

HPRAC

An Interim Report to
the Minister of Health and
Long-Term Care on Mechanisms
to Facilitate and Support
Interprofessional Collaboration
among Health Colleges and
Regulated Health Professionals



March 2008

Submitted by the
Health Professions Regulatory Advisory Council (HPRAC)





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March 31, 2008

Honourable George Smitherman
Minister of Health and Long-Term Care
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80 Grosvenor Street
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Dear Minister:

In response to your letter of June 28, 2007, HPRAC is pleased to present the first phase of its advice to you respecting Interprofessional Collaboration. This is the first stage of an important investigation, and this report lays the grounding for other work that will follow. We believe that collaboration between professionals – and between the professions themselves – is one of the best ways to ensure that patients can have access to the highest quality, comprehensive and coordinated care.

Removing obstacles to, and providing incentives for collaboration, including redefining who can provide care and under what circumstances, is essential to ensuring the best results for patients. Employers should be able to draw on health professionals to the fullest range of their skills and knowledge. Health professionals should be able to work to the maximum of their skills, training and experience, and should be able to take on new roles without being restricted by statutory, structural or cultural barriers.

At the outset, HPRAC has reviewed what is occurring in other jurisdictions, what is described in the literature, and is now receiving comment through a discussion guide. We expect that hundreds of individuals and organizations will assist us in making final recommendations to you. In the meantime, we are providing immediate observations and recommendations in areas where improved relationships between regulators can lead to better results for patients.

This report is a first step only, and our final report to you will be more definitive. It will speak to more extensive changes to legislation and regulation, structures and processes that will make a difference to the way people receive care, and ensure our health professionals can work to their full scopes of practice in providing that care.

HPRAC extends its thanks to representatives from Ontario's health colleges and health professions' associations who attended our workshops for sharing their comments, ideas and suggestions, and to the representatives from other jurisdictions who generously shared their experiences in facilitating interprofessional collaboration. Their help was invaluable in helping us to define the scope of our work in responding to your question and the issues that must be addressed.

Yours truly,



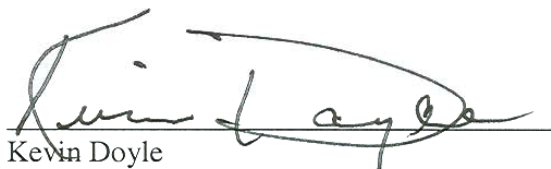
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INTERPROFESSIONAL COLLABORATION

1. The Minister's Question

On June 28, 2007, the Minister of Health and Long-Term Care, The Honourable George Smitherman, asked the Health Professions Regulatory Advisory Council (HPRAC) to:

recommend mechanisms to facilitate and support interprofessional collaboration between health Colleges, beginning with the development of standards of practice and professional practice guidelines where regulated professions share the same or similar controlled acts, acknowledging that individual health Colleges independently govern their professions and establish the competencies for their profession.

The Minister also asked that HPRAC:

take into account, when controlled acts are shared, of public expectations for high quality services, no matter which health profession is responsible for delivering care or treatment.

Prior to making his request, on November 7, 2006, the Minister wrote to the Chair of the Ontario Legislature's Standing Committee on Social Policy, which was reviewing the *Traditional Chinese Medicine Act, 2007*, as follows:

... there is a potential opportunity for regulated health professions that have overlapping scopes of practice to work together to develop standards of practice in a collaborative way. The Health Professions Regulatory Advisory Council (HPRAC) recently provided extensive recommendations on a number of complex regulatory issues in its *New Directions* Report. Some of its recommendations posed options for health professions to collaborate in the development of standards of practice for the same or similar controlled acts, while respecting the competencies of the individual professions.

In this letter, the Minister stated that he intended to seek further advice from HPRAC on these matters, including how best to facilitate that collaboration.

2. HPRAC's Central Response

A system where all health professionals can function to the fullest extent of their training and capability as part of an integrated and collaborative health care team is key to improving access to seamless, effective, patient-centred care. To deliver this kind of care, health care professionals must be able to practise to the maximum extent of their respective scopes of

practice. This requires strengthening mechanisms that make collaboration possible among regulatory bodies and among their members at the clinical level. Introducing new or revised legislation, regulations or structures and changing organizational cultures are all potential ways to facilitate interprofessional collaboration and interprofessional care.

