

# **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

Prepared by William Lahey, Director, Dalhousie Health Law Institute  
With the assistance of Leah Hutt (Research Associate) and  
Alison Hopkins and Tracy Hobson (Research Assistants)

---

**October, 2009**

## Executive Summary

This report outlines the process that was followed and the work that was completed by the Working Group of the Nova Scotia Health Professions Regulatory Network (NSHPRN) on Collaborative Regulation.<sup>1</sup> More specifically, it outlines 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.

The core of the report is the model of collaborative model for improving professional accountability that is put forward for discussion and further development. Under this model, complaints that came to individual members of the NSPHRN would in two circumstances be investigated through a collaborative investigative process staffed by employees of two or more colleges.

One of these circumstances would be where the complaint involved significant issues of interprofessional accountability, such as where it was directed at the members of two or more members of NSHPRN. The other circumstance is where the complaint exceeds the investigative capacity of the college or other regulator that receives it, in which case the collaborative interprofessional investigative process would facilitate the sharing of resources among members of NSHPRN to ensure appropriate investigation. In either scenario, the outcome of the investigation would be returned to the college or colleges (as the case may be) to which the complaint was originally made for independent disposition. A similar option for joint adjudication of complaints with a significant interprofessional accountability dimension is included in the Working Group's collaborative model for purposes of discussion. Again, disposition would be left to each participating college.

In the view of the Working Group, this model is promising and worth further consideration as a response to real limitations of the current regulatory system. These

---

<sup>1</sup> Here and throughout the report, "collaborative regulation" is regulation that is carried out through collaboration by two or more members of the NSHPRN.

limitations include the way in which accountability is fragmented among distinct regulatory processes and the wide distribution of modest regulatory resources across a relatively large number of regulators. In the view of the Working Group, the collaborative model responds to these limitations by adjusting self-regulation to reflect current health system realities, including the growing prevalence of interprofessional teams. In doing so, it avoids the justification for a restructuring of the regulatory system that reduces the scope of self-regulation. It would therefore avoid the risk that may be associated with such restructuring of minimizing the capacity of the regulatory system to harness both strong external accountability and strong internal responsibility among regulated professionals to the objective of overall regulatory effectiveness.

The report articulates four design principles used to develop the collaborative model to professional accountability. One is that it seeks to preserve and build upon the strengths of the existing regulatory system while addressing its areas of risk and vulnerability. Another is that it is closely tailored to the dimensions of the risks and vulnerabilities it seeks to address. A third is that, like existing collaborations among members of NSHPRN, it uses the collective capacity of Nova Scotia's regulatory bodies to increase the capacity of each of them to discharge their separate regulatory responsibilities. Finally, it seeks to add features to the regulatory system while minimizing unnecessary overhead, duplication, and complexity.

The report recognizes that the model proposed for collaborative action on professional accountability might not be the best that can be proposed and that a better alternative may arise from further work. The report stresses however that action is needed to bring the system of professional accountability more into line with current realities and that it is in the nature of these realities that much of this action must be of a collective nature. The report also stresses that the value of the proposed model (and of alternative approaches to collaboration that may be proposed) should be assessed not only against Nova Scotia's current regulatory system but also against the regulatory systems that are being instituted by governments in other jurisdictions. The report also concludes that any meaningful regulatory collaboration at the operational level will require a legislative platform.

Further, it stresses that Nova Scotia should consider following the lead of other jurisdictions in establishing a process that would operate in parallel to professional regulation to address patient complaints or issues arising from patient complaints that are not about or only partially about professional accountability.

Finally, the report sets out recommendations for NSHPRN on how it might use collaborative regulation to support interprofessional collaborative care and improve the regulation of health professionals in Nova Scotia more generally, and to NSHPRN and DoH on next steps. On the former, the recommendations include the following: that NSHPRN push forward with considering the applicability of collaborative approaches to other aspects of the regulatory process, such as continuing competency and policy development; that it broaden discussion of collaborative regulation (including professional accountability) within its members organizations and with other health system players, including district health authorities; and that it encourage DoH to consider options for complementing the accountability process of professional regulations with a process or processes that deal with patient complaints that raise issues about accountability for the functioning of other parts of the health care system.

With respect to recommendations on next step, the report recommends continuation of the Working Group and of the collaboration with the Dalhousie Health Law Institute. It also recommends discussions with the Minister of Health to make her aware of the leadership being shown by NSHPRN and of the strong working relationship that exists between it and the Department of Health.

### Introduction

In early 2008, the NSHPRN formed a Working Group on Collaborative Regulation (the Working Group). This followed the workshop “Regulation in the 21<sup>st</sup> Century: Interdisciplinary Team Accountability” that took place on November 16, 2007 under the sponsorship of the NSHPRN and the Nova Scotia Department of Health (DoH).

The members of the Working Group were Dr. Cameron Little (Nova Scotia College of Physicians and Surgeons); Ms. Linda Hamilton R.N. (Executive Director, Nova Scotia College of Registered Nurses); Ms. Bev Zwicker (Deputy Registrar, Nova Scotia College of Pharmacists); Ms. Ann Mann (Executive Director, Nova Scotia College of Licensed Practical Nurses); Ms. Gayle Salsman (Registrar, Nova Scotia College of Occupational Therapists); Ms. Donna Denney R.N. (Nova Scotia Department of Health); and Mr. Dennis Holland (Nova Scotia Department of Health).

To facilitate and support the Working Group, the Dalhousie Health Law Institute (HLI) was provided project funding by DoH pursuant to a provision of the existing Memorandum of Agreement between DoH and HLI under which HLI provides DoH policy advice with respect to health system legislation. This provision contemplates Amending Agreements to the Memorandum of Agreement whereby DoH funds HLI to provide research and advice beyond what is contemplated in the Memorandum. Such an Amending Agreement was executed for the purpose of engaging HLI to facilitate and support the Working Group for a term running from September of 2008 to April of 2009. By mutual agreement between DoH and HLI, this term has been extended into 2009, in part to compensate for delays that were experienced in getting the project started in 2008.

The facilitation and support contemplated by the Amending Agreement has been provided primarily by William Lahey, HLI Director, with valuable assistance from Leah Hutt, HLI Research Associate and from law students Alison Hopkins and Tracy Hobson.

This report is the “Project Report” contemplated by the Project Charter that was developed by HLI and adopted by the Working Group at the beginning of the project. A copy of the Project Charter is attached to this report as Appendix “A”. The report is written by HLI and the Working Group and provided by the Working Group to both NSPHRN and DoH.

## Project Description, Rationale and Scope

The description of the project contained in the Project Charter reads, in part, as follows:

The Nova Scotia Health Professions Regulatory Network (NSHPRN) has identified a range of challenges and opportunities facing the health care system that call for greater collaboration among health professions regulators. One of these issues is the growing reliance of the system on interprofessional teams to deliver patient-centered care. Related issues include the priority that is being placed on improved quality of care and better protection of patient safety. Members of NSHPRN 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. In this context, collaborative self-regulation is a process of collaboration among self-regulating professions that respects the self-regulatory status of each regulated profession while seeking to identify and develop opportunities for collaborative effort that will strengthen the overall capacity of the system of health professional regulation to contribute to changes that are taking place and that need to take place in the broader health care system. [Emphasis added]

The Project Charter states the rationale for the project partly in the following terms:

A range of initiatives are being pursued in the Nova Scotia health care system to achieve a range of interrelated objectives that will determine the systems’ effectiveness and sustainability. These objectives include higher quality and patient safety, greater responsiveness to patient needs, better allocation of health resources, fuller utilization of the skills and competencies of all health care providers, and enhanced professional fulfillment and improved workplaces for providers. Ultimately, all of these objectives (and others) are understood to be important enablers of a health care system that more consistently provides patient-centered care. Both the initiatives and the objectives either depend upon or stand to be benefited by increased collaboration between self-regulating health professions and their members, both at the regulatory and at the practice levels.

Consistent with this broad rationale, the Working Group defined the scope of the project as encompassing the potential for collaboration among members of NSHPRN in virtually all phases and aspects of the regulatory process. In the Project Charter, the potentially broad scope of the project was framed as follows:

Areas to be considered for greater and more organized collaboration include: accountability processes, including the investigation and disposition of complaints against providers or teams of providers; mechanisms for responding to problems and opportunities created by overlap between scopes of practice; relationships between regulatory processes and processes that operate at the level of the workplace or the health care system; educational issues, including continuing competency programming and the relationship of regulatory bodies to educational institutions; liability issues, including those that arise from changes in the allocation of responsibilities and accountabilities among regulated and unregulated health care providers; resource constraints and the opportunities that exist for addressing or reducing such constraints through interprofessional collaboration in parallel or overlapping regulatory processes; identification and sharing of regulatory “best practices”; policy development, implementation and governance; regulatory tool development, including tools needed to better support and facilitate Interprofessional Collaborative Practice (ICP).<sup>2</sup>

The Working Group agreed however to focus initially on the potential for collaboration among NSHPRN in the area of their collective responsibility to ensure appropriate accountability on the part of regulated health professionals, including through the processes by which complaints by or on behalf of patients against specific providers or teams of providers are addressed by NSHPRN members. In part this was done to define a piece of work that was manageable and feasible within the parameters of the Amending Agreement between DoH and HLI. In other words, it was done to divide the project into phases and to fit the first phase into the framework of collaboration with the HLI provided for in the Amending Agreement between DoH and HLI.

More substantively, the decision to focus on professional accountability as first topic within the broader concept of collaborative regulation reflected the view of Working Group members that collaboration among NSHPRN members on provider accountability may be particularly critical to their collective ability to contribute through collaboration to the health system goals included in the project rationale, especially to the goal of a health care system that more consistently provides patient-centered care. This rationale for focusing on provider accountability is stated in the Project Charter as follows:

---

<sup>2</sup> In the Project Charter, continuing competency was mistakenly referred to as continuing education. This mistake has been corrected in this quotation from the Charter.

Professional regulatory structures (and other legal structures) are frequently and generally identified as persistent barriers to this collaboration, particularly in the emphasis that is placed within these structures on individualized accountability and on the distinct processes of accountability of each regulated profession. At the same time, it is understood that collaboration must be facilitated and supported by models of accountability that ensure that practice is not only collaborative but also appropriate, safe, effective and ethical. This suggests both the desirability and the need for changes in regulatory frameworks and in regulatory practice that enable and facilitate collaboration while preserving and enhancing the regulatory accountability of all regulated providers to their patients and to the public more broadly through the process of self-regulation. Collaboration between members of NSHPRN in the handling of complaints and in other aspects of regulatory accountability (of regulators and regulated) is a domain of regulatory activity in which such change seems both possible and worthwhile. If the rationale for and the specific direction of this change in regulatory structures (in complaint processes and more broadly) can be identified in Nova Scotia through collaboration between regulatory bodies, the process of adjusting regulatory frameworks and/or regulator practice can become for Nova Scotia a process that not only enables but lends momentum, encouragement and direction to the shift to ICP among Nova Scotia's health care providers. One of the reasons for this project is to determine if such a model of collaborative change in regulatory structures and in regulatory practice can be enhanced through a partnership between the DoH, the NSHPRN and the HLI.

As this quote from the Project Charter indicates, the project was intended to test collaboration between DoH, NSHPRN and HLI at the same time as it developed options for collaboration among NSHPRN members on provider collaboration.

### Project Deliverables

The Project Charter outlined 6 deliverables. The first of these was the preparation of the Project Charter itself. The second deliverable was the development of a detailed work plan. This is discussed below.

The third deliverable was the preparation of a discussion document that, 'Situates [the] project and concept of "collaborative self-regulation" in national and international context, for participants [in the project] and broader audiences'. This discussion document is attached to this report as Appendix "B".



The fourth deliverable called for presentations to interested stakeholders “within NSHPRN and beyond”. Presentations were made as follows: to the Nursing Council of the College of Registered Nurses on April 7; to the strategic planning session of the College of Pharmacy on April 20; to the Board of Directors of the College of Physicians and Surgeons on May 29; to the NSHPRN on May 6; and to the Annual general Meeting of the College of Respiratory Therapists on June 13. All of these presentations were made by William Lahey of HLI on behalf of the Working Group.

In addition, a joint presentation was made by William Lahey, Linda Hamilton, Cameron Little, Bev Zwicker and Donna Denney at the Collaborating Across Borders Conference, the Canadian/American conference on interprofessional education, policy and practice that was hosted by Dalhousie University in Halifax from May 20 through to May 22, inclusive. A copy of this conference presentation (which builds on each of the earlier presentations) is attached to this report as Appendix “C”.

The fifth deliverable called for execution of the work plan. This is discussed below.

Finally the Project Charter contemplates this project report. It specifies that the project report is to address the following points:

- Conclusions on the value of collaborative self-regulation as an organizing concept for ongoing development and improvement of Nova Scotia’s system of health professions regulation;
- Recommendations to NSHPRN on how the Network and its members can, through greater regulatory collaboration, contribute to ICP [Interprofessional Collaborative Practice] in Nova Scotia and to the more general improvement of professional regulation in Nova Scotia’s health care system;
- Evaluation of the collaboration between DoH, NSHPRN and HLI; and
- Recommendations as to next steps in the ongoing dialogue between NSHPRN and DoH on enhancement of Nova Scotia’s system of health professions regulation.

Each of these elements is discussed below under the heading “Conclusions, Recommendations and Evaluations”.

### Developing and Executing the Work Plan

This section outlines the elements of the work plan and the work that was completed under each element.

#### *Definition of the problem and the opportunity –*

The Working Group began by defining the problem that warranted consideration of collaborative self-regulation and the opportunity presented by consideration of collaborative self-regulation particularly in relation to professional accountability.

It defined the problem that gives rise to the rationale for a discussion of collaborative self-regulation as having five key aspects.

1. The exclusively profession-specific organization of the professional accountability process makes it difficult for Nova Scotia’s system of health professional regulation to deal with issues that cut across the jurisdiction of two or more regulatory bodies.
2. The frustration that both complainants and providers will experience when a single matter must be processed through multiple accountability processes.
3. The wide and uneven distribution of limited regulatory resources across a large number of regulatory bodies, some of which must operate with very limited capacity, and the vulnerability that this creates at multiple levels. In addition to the vulnerability that this may create for individual complainant or provider, it creates vulnerability for the system of professional regulation due to the possibility of mismatches between the size and complexity of complaints and the capacity of regulatory bodies that may be called upon to address them.
4. The absence of clarity about how matters of accountability that are or that go beyond professional accountability (ie. those that go to accountability of managers, institutions, the system as a whole, etc.) are addressed in Nova Scotia and a lack of operational connection between these broader processes of

accountability and the process of accountability that operates through professional self-regulation.

5. The steady demand for increased and responsive accountability from all health-related institutions and the particular onus that this creates for those who are given public authority to regulate themselves, especially in the context of high profile quality of care failures (Newfoundland, New Brunswick, etc.) and the growing understanding of the dimensions of the quality and patient safety problem in health care delivery.

The Working Group defined the opportunity presented by collaborative self-regulation as including each of the following benefits.

