993, c. 12, s. 1

Nova Scotia Board of Examiners in Psychology – *Psychologists Act*, S.N.S. 2000, c. 32, s.1

Nova Scotia College of Chiropractors – *Chiropractic Act*, S.N.S. 1999, c. 4, s.1

Nova Scotia College of Dispensing Opticians – *Dispensing Opticians Act*, S.N.S. 2005, c. 39, s.1

Nova Scotia College of Medical Laboratory Technologists – *Medical Laboratory Technology Act*, S.N.S. 2000, c. 8, s. 1

Nova Scotia College of Optometrists – *Optometry Act*, S.N.S. 2005, c. 43, s. 1

Nova Scotia College of Pharmacists – *Pharmacy Act*, S.N.S. 2001, c. 36, s.1

Nova Scotia College of Physiotherapists – *Physiotherapy Act*, S.N.S. 1998, c. 22, s.1

Nova Scotia College of Respiratory Therapists – *Respiratory Therapists Act*, S.N.S. 2007, c. 13, s.1

Nova Scotia Dental Technicians Association – *Dental Technicians Act*, R.S. 1989, c. 126

Nova Scotia Dietetic Association - *Dietitians Act*, S.N.S. 2009, c. 2 – not proclaimed in force

Provincial Dental Board of Nova Scotia – *Dental Act*, S.N.S. 1992, c. 3, s.1

Appendix "2" - Health Professions Investigative Model