In responding to the Minister's questions, HPRAC has sought opportunities for professions, working in partnership, to apply standards, approaches and principles across disciplines, while respecting the unique body of knowledge and culture of individual professions.

In a separate report to the Minister on the regulation of nurse practitioners, HPRAC has proposed a fundamental change in regulatory approach, within the construct of the *Regulated Health Professions Act*. It requires greater accountability for professions and their regulators, and in turn offers greater flexibility in establishing rigorous standards for the profession. HPRAC contemplates that this new approach will have significant impact, given the emergence of advanced practice in several health professions. It provides for a new way of doing business that regulatory colleges will find relevant.

HPRAC sees an enabling regulatory framework as the next stage in the development of professional self-regulation in Ontario, and one that will not be unique to any specific profession. It will depend on those who are committed to the principles of self-regulation to make this new model work. It imposes a high standard of duty and care on each regulator. It demands interprofessional collaboration. And in the end, most importantly, it protects the public interest.

In this interim advice to the Minister, HPRAC identifies specific mechanisms for improving collaboration among the professions that practice acupuncture and psychotherapy. The recommendations relating to each of these professions are grounded in principles and mechanisms that might be adapted for a number of professions. HPRAC also discusses matters that affect people who receive eye care from professionals in Ontario. In the next phase of this work, HPRAC will look more closely at whether scopes of practice of several professions are sufficient or should be expanded to ensure that collaborative interprofessional care can be effectively provided.

3. Why is Interprofessional Collaboration an Issue?

3.1 The Base for Collaboration

In order to understand the current need for collaboration among the health professions, it is useful to review the recent history of regulation of health professions in Ontario. At the outset, it is recognized that there is a gradual trend toward breaking down the exclusive control or monopolies that some health professions have had in the delivery of care, to allow overlapping scopes of practice, and to move toward active cooperation among health professions to benefit the patient.

Prior to the 1980s, some health professions, such as medicine and nursing, were regulated under the *Health Disciplines Act*, which licensed professions with an exclusive scope of

practice. When it became apparent that there was need for change, the Health Professions Legislation Review (HPLR)¹, under the chairmanship of Alan M. Schwartz, recommended that the old professional monopolies should be replaced with a new model of regulation that entailed a system of “licensed acts”, rather than licensed professions. The thirteen such acts identified were considered to present a risk of harm to patients if they were performed by an unqualified individual.

In identifying the purpose of regulation, the HPLR stated that:

Through professional regulation the nature and quality of health care services can be regulated. Professional regulation is aimed at advancing the public interest, not the interests of the professions. The Review’s recommendations are aimed at advancing the public interest in four ways:

- Protection of the public, to the extent possible, from unqualified, incompetent and unfit health care providers,
- Developing mechanisms to encourage the provision of high quality care,
- Permitting the public to exercise freedom of choice of health care provider within a range of safe options, and
- Promoting evolution in the roles played by individual professions and flexibility in how individual professions can be utilized, so that health services are delivered with maximum efficiency.²

It bears repeating that the purpose of regulation is the advancement of the *public interest*, and that this is the first principle or fundamental ground upon which everything else is founded. It is a basic moral precept that has become enshrined in the ethical codes of the health professions, and enforced by professional regulation. From it are derived several legislative principles which reflect a broad consensus of societal values. They include the prevention of harm, the promotion of the public good, the acknowledgement of personal autonomy, and the need to adapt to change.

When the HPLR’s ways of advancing the principle of public interest is applied to the health professions, the first criterion involves the prevention of harm to patients, a requirement as old as the Hippocratic Oath. The second promotes the patient’s good or benefit, which also goes back to ancient medicine. The third facilitates personal autonomy, a more modern but a fundamental and self-evident value. Along with the fourth, demanding the evolution of the professions, their effectiveness and efficiency, these criteria reflect a broad consensus in contemporary society. There are other legislative principles grounding regulation, but these are relevant to the case for interprofessional collaboration.