1. Assuming it can be designed and applied as an effective response to the problems outlined above, collaborative self-regulation will enhance the capacity of Nova Scotia's system of professional regulation to protect patients and fairness to providers through accountability processes that are more robust, adaptable, flexible, and dependable and generally "fit for purpose".
2. Building on the first point, a system of professional self-regulation that has enhanced effectiveness because it includes mechanisms of collaboration is less vulnerable to being displaced by alternative systems of professional regulation.
3. In comparison to alternative responses to the problems outlined above, which may displace or reduce self-regulation, collaborative self-regulation may have greater potential for combining two key sources of regulatory effectiveness: strong external oversight and strong internal (and internalized) responsibility.
4. Collaborative self-regulation provides regulatory bodies with an opportunity to show leadership in health care system improvement, including through the enabling support that it can provide to appropriate utilization of team-based care that is patient-centered collaborative, and accountable.

*Definition of evaluative criteria –*

Next, the Working Group developed an evaluative framework to be used in evaluating and comparing the existing and alternative models of accountability. Drawing on the literature on regulatory design and evaluation that was distilled and summarized by HLI, the Working Group concluded that both the existing Nova Scotia model and alternative models should be consistently evaluated against the following criteria:

- Efficiency and effectiveness
- Feasibility and sustainability
- Responsiveness to existing and emerging health system realities (including ICP)
- Consistency with professional autonomy
- Implications for liability (including of providers and regulators)
- Fairness
- Flexibility, adaptiveness, responsiveness, resiliency
- Dependability
- Accountability

The Working Group recognized that there is considerable overlap between and within these criteria. It recognized that some (such as flexibility, adaptiveness, responsiveness, and resiliency) could be said to be subsumed in others (such as efficiency and effectiveness). It also recognized that the criteria are different kinds of criteria, with some (such as fairness) being of a general nature and others (such as implications for liability) being specific and functional. Nevertheless, the Working Group regarded each of the criteria as worth independent attention to ensure that the evaluation of the current and alternative models deals as comprehensively as possible with all of the relevant variables.

An application of the Evaluative Framework is presented in Appendix “D”. It shows how the framework was used by the Working Group and how it might be used more broadly as the process of evaluating the existing and alternative models of accountability (and regulation more broadly) continues and evolves.

#### *Trends and Patterns in the Regulation of Health Professionals -*

The next step in the work plan was for the Working Group to develop a shared understanding of what was happening in other jurisdictions, both within and beyond Canada. This was done largely through the discussion paper prepared by the HLI and

found in Appendix “B”. The discussion paper identified a number of trends (or patterns) of wide influence and effect. One was simply that in many jurisdictions, basic and fundamental change has been and continues to be applied by governments to the legislative and institutional framework of health professions regulation. Although the discussion paper notes the tremendous variety that exists across the changes being made in various jurisdictions, it also observes that much of the change has the effect and often the intent of a reduced role for professional self-regulation. In some cases this is through changes that make self-regulation subject to greater and more intrusive oversight (the regulation of self-regulation) while in other cases it is through changes that simply transfer important regulatory functions from self-regulation to regulators who regulate from outside the professions. The discussion paper outlined some of the forces driving both kinds of change, including: the widespread view that self-regulation is particularly susceptible to regulatory capture; dramatic examples of regulatory failure on the part of the self-regulating professions; and a widespread view that the traditional configuration of self-regulation among health care professionals has become a significant barrier to reform and improvement in the delivery of health care services.

The discussion paper also identified a number of considerations (drawn partly from the research literature on regulatory effectiveness and governance) that made it plausible to suggest that a process of change (modernization) within self-regulation that was developed through NSPHRN would be preferable to one that was imposed from government and which shifted the system away from self-regulation. These considerations include the potential loss of regulatory expertise and of regulatory legitimacy and the influence with the regulated that comes from both when change is imposed that reduces or constrains self-regulation. They also include the potential that exists in Nova Scotia, largely because of the existence and initiative of NSHPRN and its constructive engagement with DoH, for change that is carefully calibrated to specific objectives; that is developed and adopted through a process that would be widely viewed as having high legitimacy and credibility; that is linked to initiatives in the wider health care system; and that are part of a continuous process of adjustment and improvement.

Finally, the Discussion Paper set the stage for the Working Group's subsequent and more detailed consideration of the model of professional regulation of a small number of jurisdictions. It did so by indicating that the trends and patterns represented by these jurisdictions are operating not only in these jurisdictions but much more widely.

*Jurisdictional Models –*

The next stage in the process of the Working Group was to develop a model of the accountability process that operates within the Nova Scotia system of health professions regulation and within the system of health professional regulation of a range of comparator jurisdictions.

In the case of Nova Scotia, the model was built using the process of the College of Registered Nurses as representative of the process that is generally followed in most of the more than 20 regulatory bodies that are part of the Nova Scotia system.<sup>3</sup> This model is represented in Diagram A. In this and in the succeeding diagrams, the light blue represents features of the accountability process that are characterized by traditional self-regulation and by a high degree of regulatory autonomy on the part of self-regulators. The mauve represents an institution or process that applies external review or oversight to the regulatory process. Grey represents the events and actions that initiate a complaint.

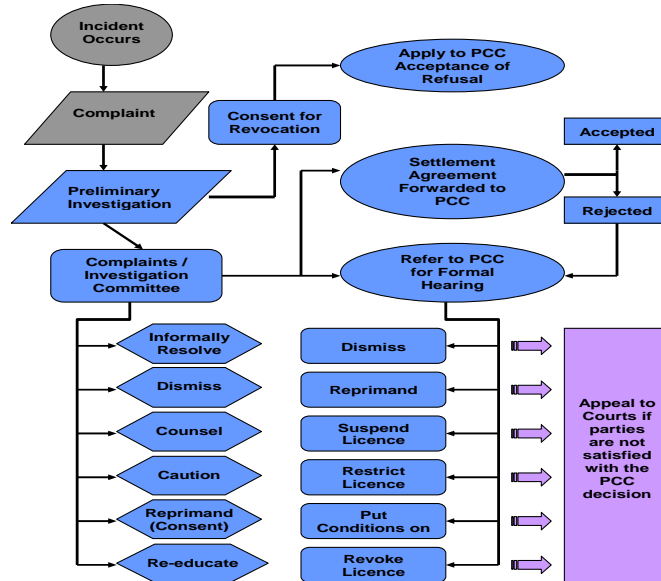
The contextual fact that is not captured by this diagram is that the Nova Scotia system essentially consists of the sum total of the internal processes of the separate self-regulators. A diagram that captures the entirety of the Nova Scotia process would be one that repeated the above diagram more than twenty times. With the exception of the fact that each of the regulators is subject to the superintending jurisdiction of the courts, there is no institutional framework or statutory process that links the individual processes of the regulatory bodies into an overall process that is inclusive of all regulators.

---

<sup>3</sup> One of the strengths of the Nova Scotia system is the consistency that exists across the internal regulatory processes of the various Nova Scotia regulators, at least at the level of organizational structure, in one of the strengths of the Nova Scotia system. The template for this consistency has been drawn over the years from the Nova Scotia *Medical Act*.

Diagram A:

# Nova Scotia



This increasingly distinguishes Nova Scotia (and the provinces of Atlantic Canada in general) from the provinces west of New Brunswick. Four of these provinces have now adopted or are in the process of adopting what has come to be known as the “Ontario model” of professional regulation.<sup>4</sup> For present purposes, there are two key features of this model. One is the controlled acts model. It substitutes descriptive scopes of practice for scopes of practice that have prohibitive effect against all those who do not belong to the profession attached to the scope of practice. It limits the prohibitive effect of professional regulation legislation to a limited number of controlled acts that everyone is prohibited from performing unless they are a member of a regulated profession, in which case they are allowed to perform the controlled acts that members of that profession are authorized to perform.

<sup>4</sup> The other provinces are Alberta, British Columbia and Manitoba, which is the province in the earliest stages of adopting this model. Quebec has a very similar model (except that it applies more broadly to all regulated professions and not just to those in health) that developed independently of the Ontario model.

The other key feature of the Ontario model is the creation of institutions that are given statutory responsibility for aspects of the regulatory system that cut across the mandates of the regulators of individual professions. Until recently, these statutory responsibilities have been largely or exclusively of an advisory nature. But in Ontario, there are recommendations pending with the Minister of Health that would, if adopted, subject the regulators of individual professions to a form of regulatory oversight, particularly with respect to the role of these regulators (as now defined in legislation) to facilitate and promote interprofessional collaborative practice among regulated health professionals.

Diagram B is an attempt to represent this model, based largely on its embodiment in Ontario legislation. Again, blue represents a sphere of regulatory autonomy (or of self-regulation). Mauve again represents an institution or process of external oversight. In the diagram, it reflects the recommendations that have been put forward in Ontario for the creation of a body that would be tasked with monitoring and reporting on progress being made by regulatory bodies in discharging their mandates around collaboration.

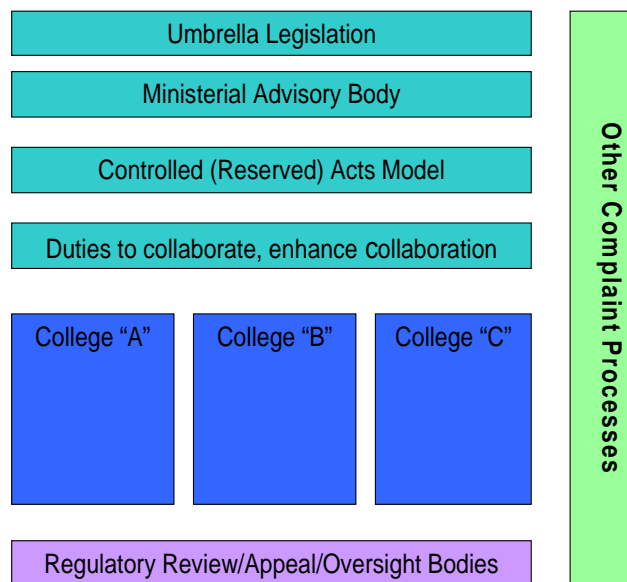
Turquoise represents elements of the legislative framework for regulation that cut across the operations of the separate regulators. Green represents processes of complaint (such as those of the Quebec Ombudsman or of the B.C. Patient Care Quality Office which is discussed below) that operate in parallel to those of professional regulation.

In this model, the processes that deal with complaints against members of regulated professions exist within each regulated profession, just as they do in Nova Scotia. But unlike Nova Scotia, the regulatory bodies that operate these separate accountability processes do so under a shared legislative framework; within the mandate of a body that is independent of them and that is mandated to provide advice to the Minister on policy matters; applying a legislative mandate that reduces the exclusiveness of their ownership of a professional domain; and (in Ontario) subject to a legal duty to collaborate and to facilitate and support collaboration among their members and in the shadow of recommendations that would subject them to a new level of proactive oversight.

Diagram B:



# “Ontario” Model



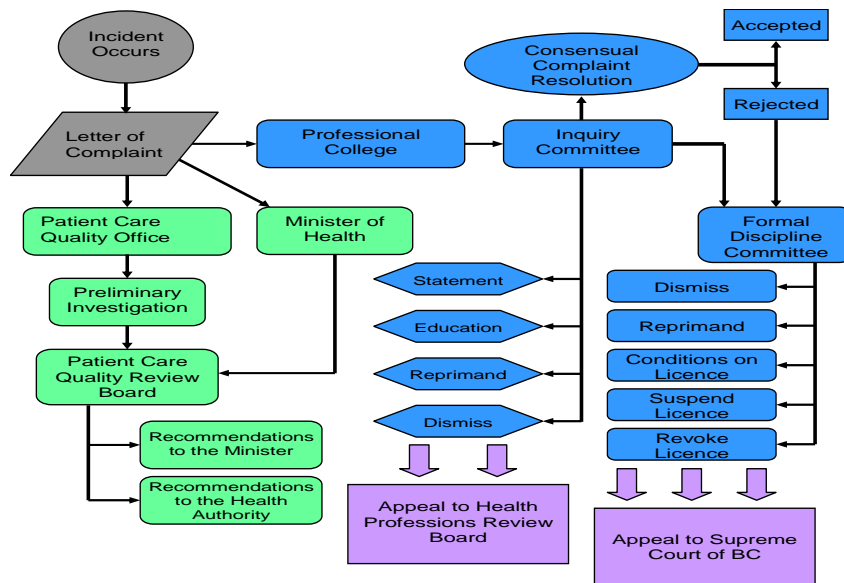
British Columbia is one of the provinces that have adopted a version of the Ontario model. More recently, it has also adopted a patient complaint framework as part of a system-wide quality initiative that operates in parallel to the accountability processes that exist within each of the regulated professions. This is illustrated in Diagram C where the colour blue represents the generic accountability process that operates within each of British Columbia’s regulators of health professionals.

As with all of the models being applied in other jurisdictions, there may be issues with the design or operational effectiveness of this model. Nevertheless, at the conceptual level, it recognizes that many of the issues that may cause harm or otherwise raise questions about accountability are not only or primarily related to the accountability of regulated professionals. Instead, they relate to the accountability of other parts of the system and to the accountability of those who have accountability for those parts of the system or for the system as a whole. It seems to make sense that there should be a process for complaints of this nature to be brought forward. It also seems likely that in

the absence of such a process, these issues will be brought to the regulators of professionals as complaints against regulated providers because it is at least possible to file a complaint with the regulators of professions.

Diagram C:

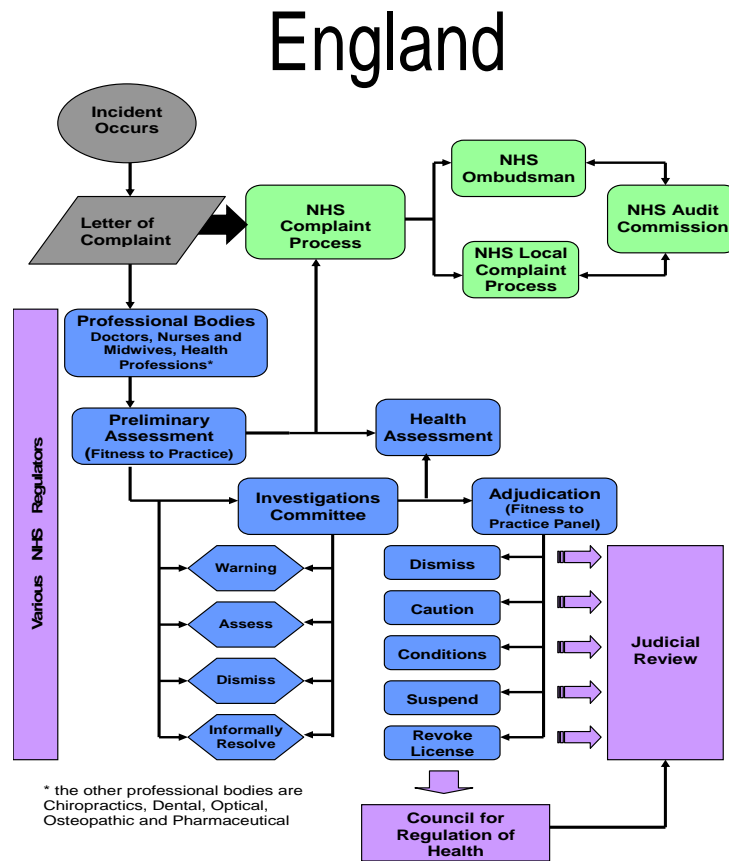
## BC Complaint Process



The other feature of the BC model to note is the availability of appeal to an independent administrative tribunal where a complaint is dismissed by a regulatory body. This implies a higher and more accessible level of accountability on the part of the regulatory body for how it disposes of complaints. It is broadly consistent with the shift to “regulation of self-regulation” introduced above.

Both aspects of the BC model are very evident in England, where the legislative framework for professional regulation and for accountability to patients more generally has undergone extensive and sustained change over the last decade. The English model is depicted in Diagram D.

Diagram D:



Again, the blue represents the internal self-regulatory process of each regulated health profession. In England, this includes the Council of Health Professions that regulates 13 professional categories, many of which are separately regulated in Nova Scotia and in other provinces. This is perhaps the institutional feature of the English model that can be most closely tied to the problem of accountability fragmentation across multiple regulatory processes in a health care system that depends on integrated effort by providers subject to different regulatory regimes.

The green represents a parallel complaint process, which in England consists of a multi-layered NHS complaint process that begins with the statutory obligation of each NHS institution to establish and operate a complaint process in accordance with a legislatively prescribed model and includes oversight of these processes by at least two national

bodies, the NHS Ombudsmen and the NHS Audit Commission (the Healthcare Commission).<sup>5</sup> In the diagram, the thickness of the arrow pointed to the NHS complaint process indicates the emphasis that is placed on this complaint process as the appropriate source of redress for most issues of accountability, relative to that placed on the regulated professions.

As with earlier diagrams, the mauve represents institutions or processes of oversight that apply to self-regulating professions. As in all Canadian provinces, this includes the courts, by way of judicial review. Similar to British Columbia, England has also created an administrative agency that is an avenue of redress for complainants that are dissatisfied when their complaint is dismissed by a self-regulating profession. The difference is that this agency is not limited to a reactive jurisdiction. It can intervene on its own prerogative to take any disciplinary matter before the courts where it forms the view that it has been managed with too much lenience by the regulator to whom the complaint was directed. It also conducts audits or reviews of the overall regulatory effectiveness of the regulators of health professions. This takes the “regulation of self-regulation” considerably farther than it has been taken in Canada. It can be seen as prelude to the next step being taken in England, which is the establishment of the Health Professions Adjudicator, an independent administrative body that will have the exclusive jurisdiction to adjudicate all matters that are determined by any regulatory body to warrant adjudication.<sup>6</sup>

The other aspect of the evolving English model to be noted is the box indicating various NHS Regulators that operate in close proximity to the jurisdiction of health professions regulators. These regulators include the Audit Commission, the Healthcare Commission, the National Institute of Clinical Excellence and the Patient Safety Institute. The point of including these bodies in the model of England’s system of professional regulation even though they have a distinct mandate is two-fold. First, they produce and enforce various

---

<sup>5</sup> The complaint system that has been established in Quebec for the Health and Social Services Network and that includes a Health Ombudsmen with province-wide jurisdiction has similarities to the NHS complaint process.

<sup>6</sup> England’s Health Profession Adjudicator will have much in common with New Zealand’s Health Practitioners Disciplinary Tribunal, discussed below.

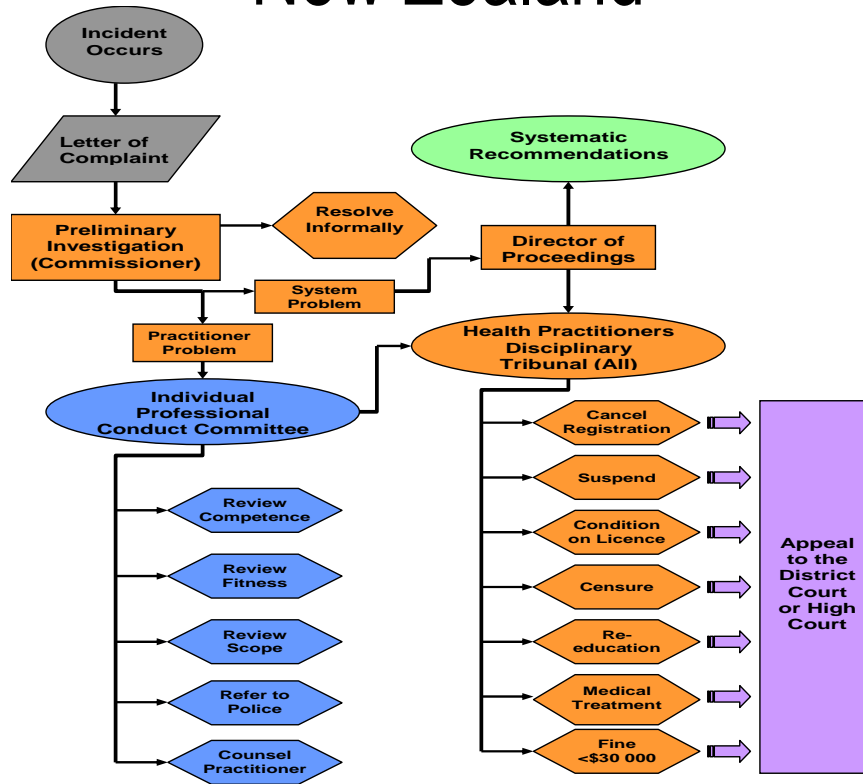
kinds of standards that must be taken into account by all regulatory bodies, including regulators of health professionals. Second, they create a context within which the regulators of health professions discharge their mandates knowing that their activities are within the view of independent bodies that have the expertise to form informed opinions about the adequacy and appropriateness of those activities. In other words, they operate “in the shadow” of other regulators even if the other regulators do not have a specific mandate of overseeing their activities.

New Zealand is another jurisdiction in which very significant change has taken place over the last decade. The English (and the more modest Ontario model) approach has been to bring self-regulation under increased oversight and (in the case of England and B.C.) to supplement it with other mechanisms of accountability that focus more broadly on the system. In contrast, New Zealand’s approach has been to integrate professional self-regulation into an integrated system of accountability that transfers significant authority from self-regulating professions to state institutions that function independently of self-regulating professions. The New Zealand model is set out in Diagram E.

Again, blue represents self-regulatory processes, mauve represents external oversight and accountability and green represents complaints that are directed away from professional providers and to the broader health care system. The new (and dominant colour) is orange, representing parts of the process that have been transferred or shifted from self-regulation to regulation by state authorities. In significant measure, the point of the diagram is to show how much of what has been traditionally part of the self-regulatory process has been removed from self-regulation.

Diagram E:

# New Zealand



There are two key elements of the New Zealand model. First all complaints go to the office of the Health and Disability Commission. That office investigates and in many cases disposes of the matter itself by resolving it informally among interested parties. If the matter is determined through investigation to be about the competency of one or more regulated professionals, it is referred to the appropriate self-regulating bodies (who otherwise are largely limited to credentialing and continuing competency functions). Otherwise, the Commissioner’s Office refers the matter to the Director of Proceedings who decides whether or not to initiate disciplinary proceedings against one or more regulated providers, with or without also making recommendations to “the system”. If proceedings are initiated, they are “prosecuted” by the Director’s Office and adjudicated by a tribunal that is mandated to hear and determine all disciplinary proceedings against

members of all regulated health professions, subject to judicial review. This tribunal sits in panels of five always with three members drawn from the profession of the provider against whom proceedings are initiated. But it is presided over by a lawyer who serves as a full-time chair and is constituted as a governmental administrative agency, not as an adjudicative body that is part of the self-regulation of each regulated profession.

This model could be described as an integrated model. The various processes for ensuring accountability that in other jurisdictions are established as distinct processes are instead configured in New Zealand as parts of a larger process of accountability that is co-extensive with the health care system to which it applies. All complaints start at the same place. This means that the onus of deciding where to initiate a complaint is removed from the patient (a feature which can also benefit providers by minimizing the risk of being targeted by complaints that really should have been taken elsewhere). It allows for greater consistency in the initial investigation of complaints and in the decisions that are made to refer or not to refer matters for further consideration, whether as to competency, conduct or the making of recommendations for improvement in the broader system. The centralized investigation process also seems well suited to provide integrated inquiry into complaints that transcend the boundaries between different regulated professions and between professional regulation and other systems of regulation.<sup>7</sup>

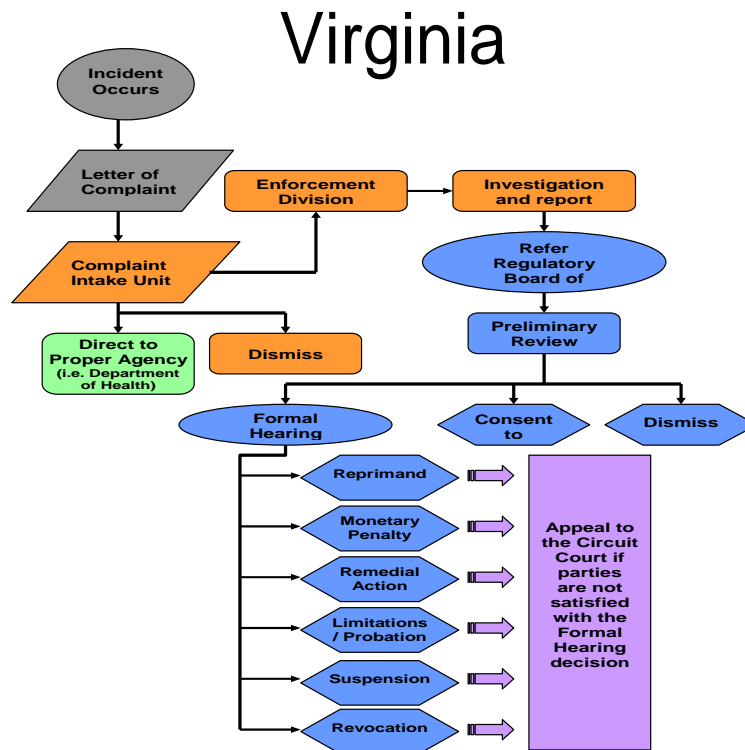
A similar model to the New Zealand model has been adopted or is in the process of being adopted in Australian states, where there is a new national agreement between the Government of the Commonwealth and the states to move towards greater consistency and a more national approach in the regulation of health professionals. Independently of the developments in New Zealand and Australia, a number of American states have models that feature a number of the elements found in the New Zealand model and in the

---

<sup>7</sup> At the same time, it is worth noting that the various parts of the system are relatively independent of each other. The Disability Commissioner does not control the regulatory bodies or the Director of Proceedings and none of these players controls the Tribunal. One can imagine a system that has centralized intake and investigation but that does not have one or the other of the Director or the Tribunal.

models being developed in Australia. Virginia’s model, which is presented in Diagram F, serves as an example.

Diagram F:



As with the New Zealand system, this one has centralized intake and investigation, linked both to recommendations out to the system and referral (where deemed appropriate in light of the initial investigation) to a self-regulating profession. It is different in that discipline as well as competency is done within self-regulation. Hence there is more blue on this diagram than the previous one, making the point that the elements of the different models are, to some extent at least, severable from one another. The other feature of Virginia’s system which is quite different from that of New Zealand is that the central intake and investigation functions are assigned, not to an independent commission, but to a department of government called the Department of Health Professions. This means important parts of the regulation of health professions function as government regulation,



rather than as regulation that is independent from both government and professional self-regulators.<sup>8</sup>

### *Developing a Collaborative Regulation Option – General Concept*

The Working Group next turned to the development of a collaborative regulation option.

It did so recognizing the potential structural advantages that the various models considered in the previous section may have over the current Nova Scotia model in making the system of health professions regulation more responsive to the three problems identified above: the fragmentation of accountability; the thin and uneven distribution of regulatory resources; and the unavailability of accountability processes for broader system accountability issues that are comparable to those that exist for regulated professionals.

At the same time, with each of the models, the Working Group questioned the proportionality of the solution to the scale of the problems it addresses. With respect to each of the models it had a concern about the level of institutional overhead that was involved, particularly in terms of Nova Scotia's capacity to support that overhead. It had a particular concern for the feasibility in Nova Scotia of anything as complex as the model being developed in England. The relative simplicity of the New Zealand model was more attractive from this perspective. But with that model, the Working Group was concerned about the extent of the entire system's reliance on one agency and even one individual.

Moreover, the Working Group had concerns that the strengths of the various models being developed and applied in other jurisdictions would come with a number of unpredictable costs. Gains in regulatory independence (themselves uncertain) might be off-set in losses in regulatory expertise. Both the shifting of regulatory authority to

---

<sup>8</sup> Montana goes further. Health professions are regulated by the Department of labour, which also regulates a wide spectrum of trades. The Department does not only intake and investigation but adjudication.

external bodies and the strengthened accountability of self-regulatory bodies to other regulators may result in an emphasis on external accountability that displaces or minimizes internal responsibility. The legitimacy of the regulatory system in the eyes of members of regulated professions (and perhaps in the eyes of the public) might be reduced, with consequences for the effectiveness of that system in influencing behavior.

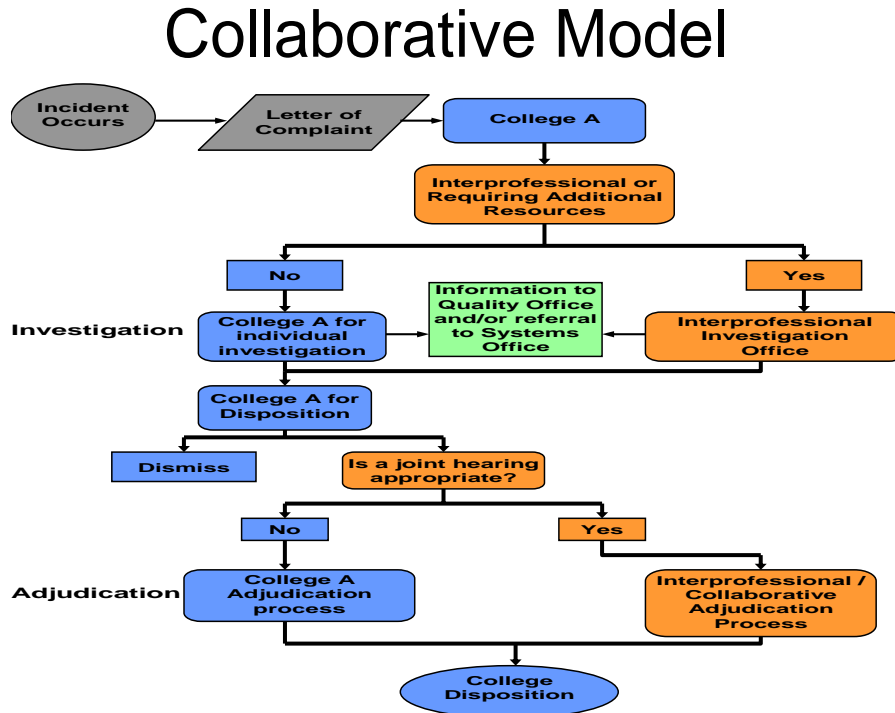
A related observation is that one of the underlying messages of the transitions from a traditional model of self-regulation taking place across multiple jurisdictions must be that self-regulation cannot be reformed from within but must be reformed from outside. This minimizes the opportunity for regulatory reform to harness the credibility of regulated professionals to the reform process and its outcomes. The result may be outcomes that are stronger on paper than they are likely to be on the ground. The result in other words may be a process of regulatory reform that enables but does not demonstrate commitment to improved regulatory effectiveness (including through improved collaboration among regulators and among those they regulate).