The HPLR led to the development of the *Regulated Health Professions Act, 1991 (RHPA)* which is based on the principles and created in the spirit identified by the HPLR. It lists

¹ Health Professions Legislation Review (1986). *Striking a New Balance: A Blueprint for the Regulation of Ontario’s Health Professions*.

² Ibid, Executive Summary.

thirteen acts, now called “controlled acts”, most of which are authorized to more than one health profession. Thus began the breaking down of the monopolies, or “silos” held by individual professions.

The term “silo” connotes not only exclusivity but also isolation – the antithesis of interprofessional collaboration. It is especially appropriate for professions that do not collaborate with other professions, but in some cases, appear to be unwilling to do so, or are consciously opposed.

While the model of the *RHPA* has been very successful in Ontario and is emulated elsewhere, it does not, by itself, encourage collaboration. The structure permits overlapping scopes of practice, and allows two or more professions to share a controlled act, which could well be performed in a collaborative setting. However, an impetus or dynamic to move toward that end is not defined or suggested. Indeed, because of restrictions that are placed on the performance of controlled acts by individual professions, collaboration is sometimes deterred or actively discouraged through the mechanics of the *RHPA*, profession-specific statutes and the regulations under them.

Does the public interest warrant, or even require, collaboration among the professions? To answer this question, one must account for the complexities of a rapidly changing health care environment, the dynamics of the people within it, and the costs incurred in supporting it. The answer is yes if individual members of the public are otherwise inadequately protected from harm, if the quality of health care is deteriorating, or if there are obvious ways in which the quality of care can be improved for patients but are not being implemented. The answer to this question will depend not on normative concepts, but on factual circumstances: the present and rapidly changing health care environment.

Given that the purpose of regulation is to protect and further the public interest, and that the public interest is met in providing high quality, safe care to individual patients, it follows that optimal care will have the patient at the centre, rather than the health professional.

All ideas expressed and recommendations made to promote collaboration between the health professions that are contained in this report should be seen through the lens of patient-centred approaches. Improvement in patient-centred care will have benefits to patients, the professions themselves, and to society in general.

3.2 The Environment for Collaboration

In considering its response to the Minister’s question, HPRAC has kept in mind the overall setting within which patient-centred, interprofessional collaboration must occur, including:

1. Ontario’s evolving legislative framework,
2. Pressures facing the health care system in Ontario and across Canada,
3. Recent initiatives to transform the province’s health care system,
4. Links between the Minister’s question on interprofessional collaboration and other questions posed in the Minister’s letter of June 28, 2007,
5. Existing interprofessional activities within Ontario’s health care system, and

6. Barriers to collaboration within Ontario's health care system.

Each element of the setting will be discussed in more detail, in what follows.

3.3 Ontario's Evolving Legislative Framework

Regulated Health Professions Act, 1991

The *Regulated Health Professions Act, 1991 (RHPA)* governs Ontario's health professions generally. It includes provisions restricting the performance of certain controlled acts to members of the regulated professions and restricts the performance of acts that would cause serious harm. It also contains a Procedural Code that covers matters such as the functioning of the health professional Colleges, registration of health professionals, complaints, discipline, quality assurance and patient relations.

The *RHPA* allows overlapping scopes of practice, meaning that more than one profession is authorized to perform some of the same or similar controlled acts and to set standards for the performance of those acts. All professions who share the same or similar controlled acts must do so in the context of providing patient care of the highest quality.

Overlapping scopes of practice and sharing of the same or similar controlled acts represent both an opportunity and a potential barrier to promoting greater interprofessional collaboration. By making it possible for a number of health professions to initiate and perform many of the same activities, they enable interprofessional collaboration. This increases access to much-needed health services.

On the other hand, different interpretations of the same or similar controlled acts, and different standards of practice employed by professions that perform the same or similar controlled acts, can create competition and turf protection among those professions and, when standards are inconsistent, concerns arise about the quality of care that is provided.