Against this background, the Working Group adopted some key design principles to guide the development of a collaborative regulation option for improving the regulatory systems' ability to ensure accountability, on the part of regulated and regulators. These can be summarized as follows:

- Build on strengths of current system while addressing its weaknesses and vulnerabilities;
- Design solutions that can be used to address problems (current vulnerabilities) where they exist and that otherwise leaves the regulatory process to run its course;
- Learn from existing collaborations (such as the prescription drug monitoring process) where collaboration feeds (and therefore improves) but does not displace independent processes of self-regulation; and
- Avoid unnecessary overhead, bureaucratization, complexity and duplication by emphasizing improved capacity to shift resources to where they are needed.

With these design principles in mind, the Working group developed the collaborative model that is depicted in Diagram G.

Diagram G:



In this model, decision-making authority is left with the regulatory bodies of each regulated profession. What changes from the status quo is that in some cases elements of the process that leads to those decisions become collaborative, involving two or more regulatory bodies, each of which retains decision-making autonomy.

Complaints would come to individual colleges, as is currently the case. Assuming the complaint proceeds to investigation, it can proceed in either of two directions. For complaints that do not raise regulatory capacity or interprofessional issues, investigation would proceed within the investigative process of the college that has received the complaint. Conversely, where a determination is made that the complaint has a significant interprofessional component (either because it involves providers from

multiple professions or because it concerns conduct related closely to interprofessional or team practice) or where a determination is made that the matter is beyond the capacity of the college that has received the complaint, investigation would proceed through a multi-regulator collaborative process that is organized by the Interprofessional Investigation Office. For lack of capacity complaints, resources would be drawn from regulators that had available capacity. For complaints that have a significant interprofessional dimension, resources would be drawn primarily from regulatory bodies of the relevant professions. In many cases, this would presumably mean the regulators that would otherwise be conducting their own independent investigation.

With either investigative course, the process of investigation would be linked (in a manner to be determined) to a health care system-level process that is established to deal with issues that go to the functioning of the system (at the institutional or broader level) rather than to professional practice. This linkage would be designed to deal with both the referral of matters to the broader system where that was appropriate and with the referral to the broader system of specific issues that are of systemic significance that arise in the course of continuing professional accountability proceedings.

Also, under either investigative scenario, the decision to either dismiss the complaint (with or without whatever corrective or disciplinary action is possible and appropriate at that stage of the process) or to proceed to adjudication is taken by the college (or colleges separately) that received the complaint (or complaints). In short, under either procedural scenario, the investigative process continues to be an investigative process that produces a report which informs decisions made in each college by those who have the authority to make those decisions on the basis of an investigation that is conducted by others.

For complaints that proceed to adjudication that raise significant issues around interprofessional accountability, the model as diagramed above proposes (for discussion purposes) a procedural divide between those that are adjudicated in the separate processes of each regulatory body and those that are jointly adjudicated by all of the regulatory bodies that decide to proceed to adjudication once the investigative stage has been

completed. This option is put forward in this more tentative way to emphasize that the Working Group recognized that a formalized process of collaboration at the adjudicative phases was likely to be more complex and difficult (and perhaps less beneficial) than it would be at the investigative phase. That being said, the idea is not that individual colleges would cede their adjudicative responsibilities to other colleges or to a tribunal for all health professions such as that which has been established in New Zealand. Instead, the idea is that each college would conduct its own adjudicative process in collaboration with other colleges engaged in overlapping adjudication. In other words, two or more proceedings would be conducted jointly rather than separately but they would continue to be distinct processes. At the end of the joint process, each college would make its own determinations with respect to its own members.

Whether limited to the investigative phase or extended into adjudication, the underlying rationale for this model is to address the institutional limitations of the *status quo*: multiple regulators with no authority to work together, some with very limited regulatory capacity, all striving to be effective in a health care system that stresses integration and interprofessional practice. It seeks to do so by building a collaborative component into professional self-regulation where other approaches would instead reallocate regulatory responsibility outside of self-regulation. The policy rationale for this approach is the possibility that it responds to the institutional limitations that are often regarded as inherent in self-regulation while avoiding the risks that can be associated with a shift to regulation of the professions by others (lack of expertise, credibility, legitimacy). The further rationale is the possibility that it fixes what needs to be fixed while retaining the strengths of a regulatory model that at its best, combines the effectiveness that comes from external accountability with the effectiveness that comes from internal responsibility.

#### *Developing a Collaborative Regulation Option – Detailed Elaboration*

The final phase of the work plan was to identify and develop answers for the many more detailed questions that would have to be addressed in developing the collaborative model

to the point where it could be incorporated into legislation. In undertaking this task, the Working Group was careful to respect the statement in the Project Charter that it was not to deal with legislation. Accordingly, the Working group focused on questions that were relevant to determining if the model warranted consideration for incorporation into legislation (particularly regarding its workability), as well as those that would be answered in the process of developing legislative drafting instructions.

The Working Group began but has not had an opportunity to complete this phase of the work plan. The following are examples only of the type of question that the Working Group has begun to consider:

- Do colleges have the discretion or the responsibility to refer matters to the interprofessional investigative process if they meet the criteria for referral?
- When will a complaint be considered to be interprofessional?
- Do parties to a complaint have procedural rights in respect of the decision as to which investigative process should apply?
- What happens where there is disagreement between colleges as to whether or not the interprofessional process should be followed?
- Can a referral to the interprofessional investigative office be refused/declined?
- What is the nature of the mandate of the interprofessional investigative office? Is it a distinct statutory body? How is it constituted and staffed? and
- What are the investigative powers of the interprofessional investigative office (or do participating colleges exercise the powers they have under their respective statutes)?

The Working Group intends to complete this aspect of the work plan in the near future.

## Conclusions, Recommendations and Evaluation

As outlined above, the Project Charter calls for a final report for the collaboration between NSPHRN (through the Working Group), DoH and HLI that addresses the following headings:

- Conclusions on the value of collaborative self-regulation as an organizing concept for ongoing development and improvement of Nova Scotia's system of health professions regulation;
- Recommendations to NSHPRN on how the Network and its members can, through greater regulatory collaboration, contribute to ICP [Interprofessional Collaborative Practice] in Nova Scotia and to the more general improvement of professional regulation in Nova Scotia's health care system;
- Evaluation of the collaboration between DoH, NSHPRN and HLI; and
- Recommendations as to next steps in the ongoing dialogue between NSHPRN and DoH on enhancement of Nova Scotia's system of health professions regulation.

*Conclusions on the value of collaborative self-regulation as an organizing concept etc.*

In addition to the provisional conclusions documented throughout this report, the Working Group also reached the following conclusions:

1. **The need for action** - Health professions regulators must take steps to ensure that the regulation of health professions maintains and enhances its effectiveness and the confidence of Nova Scotians in its effectiveness. This includes evolving to respond to changes that have taken place and that are taking place in how care is organized and delivered, including through collaborative interprofessional teams that aim to provide patient centered care. The Working Group is struck by the amount of change in the legislative frameworks and organizational structures that govern professional regulation that is taking place in many other jurisdictions and in virtually every provincial jurisdiction in Canada outside of Atlantic Canada;
2. **At least some of the action must be collective action** - Some of the challenges that must be met are not challenges that can be met easily or at all through independent effort by each regulatory body. By their nature, they demand responses that cut across the jurisdictional boundaries of different regulators. They also demand responses that cut across the boundaries between professional and other systems of accountability. The current legislative framework does not provide dependable mechanisms for this kind of concerted effort;

3. **Value should be assessed in relative terms** - The value of collaborative regulation as an “organizing concept” needs to be assessed not only against the legislative framework and regulatory system that currently exists in Nova Scotia but also against the legislative models that have been adopted in many other jurisdictions in and outside Canada, as represented by the jurisdictions considered in this report. The strength of collaborative regulation as an organizing concept may be that it can address the institutional and legislative limits that constrain the effectiveness of Nova Scotia’s regulators without jeopardizing the expertise, credibility and legitimacy that should be the relative strengths of the current system. Another consideration of importance is that collaborative approaches among regulators, relative to alternative approaches, should be better able to harness both external accountability and internal responsibility as reinforcing sources of regulatory influence and leverage. Finally, a collaborative approach may simply be more feasible in a Nova Scotia context;
4. **Important collateral opportunities should be taken into account** - The value of effective collaboration among health professions regulators may include more intangible benefits in the broader health care system. Specifically, such collaboration can be an enabler of collaboration at other levels, including among providers who are accountable within the processes of different regulated professions. For this reason, the concept needs to be considered for application in other aspects of the regulatory process, whether or not it is applied in a significant way to processes of professional accountability;
5. **The concept is bigger than particular models of it** - The model of collaborative regulation in professional accountability presented in this report is precisely that - a model of collaborative regulation. There may be other and better models of collaborative regulation to be considered. The weaknesses or deficiencies of the model presented here should prompt the development of superior models, not abandonment of the idea of collaborative regulation.
6. **Solutions must be proportionate and responsive to problems and opportunities** – The working Group believes that one of the strengths of the model of collaborative regulation presented in this report is that it responds to the vulnerabilities of the current system while leaving the process as it is currently structured to continue to operate where it is not at risk from these vulnerabilities. At the same time, the Working Group is aware that the model will introduce additional procedural and governance complexity into the system. Therefore, care must be taken to ensure that collaborative regulation is developed so as to avoid unnecessary complexity and to ensure that real regulatory benefits flow from the complexity that cannot be avoided (or minimized).
7. **Legislative support will be needed** - Whatever model is developed, collaboration in the regulatory field that is not underpinned by a secure and clear legislative mandate for collaboration is not likely to be effective, dependable or ultimately utilized.



8. **Professional regulation can't do it all** - The Working Group has observed that even though the changes being made to professional regulation are very different across jurisdictions, including in the extent to which they shift regulation away from self-regulation, a common element is the creation of legislative processes and accountabilities for receiving and dealing with complaints that go beyond professional accountability to accountability for the broader health care system or for other components of that system. The members of the Working Group find this trend to be of particular interest given that their experience indicates (a) that some complaints that come to their organizations as complaints about regulated professionals are actually complaints about how the broader system has functioned; and (b) that the absence of a clear mechanism of accountability for dealing with systemic aspects of the complaints that their organizations receive is one of the key limitations on their ability to adequately respond to many of the complaints that properly come to them as complaints about regulated professionals.

*Recommendations to NSHPRN on how ... regulatory collaboration [can] contribute to ICP ... and to the more general improvement of professional regulation etc.*

The Working Group makes the following recommendations to NSHPRN:

1. Continue to support the activities of the Working Group, including in the further development of a collaborative model for enhancing the parts of the regulatory process that deal with professional accountability;
2. Expand consideration of the potential of collaborative regulation in other phases and aspects of the regulatory process. In particular,
  - Undertake consideration of how collaborative regulation can provide redress for genuine problems caused by the way in which scopes of practice are described or interpreted and applied;
  - Consider options for greater collaboration in developing and implementing regulatory policies, particularly in areas of policy-making that are or should be reasonably consistent across regulated professionals;
  - Consider options for collaboration in continuing competency activities, including in reference to skills and competencies around collaborative interprofessional practice;
  - Explore partnerships with educational institutions around pre- and post-licensure interprofessional education and with health care delivery organizations around proactive identification and resolution of recurring issues;

3. Broaden the discussion to engage the governance level of colleges and other regulators, membership of regulated professionals, professional associations, unions, district health authorities and other employers and institutional providers of care;
4. Promote consideration by Nova Scotia health care system, including by DoH, of a patient complaint process that operates in parallel to but linked with the accountability of providers through professional regulation.

*Evaluation of the collaboration between DoH, NSHPRN and HLI*

From the perspective of the Working Group (including DoH) and HLI, the collaboration was a positive example of how academia and policy-makers can work together to combine their strengths while respecting their respective limitations.

The dialogue within the Working Group was richer because it combined the practical experience of members of NSPHRN; the knowledge and perspective of representatives of DoH on the broader status and prospects of the Nova Scotia Health care system and on more specific but critically important dynamics such as the legislative process and the quality of care initiative; and the research-informed expertise of HLI on jurisdictional trends and developments, current scholarship on regulation in and beyond professional regulation and the place of regulation in broader health system governance, in and beyond Canada. More practically, the participation of HLI ensured that high quality information and analysis was made available to the Working Group. This allowed the Working Group to put Nova Scotia's situation into a broader context and to make more informed decisions than might otherwise have been possible about the direction that the work should take at each stage of the work plan. At the same time, HLI's analysis and understanding of developments elsewhere and of the scholarly analysis of those developments and of regulation more broadly benefited from the ability of Working Group members to put the work of HLI into a practical context and, more specifically, into the realities of the Nova Scotia context.

From the Working Group perspective, the result was significant progress in making a fairly abstract concept (collaborative regulation) into a concrete if still high-level proposal, at least in respect of one important aspect of the regulatory process. To some extent, this progress should be taken to validate the importance of the NSHPRN. It should also allow NSHPRN to make more informed decisions about the effort it wants to direct to collaborative regulation moving forward.

From the HLI perspective, the collaboration provided a unique opportunity to sharpen the policy relevance of continuing research and scholarship on professional regulation, regulatory governance and regulation in health care more broadly, all topics of growing significance in the academic health policy literature.

From a broader Nova Scotia perspective, the result was the early-stage development of a distinct approach to the modernization and improvement of health professions regulation that is informed by solid understanding of what is happening in the broader world of professional regulation and the practical knowledge of experienced regulators. One indication of the potential merit of this distinctive approach was the very positive response received from a national and international audience to the presentation made on the Nova Scotia approach to collaborative regulation at the Collaborating Across Borders Conference held in Halifax in May.

*Recommendations as to next steps in the ongoing dialogue between NSHPRN and DoH*

The recommendations of the Working Group to NSHPRN and DoH as to next steps are as follows:

1. Update Minister and explore interest of new government in professional regulation, broader system of accountability and collaborative regulation as an approach to regulatory improvement;
2. Explore and assess options for putting continuing collaboration between NSOPRN and DoH, with or without continuing participation of HLI, on a sustainable footing;
3. Establish stronger dialogue and linkages with DoH and health care system initiatives around quality and patient safety; and
4. Assess relevance of continuing work on regulatory improvement (and collaborative regulation more specifically) for relationship between NSHPRN and DoH and for future legislative agenda and priorities related to professional regulation.