New Regulatory Directions

In Ontario, the regulation of health professions is an ongoing, evolving process. In April 2006, HPRAC provided advice to the Minister of Health and Long-Term Care through its report, *Regulation of Health Professions in Ontario: New Directions (New Directions)*.³ In *New Directions*, HPRAC recognized the importance of interprofessional collaboration. It recommended structuring Ontario's health professions' regulatory environment to support innovative ways to deliver health care to patients – including a greater focus on interprofessional care. HPRAC noted significant societal changes that had occurred since 1991, when the *RHPA* was first introduced, that have led to pressures on the health system and on health professionals. These arise from:

³ HPRAC (April 2006). *Regulation of Health Professions in Ontario: New Directions* (available at <http://www.hprac.org/>).

- rapid change in technology and communications,
- advances in clinical practice and pharmacology,
- increasing patient involvement in decision-making and self-care,
- an aging population and aging professional cohort,
- greater cultural, faith and linguistic diversity,
- increasing amounts of care provided in community settings rather than hospitals,
- rise in the use of alternate and complementary medicines,
- growing service delivery models involving multidisciplinary and collaborative care,
- new emphasis on accountability and transparency, and
- global influences, including rising costs and recruitment and retention issues.

The Council also noted a series of structural challenges within Ontario's existing regulatory structure for health professions. These included delegation of controlled acts, overlapping scopes of practice and the need for greater sharing of information and enhancing collaboration among health Colleges.

HPRAC recommended that the *RHPA* be amended by adding new objectives for the regulatory colleges that related specifically to collaboration among the colleges. Following HPRAC's report, the *Health System Improvement Act, 2007* added three new objects to the *RHPA*'s Procedural Code to support interprofessional collaboration. New mandates were added for health regulatory colleges to:

- promote and enhance relations between the College and its members, other health profession Colleges, key stakeholders and the public,
- promote interprofessional collaboration with other health profession Colleges, and
- develop, establish and maintain standards and programs to promote the ability of members to respond to changes in practice environments, advances in technology and other emerging issues.

These amendments explicitly call on health Colleges to engage in activities to enhance interprofessional collaboration as a way of facilitating the ability of professionals and the health care system to respond to changes in practice environments, advances in technology and other emerging issues.

New Directions also recommended the regulation under the *RHPA* of the then-unregulated professions of homeopathy, kinesiology, pharmacy technicians and psychotherapy, and moving the regulation of naturopathy from the outdated *Drugless Practitioners Act, 1990* to the *RHPA*. The *Health Systems Improvement Act, 2007*, regulated the profession of naturopathy under the *RHPA* and introduced new professions under new profession-specific acts:

- homeopathy under the *Homeopathy Act, 2007*,
- kinesiology under the *Kinesiology Act, 2007*,

- naturopathy under the *Naturopathy Act, 2007*,
- pharmacy technicians under the *Pharmacy Act, 1991*, and
- psychotherapy under the *Psychotherapy Act, 2007*.

Prior to this, The *Traditional Chinese Medicine Act, 2006*, regulating the practice of traditional Chinese medicine and acupuncture, received Royal Assent on December 20, 2006.

3.4 Health System Pressures

Over the past decade, provincial and federal governments across Canada have grappled with implementing broad-based health care reforms to respond to systemic challenges. These challenges include the growing and changing needs of an aging, more diverse population, new technologies, health human resources shortages, and escalating health care expenditures. All governments today are continuing to focus on wait times, patient safety, quality of care and the health care system's sustainability.

As part of the process of health system reform, the Standing Committee on Social Affairs, Science and Technology (2001), the Commission on the Future of Health Care in Canada (2002), the First Ministers' Accord on Health Care Renewal (2003), the Health Council of Canada (2005) and other commissions, committees and organizations have published reports on these matters and how best to resolve them.

In Ontario, training, recruiting, retaining and attracting highly skilled physicians, nurses, technologists and other health professionals continues to be a challenge, not only in northern, rural and remote areas but, increasingly, in urban settings as well. This will intensify with the aging of Ontario's health care workforce.

At the same time, patients and their families are more actively engaged in managing their health conditions than ever before. Patients increasingly expect that the health care they receive will respond to their needs for appropriate services, from qualified providers, when they need it, and be provided in a way that is consistent with their values. They also expect that, when more than one health care professional is involved in their care, that there will be communication between those professionals and an understanding of their health status and course of treatment. Patients are also increasingly impatient when the health system, and its leadership, does not react nimbly to these needs.

Patients and their families want to be actively engaged in managing their health conditions, expecting the right care at the right time.