# APPENDIX “A” PROJECT CHARTER

<b>1. PROJECT IDENTIFICATION</b>	
<b>Project Name</b>	<b>Collaborative self-regulation of regulated health professions in Nova Scotia.</b>
<b>Description</b>	<p>The Nova Scotia Health Professions Regulatory Network (NSHPRN) has identified a range of challenges and opportunities facing the health care system that call for greater collaboration among health professions regulators. One of these issues is the growing reliance of the system on interprofessional teams to deliver patient-centered care. Related issues include the priority that is being placed on improved quality of care and better protection of patient safety. Members of NSHPRN 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. In this context, collaborative self-regulation is a process of collaboration among self-regulating professions that respects the self-regulatory status of each regulated profession while seeking to identify and develop opportunities for collaborative effort that will strengthen the overall capacity of the system of health professional regulation to contribute to changes that are taking place and that need to take place in the broader health care system. Areas to be considered for greater and more organized collaboration include: accountability processes, including the investigation and disposition of complaints against providers or teams of providers; mechanisms for responding to problems and opportunities created by overlap between scopes of practice; relationships between regulatory processes and processes that operate at the level of the workplace or the health care system; educational issues, including continuing education programming and the relationship of regulatory bodies to educational institutions; liability issues, including those that arise from changes in the allocation of responsibilities and accountabilities among regulated and unregulated health care providers; resource constraints and the opportunities that exist for addressing or reducing such constraints through interprofessional collaboration in parallel or overlapping regulatory processes; identification and sharing of regulatory “best practices”; policy development, implementation and governance; regulatory tool development, including tools needed to better support and facilitate Interprofessional Collaborative Practice (ICP).</p> <p>As a first priority, the NSHPRN has decided to work on models for collaboration and cooperation between regulatory bodies in respect of processes of accountability, including the response of NSHPRN members to complaints that involve providers from more than one regulated profession or that otherwise raises issues of collaboration or interprofessional practice.</p>
<b>Project Sponsor(s)</b>	Nova Scotia Department of Health (Nursing Policy Services and Health Policy and Legislation) and the Nova Scotia Health Professions Regulatory Network
<b>Project Manager</b>	Dennis Holland, Donna Denney, NSHPRN.
<b>Project Team Resources</b>	Through the Department of Health (DoH), the Dalhousie Health Law Institute (HLI) has been engaged to provide research and analytical support to this project under a six month addendum to the Memorandum of Understanding under which DoH and HLI collaborate on the development and modernization of health legislative policy on in Nova Scotia. The other significant project team resource is the collective experience and knowledge of representatives of Nova Scotia’s regulatory bodies who have committed to being part of this process.
<b>Version</b>	2 (January, 2009)

<b>2. BUSINESS REASONS FOR PROJECT</b>	
<p>A range of initiatives are being pursued in the Nova Scotia health care system to achieve a range of interrelated objectives that will determine the systems’ effectiveness and sustainability. These objectives include higher quality and patient safety, greater responsiveness to patient needs, better allocation of health resources, fuller utilization of the skills and competencies of all health care providers, and enhanced professional fulfillment and improved workplaces for providers. Ultimately, all of these objectives (and others) are understood to be important enablers of a health care system that more consistently provides patient-centered care. Both the initiatives and the objectives either depend upon or stand to be benefited by increased collaboration between self-regulating health professions and their members, both at the regulatory and at the practice levels. Professional regulatory structures (and other legal structures) are frequently and generally identified as persistent barriers to this collaboration, particularly in the emphasis that is placed within these structures on individualized accountability and on the distinct processes of accountability of each regulated profession. At the same time, it is understood that collaboration must be facilitated and supported by models of accountability that ensure that practice is not only collaborative but also appropriate, safe, effective and ethical. This suggests both the desirability and the need for changes in regulatory frameworks and in regulatory practice that enable and facilitate collaboration while preserving and enhancing the regulatory accountability of all regulated providers to their patients and to the public more broadly</p>	

# PROJECT CHARTER

---

---

through the process of self-regulation. Collaboration between members of NSHPRN in the handling of complaints and in other aspects of regulatory accountability (of regulators and regulated) is a domain of regulatory activity in which such change seems both possible and worthwhile. If the rationale for and the specific direction of this change in regulatory structures (in compliant processes and more broadly) can be identified in Nova Scotia through collaboration between regulatory bodies, the process of adjusting regulatory frameworks and/or regulator practice can become for Nova Scotia a process that not only enables but lends momentum, encouragement and direction to the shift to ICP among Nova Scotia's health care providers. One of the reasons for this project is to determine if such a model of collaborative change in regulatory structures and in regulatory practice can be enhanced through a partnership between the DoH, the NSHPRN and the HLI.

### 3. PROJECT OBJECTIVES (PURPOSE)

The objectives of the project include:

- Further development of the commitment of project participants to collaborative self-regulation as a model of improvement that better aligns Nova Scotia's system of professional self-regulation with health care system changes and the imperatives for improved performance, accountability and sustainability;
- Development of specific proposals for enhancing the contribution of NSHPRN members to the development, adoption and support of ICP in Nova Scotia, building on the conference held on November 16, 2007 on "Regulation in the 21<sup>st</sup> Century: Interdisciplinary Team Accountability";
- Development of specific proposals for improving regulatory processes of provider and profession accountability that maintain and improve on current levels of general effectiveness while better enabling and responding to ICP in Nova Scotia;
- Identification and assessment of additional areas for priority attention in regulatory collaboration, both as regards ICP and more broadly;
- Identification and assessment of options for obtaining support and effective implementation of specific improvements in the regulatory framework (including applicable legislation) and/or in regulatory practice to enhance interdisciplinary team accountability, as regards disciplinary processes or more broadly;
- Advancement of understanding among key Nova Scotia decision-makers of the specific relationship between regulatory structures and practices and the barriers to and enablers of ICP and other initiatives that are intended to enhance patient-centered care;
- Identification and exploration of opportunities for better alignment and better linkages between the processes and activities of members of NSHPRN and other processes and activities that contribute to the capacity of the system to achieve improvements in quality of care, patient safety and the adoption and implementation of ICP;
- Assessment of options for further consideration and development of a framework for collaborative self-regulation beyond the term of the addendum under which the DoH has engaged the HLI to work with the NSHPRN.

### 4. PROJECT SCOPE

The scope of the project includes the following:

- Research, information-gathering and analysis – that places Nova Scotia's system of health professions regulation within national and international trends in the regulation of health professionals, including as regards changes that are directed toward enabling and supporting ICP and holding health professionals accountable within interdisciplinary approaches to the delivery of health care;
- Goal setting – that brings knowledge based on research and knowledge based on experience together through a process of collaborative and structured dialogue to identify the specific objectives to be addressed or advanced in development of priorities and initiatives for developing collaborative self-regulation as the process that Nova Scotia follows to better align the regulation of health professionals with broader efforts to improve quality of care and the protection of patient safety through ICP and other initiatives;
- Model development – that builds on the models outlined at the conference held in 2008 on "Regulation in the 21<sup>st</sup> Century: Interdisciplinary Team Accountability", as well as the models that have been considered or implemented in other jurisdictions, for achieving regulatory objectives in respect of quality of care, patient safety and ICP;
- Policy Analysis - that develops options for implementing specific changes in regulatory processes, including those related to accountability of professions and of individual members, that will contribute to the achievement of objectives relating to quality of care, patient safety and ICP;
- Tool development – that establishes a set of governing principles, an analytical framework, a

# PROJECT CHARTER

4. PROJECT SCOPE	
<p>longer-term agenda, provisional time-lines and procedural options that can be used to guide the ongoing development, assessment, implementation and evaluation of collaborative self-regulation and ICP in Nova Scotia; and</p> <ul style="list-style-type: none"> <li>Reporting – that (1) enables the members of NSHPRN to make more informed decisions on options for increasing their individual and collective contribution to the more consistent delivery of patient-centered care, including through ICP that is subject to appropriate accountability, and that (2) enables the NSPRN, the DoH and other partners to better understand and to make more informed decisions on options for addressing issues that are outside the system of professional regulation but that either constrain the capacity of the regulatory system to contribute to the achievement of health system objectives in areas such as quality of care, patient safety or ICP, or that minimize the effectiveness of measures taken within the system of health professional regulation to advance these and related objectives.</li> </ul> <p>The scope of the project does not include:</p> <ul style="list-style-type: none"> <li>Development of draft legislation; or</li> <li>Decision-making in regulatory bodies, in DoH or in the Province of Nova Scotia.</li> </ul>	

5. KEY PROJECT DELIVERABLES			
Item	Name	Description	Resources
1	Project Charter	Provides a clear statement of objectives, scope of project, key deliverables and expectations of participants.	HLI, Working Group
2	Detailed Work Plan	Divides the project into stages, identifies the “product” to be produced by HLI and other project participants at each stage, links each stage to completion of overall project.	HLI, Working Group
3	Discussion Document	Situates project and concept of “collaborative self-regulation” in national and international context, for participants and broader audience.	HLI
4	Presentations to interested stakeholders	Presentations that explain the project and its objectives within NSHPRN and beyond. For example, DoH leadership, Boards of NSPHRN members, DHA CEO’s; employee organizations, Collaborating Across Borders Conference.	As determined
5	Execution of work plan	As set out in work plan.	As determined
6	Project Report	The Project Report will contain conclusions on the value of collaborative self-regulation as an organizing concept for ongoing development and improvement of Nova Scotia’s system of health professions regulation. It will contain recommendations to NSHPRN on how the Network and its members can, through greater regulatory collaboration, contribute to the development of ICP in Nova Scotia and to the more general improvement of professional regulation in Nova Scotia’s health care system. It will also contain an evaluation of the collaboration between DoH, NSHPRN and HLI and recommendations as to next steps in the ongoing dialogue between NSHPRN and DoH on enhancement of Nova Scotia’s system of health professions regulation.	HLI, Working Group

# PROJECT CHARTER

6. MILESTONES		
Item	Milestone	Date
1	Completion of Project Charter	January, 2009
2	Completion of Work Plan	February, 2009
3	Staged implementation of Work Plan	February through June, 2009
4	Identification, development and approval of specific options for advancing the objective of NSHPRN members to improve their individual and collective contribution to the public interest through greater and more effective collaboration	Ongoing
5	Preparation, review, approval of project report	June, July, 2009

7. KEY ISSUES	
Severity (H, M, L)	Description
H	Pervasiveness of “interdisciplinary” teams and misalignment with frameworks of accountability
H	Need for wider adoption of ICP that is subject to appropriate accountability
H	Need for responses to patient safety “crisis”
M	Public awareness, confidence
L	Jurisdictional trends and developments (Ontario)

8. RISKS		
Probability (H, M, L)	Impact (H, M, L)	Description
M	H	Perception and reality of self-interest in self-regulation
M	H	Resistance within NSHPRN members or from NSPHRN members, key partners
H	M	Lack of resources, capacity in NSHPRN or NSHPRN members
L	M	Lack of interest and response from government, DHA’s, other key institutions
H	H	Fixing the wrong thing (while doing collateral damage)
L	H	Excessive or misdirected government (legislative) intervention

9. PROJECT ASSUMPTIONS
<p>The following assumptions have been made in documenting this charter:</p> <ul style="list-style-type: none"> <li>• That care that is patient-centered requires regulatory frameworks and regulatory practice (processes) that support and enable ICP while maintaining or improving protection of patients and the public interest through systems and processes of accountability that demand individual and team accountability;</li> <li>• That the NSHPRN represents a collaborative model of leadership and accountability among regulatory bodies that is unique in Canada that: (1) can be leveraged to enable innovation and improved effectiveness in the regulation of health professions in Nova Scotia; and that (2) can be a model of the collaborative behavior that is needed in the organization, administration and delivery of health care services; and</li> <li>• That collaborative effort among regulatory bodies to enable and support ICP through the adjustment of regulatory frameworks and enhanced regulatory practice (processes) will yield greatest value if aligned with broader initiatives in the health care system to encourage the broader adoption of team-based approaches to the delivery of health care services.</li> </ul>

10. PROJECT’S CRITERIA FOR SUCCESS
<p>This project will be successful when:</p> <ul style="list-style-type: none"> <li>• Clear and practical options have been identified, developed and assessed for bringing processes of accountability in Nova Scotia’s system of health professions regulation into better alignment with health system dynamics and directions, including ICP;</li> <li>• Objectives, governing principles and evaluative criteria have been developed for ongoing efforts to strengthen alignment (with regard to accountability and more broadly) between Nova Scotia’s system of health professional regulation and health system dynamics, including ICP;</li> </ul>

# PROJECT CHARTER

---

---

## 10. PROJECT'S CRITERIA FOR SUCCESS

- Priorities have been established for subsequent phases of the continuing work of the NSHPRN to improve the regulation of health professionals in Nova Scotia, including through greater and more effective regulatory collaboration; and
- Participants are able to agree upon a path forward for deciding between and implementing options for improving accountability (as regards ICP and more broadly) and for tackling other identified priorities in aligning professional regulation and ICP.

## 11. CRITICAL SUCCESS FACTORS

There are defining factors that must be met in order to meet the objectives of the project. This set of criteria will contribute to the overall success of the development and implementation of the project. These include:

- Focus on patient (public safety)
- Patient-centeredness
- Accountability
- Openness, transparency, fairness
- Effectiveness, dependability
- Realism, cost-effectiveness, operational feasibility, sustainability (including affordability)
- Informed by evidence and experience, with outcome measures and evaluative mechanisms built in
- Collaborative (leading by example)
- Continuous improvement
- Flexibility, adaptability, responsiveness, resiliency

## 12. SPONSOR SIGN-OFF

<b>Name</b>	
<b>Title</b>	
<b>Signature</b>	
<b>Date</b>	



# **APPENDIX “B”**

## **Discussion Framework Document**

Meeting of the Working Group of the  
Nova Scotia Health Professions Regulatory Network on  
“Collaborative Regulation and Interprofessional  
Collaborative Practice”

December 11, 2008

Prepared by William Lahey, Dalhousie Health Law Institute

## **Introduction:**

The Nova Scotia Health Professions Regulatory Network (NSHPRN) has identified interprofessional collaborative practice (ICP) as an important trend in the delivery of health care that needs to be better reflected in and enabled by the regulation of health professions in Nova Scotia. It has established a working group to develop options and recommendations for achieving greater alignment between Nova Scotia's system of health professions regulation and ICP.

Through the support of the Nova Scotia Department of Health, the Dalhousie Health Law Institute (HLI) has been asked to assist the working group in moving this undertaking forward. Discussions to date have confirmed a desire on the part of working group members to focus on the disciplinary process as a possible first step in achieving more general alignment between regulation and ICP. The discussions have also confirmed a desire to generally build on the conference, "Regulation in the 21<sup>st</sup> Century: Interdisciplinary Team Accountability", that was held on November 16, 2007, including the models for "collaborative regulation" that were developed during that conference.

The purpose of this document is to set a context for a discussion on December 11, 2008 and beyond that will hopefully move the process forward in three areas: (1) refinement of specific working group objectives with respect to collaborative regulation in respect of disciplinary matters; (2) shared understanding and agreement to criteria of evaluation for alternative models of collaborative regulation, including those developed at the above mentioned conference; and (3) development of a list of more specific deliverables for the balance of the collaboration between the working group, the DoH and the HLI.

This document should be read and used in conjunction with the following documents: (1) notes from November 16 conference, including the 6 regulatory model diagrams developed at that conference; (2) draft evaluation "matrix" listing 6 models developed at conference and proposed criteria of evaluation; (3) diagrams showing the "generic" disciplinary process in place under current N.S. legislation and the disciplinary process in British Columbia, New Zealand and the United Kingdom (England); (4) list of possible topics that might be addressed in a sustained process of policy and practice improvement that was designed to enable, support, encourage or promote ICP through collaborative regulation; and (5) draft "project charter" for collaboration between the working group, DoH and HLI.

## **The Wider Jurisdictional Context:**

The regulation of health professionals in and beyond Canada has been distinguished by the extent of its reliance on self-regulation. In the regulation of health professionals, self-regulation and regulation by government have been understood to be mutually exclusive. Self-regulation has also generally meant self-regulation by each profession, not collective self-regulation.

For more than a decade, this pattern has been changing in and beyond Canada. It has been changing through legislative intervention by governments. There is significant variety across jurisdictions as to the direction and extent of the change. Nevertheless, most of the dominant approaches can be summarized as follows:

- Greater centralization and elevation of the policy-making process from the governance and decision-making processes that apply to specific professions (Ontario, Alberta, British Columbia, Quebec, England);
- Centralized “in-take” and initial assessment of public complaints, with or without institutional separation of the in-take and initial assessment process from regulatory bodies that regulate specific professions or groups of professions (New Zealand, various U.S. states);
- Establishment of complaint processes that operate independently of and in parallel to or in place of complaint processes that are administered within regulated professions (England, New Zealand, Australia, various U.S. states, Quebec);
- Regulatory structures (including disciplinary processes) that apply to multiple regulated professionals rather than to individual professions (England, New Zealand, various U.S. states);
- Consolidation of all adjudicative functions or of non-judicial appeal functions to adjudicative bodies that are independent of specific regulatory bodies (New Zealand, Quebec, various U.S. states);
- Separation of disciplinary responsibilities from licensure responsibilities (New Zealand, various U.S. states)
- Regulatory oversight of health professions regulators by independent regulatory bodies (England);
- Legislative standardization of governance structures and of regulatory institutions, processes and instruments; (most Canadian provinces to varying degree, England, Australian states); and
- A wide spectrum of changes that have been taken to enhance external accountability and to weaken “regulatory capture” including the appointment of “outsiders” to regulatory bodies, increased legislative prescription of procedural norms (including those governing openness) and more detailed and extensive reporting responsibilities.

Many factors account for this diverse list of changes to the traditional framework. Different changes rest on different and perhaps even contradictory policy rationales. Even where the same or a similar change has been made in multiple jurisdictions, the reason for the change may vary from one jurisdiction to another. In each or in many of the jurisdictions that adopt a similar change, the rationale for the change may have more to do with local circumstances than it does with any generally followed rationale.

It is however, reasonably clear that the general tendency of change is clearly away from the traditional regulatory model. It is also reasonably certain that most of the change that has taken place in most jurisdictions rests at least to some degree on a small number of consistently present motivations. These are:

- Dissatisfaction with self-regulation in general and/or with the extent of the health care system's reliance on self-regulation, based largely on the concern that self-regulation has a greater tendency than other kinds of regulation to be self-interested regulation;
- A related but distinct concern with the accountability of self-regulators and of the effectiveness with which they are likely to demand accountability from those who they regulate; and
- Recognition that the regulation of health professionals is a fundamental element of the governance of the broader health care system, which is largely understood in OECD countries to be a governmental responsibility.

### **The End of Self-Regulation?**

A simplistic interpretation of the changes being made across jurisdictions would be that they not only represent abandonment of the traditional model of self-regulation for the health professions but that they also represent abandonment of self-regulation itself.

This ignores how much regulatory responsibility is being left with self-governing regulatory bodies even in jurisdictions (such as New Zealand) that have most significantly departed from the traditional model. It overlooks the fact that many of the changes, whether viewed in isolation or in combination, can be seen as attempts to respond to the weaknesses that are inherent in self-regulation while retaining the essential strengths of a system of regulation that is based on self-regulation, including the expertise and regulatory legitimacy that self-regulatory bodies are able to bring to their responsibilities.

This last point serves to remind that concerns about self-regulation are matched by concerns about regulation by government. The concerns about government regulation tend to be different but that does not mean that they are less important. In the case of regulation in health care, one concern about regulation by government is that such regulation may also be compromised by a structural conflict of interest, that being the preoccupation of governments with the cost implications to government of regulatory requirements.

It has been suggested that the directional thrust of the changes being made in the regulation of health professionals in multiple jurisdictions should be understood as a shift from self-regulation to “regulated self-regulation”, rather than as a shift from self-regulation to governmental regulation. This concept is meant to suggest that the object of public policy in this realm is not limited to the binary choice between self-regulation and government regulation but should instead extend to the development of systems of regulation that more optimally mix the strengths of both of the traditional approaches to regulation, while minimizing the operation of the weaknesses of each. The closely related point is that a system of self-regulation can be designed and governed in many different ways. Collaborative regulation among and across self-regulatory bodies is not

how self-regulation in the health professions has been traditionally practiced but it is not contrary to the concept of self-regulation. Indeed, to the extent that it deals with problems or limitations that are associated with the more traditional approach to self-regulation, collaborative self-regulation can be seen as an evolution of the self-regulatory concept that has the potential to function as an alternative mechanism for achieving the outcomes that other jurisdictions seek to achieve through departures from self-regulation. It also has the collateral benefit of being a demonstration of the attitudes, behaviors and skills that ICP also depends upon.

### **The Influence of Regulatory Reform as a General Policy Preoccupation:**

The changes that have been made to the legislative frameworks that govern the regulation of health professions in other jurisdictions reflect wider health system governance dynamics, as mentioned above. One aspect of this influence is greater reliance on regulation as a tool for achieving system performance objectives, with England being the leading example of this tendency.

The changes being made seem also to be related to the growing tendency of governments across the world to think of regulatory programs as something that governments must manage on a comprehensive basis just as they must manage spending or taxing programs on a comprehensive basis. This tendency is built on concern about the impact of regulations on economic productivity. It tends to emphasize the reduction of regulatory burden and policies that are intended to bring regulatory programs and their regulators under more centralized control. These two objectives are not always compatible since the instrument that is often used to bring regulators under control is itself of a regulatory character. This tension is strongly represented in the changes that have been made to professional self-regulation in England and New Zealand, for example. On the one hand, the scope of self-regulatory authority has been reduced to prevent or inhibit regulation that creates unnecessary barriers because it is thought to be self-interested. On the other hand, the regulatory authority that is left with self-regulators is subject to more intense oversight from new regulatory bodies or from regulatory bodies that are given broader authority.

This context needs to be kept in mind in assessing the changes that have been made in other jurisdictions.<sup>1</sup> It helps to explain why other jurisdictions have placed so much emphasis on reforming regulation by changing the legislation that applies to regulation and less attention to changing regulatory practices that govern the administration of legislation. The importance of this point is simply that legislation and regulatory practice are, more often than not, both of critical importance in determining what a regulation “means” in terms of its impact on the part of the world to which it applies. This reminds us that while certain types of changes are impossible without changes in legislation, significant regulatory change is often possible without legislative

---

<sup>1</sup> As does many other more specific contextual factors, such as the fact that British doctors are employees of the NHS (for the most part) and are as such much more subject to the complaint and disciplinary processes in place in British hospitals (or trusts) than is the case in Canada.

change and also that legislative change by itself is often not enough to accomplish meaningful regulatory improvement.

### **Professional Regulation and ICP:**

There is no doubt that in many jurisdictions, regulatory structures have been changed partly out of concern that the traditional model of self-regulation acts as a barrier to ICP and, more specifically, to the optimal distribution of responsibility among health providers from different health professions. There is also no doubt that one of the rationales for some structural change has been a concern that the traditional model of professional self-regulation reinforces or perpetuates the hierarchical organization of care delivery, which many regard as inimical to interprofessional collaboration and the benefits it can bring to patients and providers. These statements are undoubtedly accurate as regards the Canadian provinces that have made the most significant modifications to the traditional regulatory model, being Ontario, Quebec, Alberta and British Columbia.

At the same time, it is clear that a desire for more ICP has not typically been the driving force behind many of the changes that have been adopted in other jurisdictions. Indeed, it is possible that time will tell that some of the more drastic changes will be inimical to ICP, precisely because they accentuate the perceived rationale for “turf protection”. Nevertheless, regardless of the rationale for the adoption of various changes or combinations of changes, it is broadly true that those being adopted in a large number of jurisdictions move the system of health professions regulation in a direction that is generally, at least at a structural level, more aligned with ICP than the traditional model of self-regulation has been. A specific example of this is the current utilization of framework (umbrella) legislation by Ontario’s Minister of Health to add support for ICP to the statutory mandate of all regulatory colleges in Ontario and to launch a review (by the Health Professions Regulatory Advisory Council) on the further actions that should be taken within the system of health professions regulation to make ICP happen.

### **NSHPRN: A Unique Opportunity for Nova Scotia’s Health System?**

Many of the changes discussed above have been made by governments to regulatory bodies and to the broader regulatory system of which they are a part. They have not primarily come from regulatory bodies or from the communities that are regulated by these bodies.

There is no doubt that governments have the authority to make such changes, since governments are ultimately accountable for the regulatory system and its effectiveness. There are however, risks associated with significant changes in a system of self-regulation that are initiated and imposed by government. These risks rest on the limitations of governments that have historically explained the health care system’s reliance on occupational self-regulation in the first place. More specifically, change that is imposed can undermine the legitimacy with providers (and with patients) on which the effectiveness of the regulatory system must ultimately depend, whether the system is a

system of self-regulation, a system of government regulation or a system of “regulated self-regulation”.

The NSHPRN is an initiative of Nova Scotia’s regulatory bodies. It works in collaborative partnership with the DoH and with other parts of Nova Scotia’s health care system. It is proactively engaged with a range of issues that determine the effectiveness of each regulatory body and regulatory system as a whole. In other jurisdictions, some of these issues are those that have resulted in significant structural changes being made to the regulatory system by governments to shift the system away from traditional self-regulation. Specifically, the NSHPRN has proactively identified and given priority to the responsibilities of Network members to enable and support the wider and more effective adoption of ICP as an emerging pillar of Nova Scotia’s health care system.

In at least four respects, these circumstances create the potential for a change process that is “better” than the change process that has been followed in many other jurisdictions. First, these circumstances increase the possibility that the changes that are agreed upon and implemented will be carefully calibrated to achieve specific goals while maintaining the essential strengths of the regulatory system as a whole. Second, they increase the possibility that the changes that are agreed upon and adopted will be regarded as legitimate by those to whom they are to be applied. Third, they increase the possibility that the changes agreed upon and implemented as regards the regulation of health professionals will be aligned with other initiatives taking place in the broader health care system that are also directed to advancing and supporting ICP. Fourth, these circumstances increase the possibility that the changes adopted in Nova Scotia will be part of a continuous process of regulatory learning, improvement and adaptation. In the end, such a process may be more likely to produce greater benefits and more sustainable benefits than a legislative “fix” that substitutes one regulatory framework for another.

### **The Importance of Clear Objectives:**

Seizing the opportunities for success outlined in the previous section depends on many variables. One of these variables is clear objectives. This is obvious but nevertheless worth emphasizing.

There is a strong tendency in discussions of professional regulation and ICP to assume causal relationships between regulatory structures and provider behavior. Conclusions are based on what seem like the self-evident tensions between (for example) exclusive scopes of practice under the authority of multiple regulators and the need in ICP for the sharing of responsibility and the recognition of overlapping competencies. These conclusions become the rationale for changes (such as the elimination of exclusive scopes of practice or the reduction in the number of regulators) that at most increase the possibility for additional ICP but that are not capable, by themselves, of making ICP happen. Meanwhile, more meaningful barriers to ICP (such as liability uncertainty) may go unaddressed while regulatory effectiveness in patient protection may be jeopardized.

To avoid and go beyond this kind of simplistic analysis, the NSHPRN needs clear objectives. More specifically, it needs clear objectives based on a clear understanding of what prevents ICP from being optimally adopted in Nova Scotia, of the changes that will enable and support its wider and successful adoption and of the contribution that regulatory bodies and the regulatory system as a whole must or can make to the removal of the barriers and to the creation of the enablers.

It may be helpful to think of potential objectives as lying along a spectrum of ambitiousness. At one end of the spectrum is the removal of barriers that prevent ICP and that are created or reinforced by the regulation of health professions, at least to the extent that removal is consistent with discharge of the regulatory mandate. This can be described as enabling ICP but as otherwise leaving the adoption of ICP to professional judgment (to extent it depends on provider decision-making). At the other end of the spectrum is making ICP and participation in ICP (at least in defined circumstances) mandatory. In between are contributions that might be described as supporting, encouraging and promoting. At a general level, the NSHPRN needs to have a clear idea of where the contributions it can and wants to make to ICP fit on this spectrum.

At one level, this will require NSHPRN to develop a clear understanding of how the regulatory process and system are implicated in both the barriers to and the opportunities for ICP. This calls for an “on the ground” situation analysis that aims to identify and create an inventory of specific barriers and specific opportunities. But at another level, a clear understanding of the nature and extent of the contribution that NSHPRN and its members can make to ICP will depend upon our understanding of the authority and responsibilities of regulatory bodies that have the mandate to regulate the competency of health professionals. Is the regulatory role limited to the prevention of bad things? Or does it extend to responsibility for ensuring that good things happen? If the latter, does this authority and responsibility go beyond encouragement and promotion into prescription? If the regulators of health professionals can go there, should they? Assuming that regulation is about more than the prevention of bad things but extends to the promotion of good things (including ICP), are these distinct regulatory roles best assigned to distinct regulatory bodies? England and other countries (such as Denmark) have to some degree answered this question in the affirmative, by creating various kinds of institutional separations between disciplinary and other regulatory functions.

This discussion raises the importance of clarity on the regulatory rationale for ICP. By this I mean something more specific than the health system rationale for ICP. I mean a rationale for ICP that isolates the specific connections of ICP to the statutory powers and responsibilities that regulatory bodies currently have, or that they should have.

### **Objectives Should Determine Nature and Scope of Deliberations:**

The NSHPRN has decided to initially focus on the discipline process and ICP. This focus could take many different shapes. The issues that could be discussed within such a focus could be quite limited or quite extensive. The focus could be on specific



aspects of the disciplinary process or on the disciplinary process broadly conceived. For example, a focus on the disciplinary process could extend to the creation of a common disciplinary process or be limited to the creation of stronger linkages between disciplinary processes. A focus on ICP and the disciplinary process could be primarily concerned with the management and investigation and adjudication of complaints that involve providers from different regulated professions. It could instead or in addition be concerned with how each regulatory body handles complaints against its own registrants when the complaint includes allegations or information that raises ICP issues. A focus of the disciplinary process and ICP could also (or instead) concentrate on mechanisms for ensuring that each regulatory body deals with disciplinary matters in procedurally and (or) substantively consistent ways, including in the standards and guidelines that each applies around ICP.

The decision between these alternatives will depend on many factors. It will, for example, be important to take account of how disciplinary options connect to the rest of the regulatory framework, both to avoid adverse impact on the rest of the framework and to exploit opportunities to make wider improvements while making changes in the disciplinary process to achieve objectives that are related to ICP. Another consideration should be the relevance of the alternatives to the objectives that NSPRN decides it can or should pursue with respect to ICP and the location of these objectives along the spectrum described above, with “staying out of the way” at one end of the spectrum and making ICP mandatory (in some sense) being the other end of that spectrum.

## APPENDIX “C”

# Collaborative Regulation – the Nova Scotia Approach



# Agenda

- Nova Scotia's Health Professions Regulatory Network
- Illustrative cases
- Collaborative Regulation
- Department of Health Perspective
- Concluding Thoughts



# Nova Scotia Health Professions Regulatory Network

Linda Hamilton  
Executive Director  
Nova Scotia College of Registered Nurses



# Health Professions Regulatory Network

- 22 regulated health professions, established and emerging
- Department of Health
- Quarterly meetings



# Health Professions Regulatory Network

Forum for

- Communication
- Identification of common issues and concerns
- Sharing of resources and expertise
- Joint /collaborative actions and projects



# Working Group on “Collaborative Regulation”

- Focus on interdisciplinary accountability
- Other priorities
  - Operation of scopes of practice
  - Continuing education
  - Consistency in policy-making
  - Linkages to other accountability processes



# Two Illustrative Cases

Cameron Little MD  
College of Physicians and Surgeons of Nova Scotia  
May 21, 2009





# 42 yr old female physician

- Past Hx of prescription drug (opioid) abuse
  - Completed treatment and 6 years drug free
  - Cannot prescribe opioids as condition of practice
- Partnership with another physician
  - Partner leaves 3 signed blank prescriptions



- Approaches local pharmacists
  - Requests opioids without prescription
  - Uses signed blank scripts
- Reported to medical professional regulatory authority



# 56 yr old ObGyn

- 25 yr old - 4 mo pregnant with twins
- Seen every 3 wks
- Premature labour @ 6 mo; fluid retention
- Did not determine placenta(s) or sac(s) of twins
- No biophysical profile
- Electronic fetal monitoring only
- Ultrasound – no fetal heart activity
- One placenta and two sacs
- Twin to twin fetal transfusion



- Hospital policy
  - Determine # of placenta(s) and sac(s)
  - Do biophysical profile
  
- Nursing
  - Nurse doing fetal monitoring replacement from ER



# More Illustrative Cases

Beverley Zwicker  
Nova Scotia College of Pharmacists  
May 21, 2009



# Legal guardian of LTCF resident calls NSCP

- Dramatic decline in alertness and engagement of sister
- List of meds reviewed -> red flags (BEERS criteria meds including diazepam and indomethacin)
- Raised concern with pharmacy providing care to LTC -> no concern and no action
- Raised concern with prescribing physician serving the LTC facility -> no concern and no action
- Met with LTC & advised of legal action and media if concerns not addressed -< d/c threat from LTCF



# Regulatory Issues

- For College of Pharmacists:
  - Pharmacist obligation to provide optimal care
  - Gathering evidence on appropriateness of meds and pharmacists steps to achieve optimal care (assessment for drug related problems, collaborative steps with physician, LTCF, etc.)
- For other Regulators
  - Inappropriate prescribing? (CPSNS)
  - Failure to report? (CRNNS)
  - Threat to withhold service? (DHA)

# Collaborative Regulation

William Lahey  
Dalhousie Health Law Institute





# Case Studies

- Illustrate core tensions
- Focus attention on larger issue
- Beg the question: Is the problem
  - self-regulation
  - regulatory effectiveness
  - the relationship between the two?



# Nova Scotia's Model

- Regulation within professional boundaries
- It uses most restrictive legislation
- It relies on familiar tools
- Spreads resources thinly
- Relies on segmented and internal accountability relationships
- Is the sum of parts

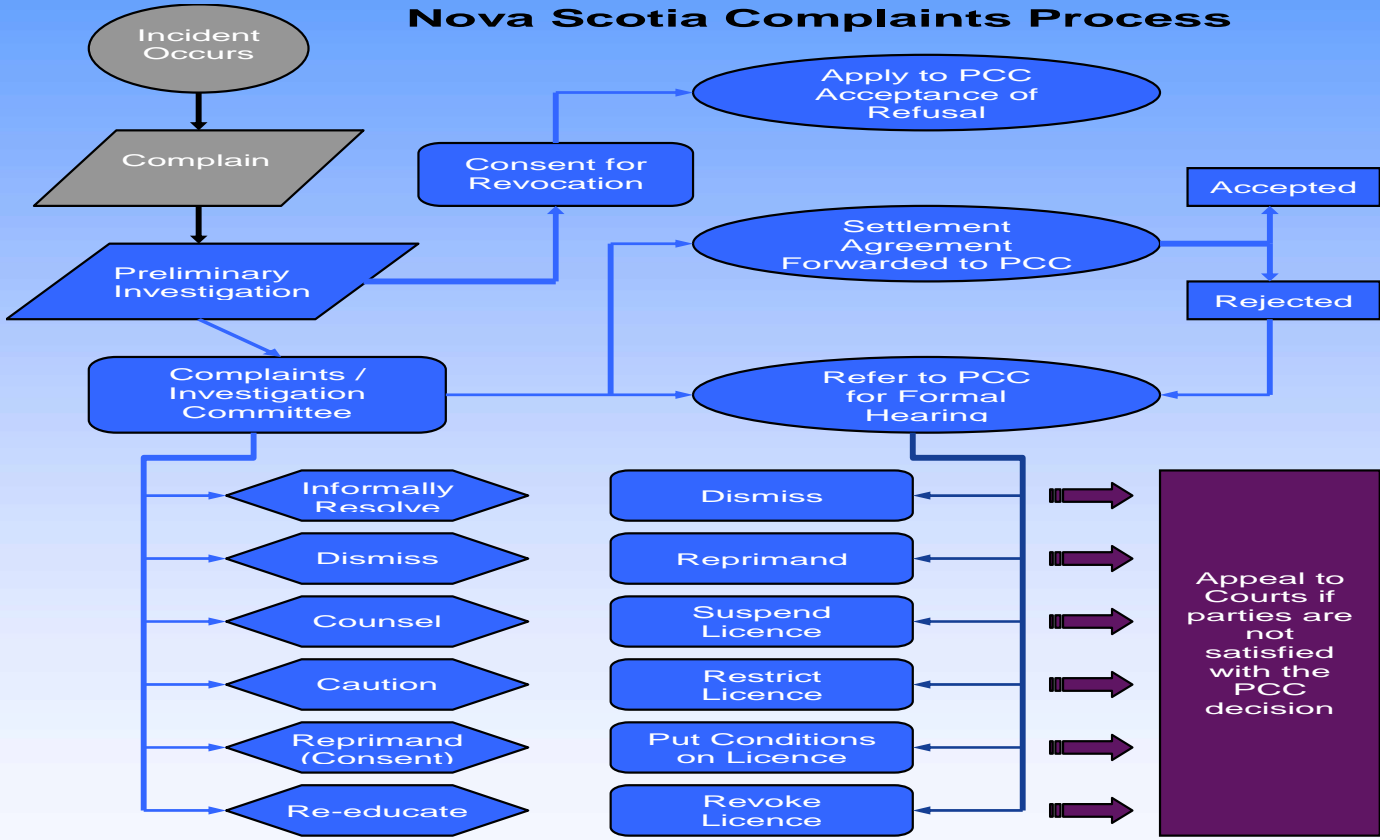


# Elsewhere

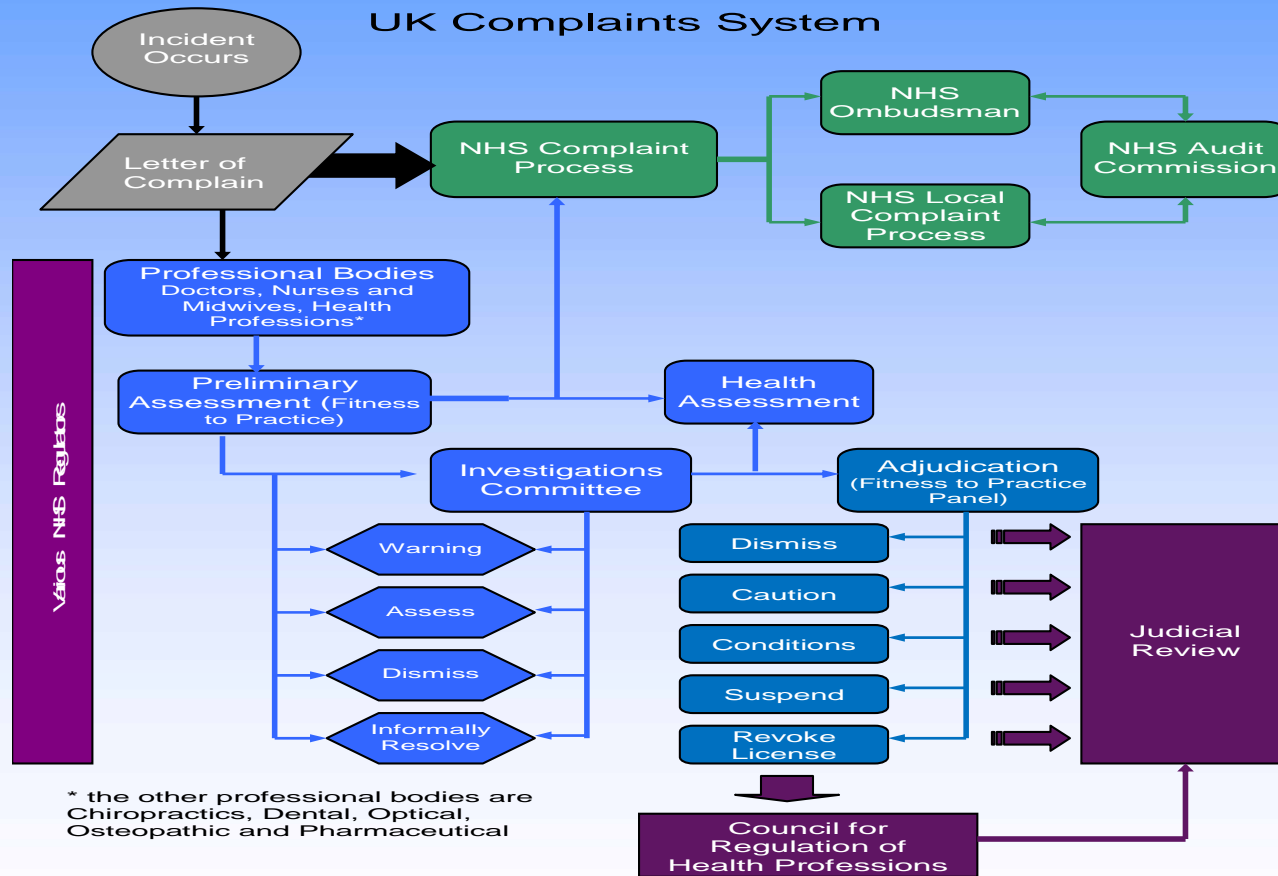
- Self-regulation is being
  - Governed from outside
  - Integrated into larger systems
  - Increasingly regulated
  - Displaced, confined



# Nova Scotia

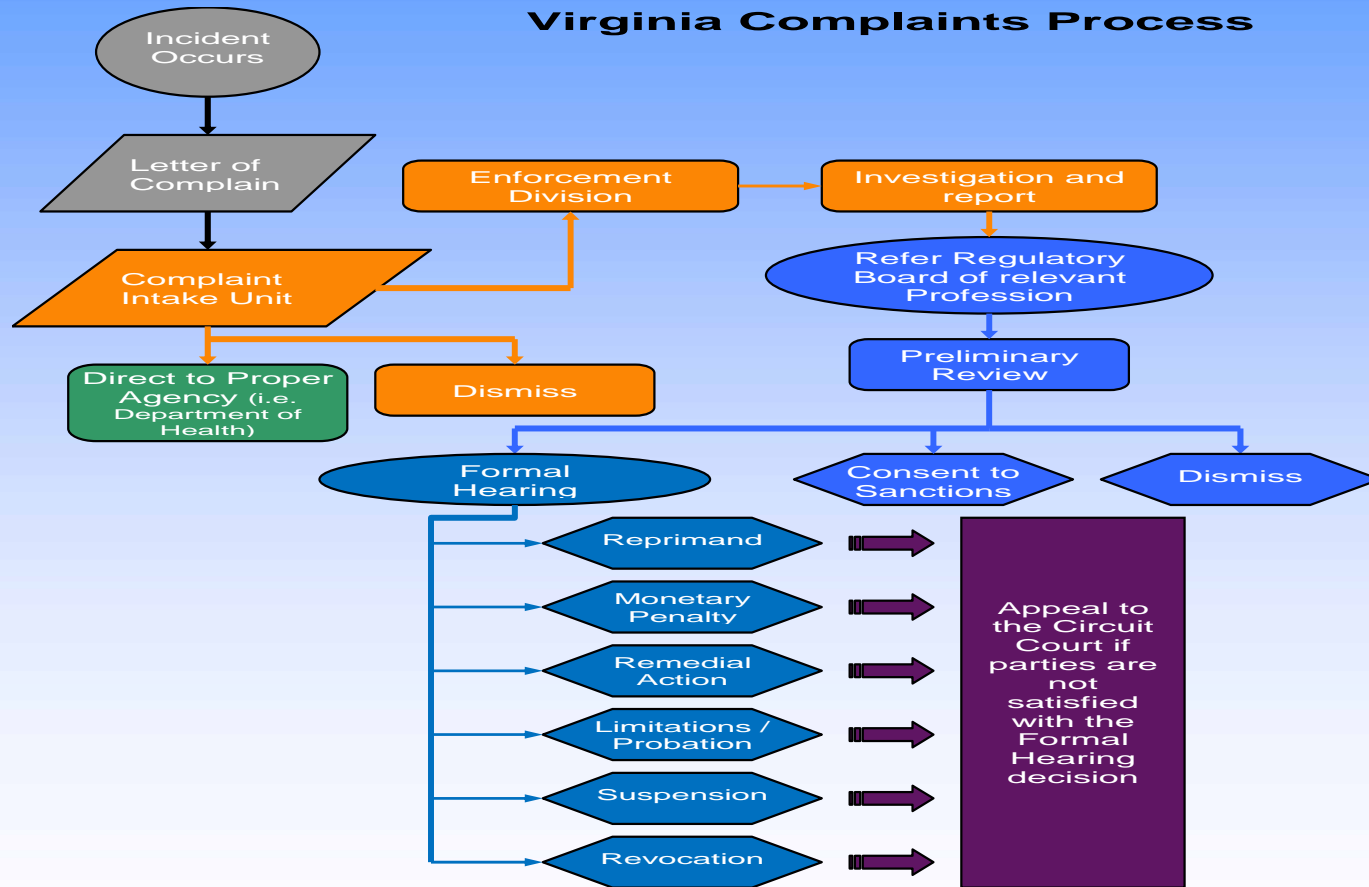


# England



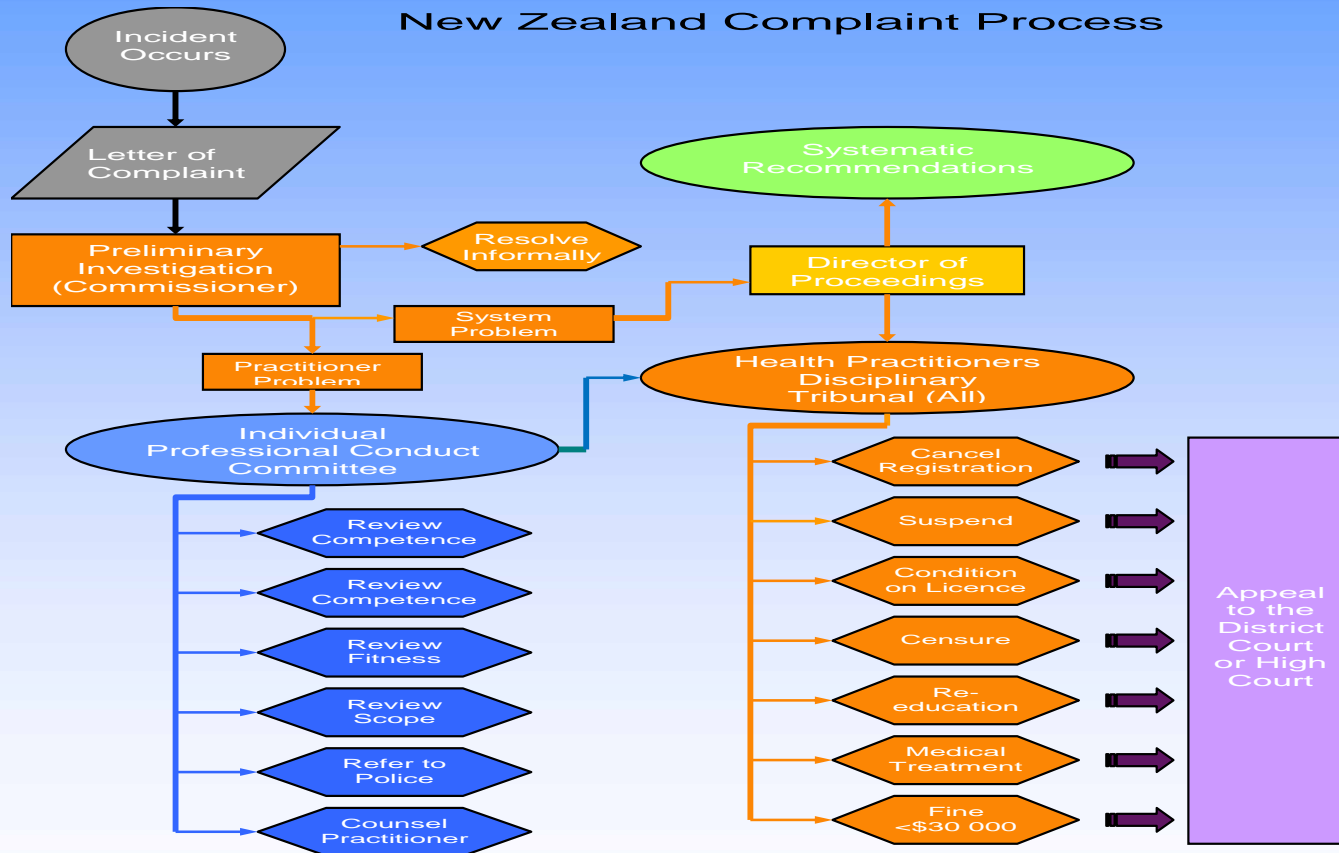
# Virginia

## Virginia Complaints Process

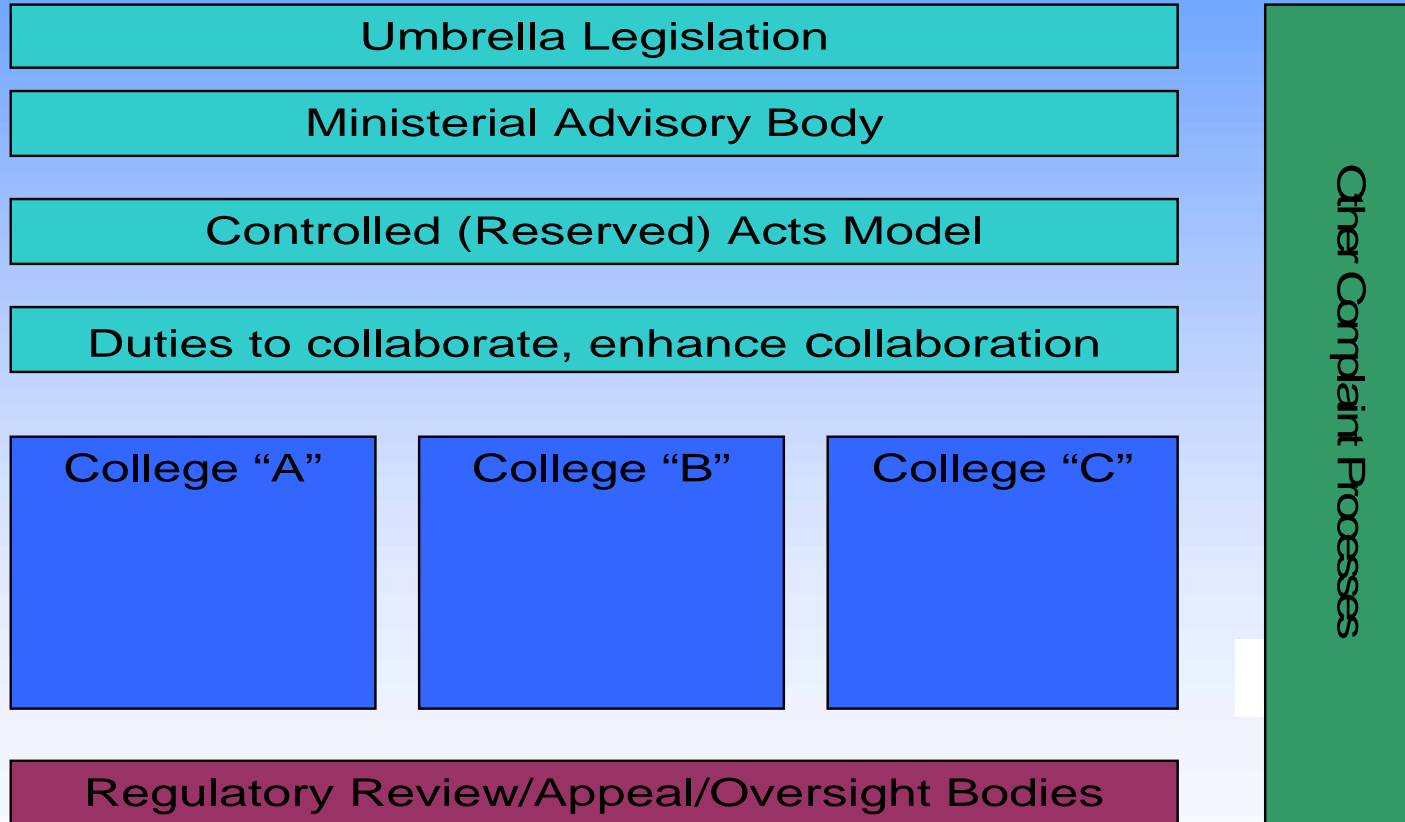


# New Zealand

## New Zealand Complaint Process



# “Ontario” Model





# Reflections

- Trends send a strong message
- Much to emulate
- Key similarities and differences
- Key questions
  - What does more effective regulation require?
  - What should effective regulation accomplish?
  - Does professional regulation rest on collaborative professionalism?

# Collaborative Regulation

- A shift to collective self-regulation
- Address weaknesses, retain strengths
- Internal leadership, external reinforcement
- Calibrate reform
- Experimentation, continuous improvement
- Demonstrate while enabling collaboration
- Functional institutional development



# Existing Examples

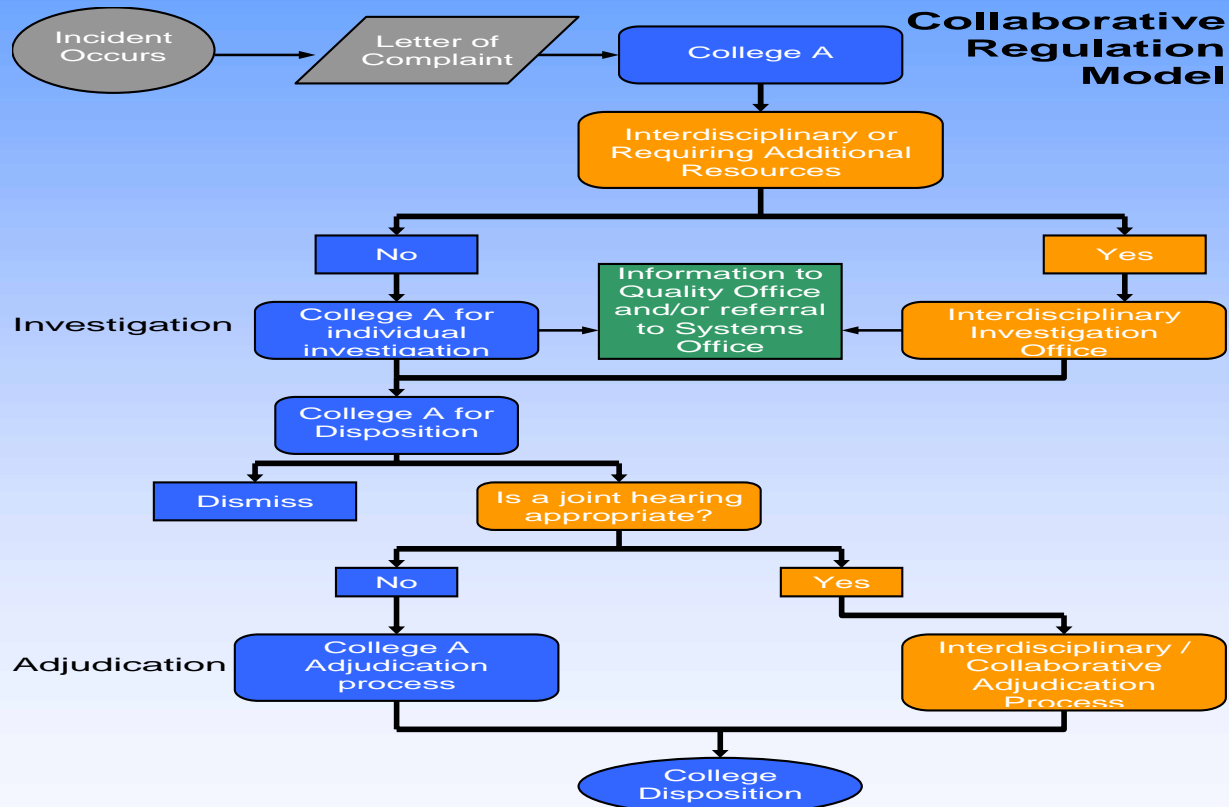
- Evaluation of NP/GP collaborative practices
- Prescription Monitoring Program
- Collaboration “feeding” independent self-regulation

# Interdisciplinary Accountability

- The issues
- The options
- Office of Interdisciplinary Accountability



# Collaborative Model



# Where to From Here?

- Dealing with the devils
- Collaborative management of scopes of practice?
- Other priorities
  - Continuing education
  - Consistency in policy-making
  - Linkages to other accountability processes
- Building awareness, engagement, support



# The Department of Health Perspective

Donna Denney  
Senior Nursing Advisor

Nova Scotia Department of Health



# Opportunities for Government

- Enhance relations with regulatory bodies through collaboration and support for HRN
  - Mutual respect and appreciation of respective roles
- Vehicle for engagement in relation to government legislative changes
  - Apology Act
  - FARPA
- Better understanding of legislative scopes of practice and opportunities for collaboration
  - Pandemic competencies
  - Health transformation



# Opportunities for Government

- New model provides mechanism for regulatory colleges to demonstrate accountability across boundaries
- Link with the current work in Nova Scotia on the health system's quality and patient safety agenda



# Concluding Thoughts

- Improvement is needed
- Change will come
- Will it come from within or from outside?
- Is collaborative self-regulation a valid option? A better option?
- Can change harness regulatory value of self-regulation



# APPENDIX "D"

## Evaluation Matrix (Draft) Regulatory Models for Interdisciplinary Teams

December 11, 2008

Criteria of Evaluation								
Regulatory Models <sup>1</sup>		Effectiveness in protecting patients <sup>2</sup>	Impact on ICP <sup>3</sup>	Feasibility and sustainability <sup>4</sup>	Fairness <sup>5</sup>	Flexibility, adaptiveness, responsiveness, resiliency <sup>6</sup>	Dependability <sup>7</sup>	Accountability <sup>8</sup>
	Inter-disciplinary Investigation Model							
	Joint Action Board Model							
	IDHP "Building" Model							
	Healing Professions Act							
	Interdisciplinary Board/Council							
	Regulated Health Professions Joint Board for Public Accountability							

---

<sup>1</sup> “Regulatory Models” refers to the models developed at the Conference on “Regulation in the 21<sup>st</sup> Century: Interdisciplinary Team Accountability”, which took place on November 16, 2007, at Dartmouth Nova Scotia.

<sup>2</sup> “Effectiveness in protecting patients” means effectiveness in discharging the core mandate of regulatory bodies to protect the safety and rights of the public with respect to qualifications, competency and fitness of regulated health care providers, to encourage and support the provision of high quality and ethical care and to support patient choice within a safe range of options.

<sup>3</sup> “Impact on ICP (Interdisciplinary collaborative practice)” refers to the extent and nature of the impact that each of the proposed models could have on the policy objective of aligning the regulatory system with interdisciplinary collaborative practice.

<sup>4</sup> “Feasibility and sustainability” includes implementation feasibility, capacity of regulatory bodies and of the members of regulated professions, availability of relevant sources of expertise and professional assistance, administrative and governance complexity, immediate and longer term affordability, and legislative feasibility.

<sup>5</sup> “Fairness” means fairness in policy making and in investigative and adjudicative functions, including compliance with the common law principles of procedural fairness as applicable to the case, accessibility, consistency (like cases alike), transparency and timeliness.

<sup>6</sup> “Flexibility, adaptiveness, responsiveness, resiliency” are associated concepts that deal with the capacity of a regulatory system to calibrate its response to the circumstances of particular cases (while maintaining consistency), to evolve with changing circumstances and to “learn” from experience. In a word, all these words refer to aspects of the capacity of regulators, regulatory bodies and regulatory systems to achieve substantive results while playing by the rules and principles that differentiate rule “according to law” from other forms of governance.

<sup>7</sup> “Dependability” means the robustness of a regulatory program or system, meaning specifically its capacity to establish and maintain provider, public and governmental confidence, including while evolving to address new challenges and opportunities or to do things in new ways.

<sup>8</sup> “Accountability” means accountability of regulatory bodies and of the system of health professions regulation to the public, including through the Department of Health and the accountability of individual providers and teams of providers to the public and their patients through regulatory bodies and processes. Accountability encompasses the mechanisms of accountability (public proceedings, transparency, public participation) and the substance of accountability (being accountable).