- Interprofessional Care: A Blueprint for Action in Ontario

Currently, Ontario is experiencing a shortage of health human resources across many of the health professions. This situation is not likely to be reversed; it is predicted that it will continue for at least the next two decades. In the interim, an increased number of older patients, with complex chronic care requirements and multiple diagnoses will rely on fewer professionals to provide the care they need.

When all health professionals can function to the fullest extent of their training and capability as part of an integrated and collaborative health care team, the effectiveness of care and patient access to care is improved. To deliver this kind of care, health care professionals must be able to practice to the maximum extent of their respective scopes of practice.

Health system transformation that seeks to ensure that all Ontarians have timely access to needed health care services is an ongoing process. Maximizing the capabilities of Ontario's health care professionals, while constrained by human resource availability in many professions, is an essential element of this process. It will be crucial to addressing the demographic and health human resource challenges in the coming years.

These matters are succinctly expressed by the McGill Education Initiative on Interprofessional Collaboration:

A growing impetus has emerged across different levels of government, the health care system, and professional health schools to address the many issues affecting the quality of patient care in today's Canadian health care landscape. Currently, the promotion of increased teamwork and collaboration among administrators and practitioners is an important approach that is being implemented to manage the financial costs of health care in our country, improve the working environments for health professionals, and ultimately, serve to provide a better model in delivering comprehensive and holistic patient care.⁴

3.5 Ontario's Health Transformation Initiatives

Ontario has recently undertaken a series of initiatives to transform Ontario's health care system so that it remains sustainable while continuing to offer safe and high quality health care to patients. Some examples include the establishment of Community Health Centres (2004), Family Health Teams (2005), the Local Health Integration Networks (2006), HealthForceOntario (2006) and the Sudbury District Nurse Practitioner Clinics (2007). Each of these initiatives fundamentally requires health care providers and professionals to collaborate.

In May 2006, the Ministry of Health and Long-Term Care created HealthForceOntario⁵ – a multi-year strategy to give Ontario the right number and mix of health care providers. It includes initiatives to help predict Ontario's health human resource requirements, develop new provider roles to meet changing needs, reshape educational programs to develop people with the right knowledge, skills and attitudes and recruit and retain health professionals by competing effectively with other jurisdictions.

A key priority for HealthForceOntario is to place more emphasis on interprofessional, collaborative care to make better use of vital health human resources. In July 2007, the Interprofessional Care Steering Committee submitted the report, *Interprofessional Care: A*

⁴ <http://www.interprofessionalcare.mcgill.ca/>

⁵ <http://www.healthforceontario.ca/WhatIsHFO.aspx>

Blueprint for Action in Ontario. It defines interprofessional care as “the provision of comprehensive health services to patients by multiple health caregivers who work collaboratively to deliver quality care within and across settings.”⁶

As the report observes, “The health care system is gradually being transformed to ensure that the patient is at the centre, delivery is timely, care is safe, continuity is maintained and access is guaranteed.” Improved collaboration and teamwork are expected to help caregivers manage increasing workloads, decrease duplication, lower wait times and reduce the likelihood of adverse reactions to care.⁷

The report calls for the incorporation of interprofessional care into existing legislation, systems and infrastructure and notes that recent initiatives such as Family Health Teams, wait-times management and Local Health Integration Networks (LHINs) are all based on a model of interprofessional care.

3.6 Linkages with Other Questions

Interprofessional collaboration is one of several questions on which the Minister requested HPRAC’s advice in his letter of June 28, 2007. The other matters are:

- scope of practice of registered nurses in the extended class (nurse practitioners),
- non-physician professions who prescribe and/or use drugs in the course of their practice,
- framework and process for changes to drug regulations for non-physician prescribers,
- regulation of diagnostic sonographers,
- consideration of an association model for personal support workers,
- regulation of dental assistants,
- regulation of paramedics and emergency medical attendants, and
- regulation of chiropody and podiatry.

Many of these questions have implications for interprofessional collaboration. For example, dental assistants work collaboratively with other regulated health professions. Chiropody and podiatry are both regulated by the same College and provide related services involving the same area of the body. Nurse practitioners work in collaborative teams, and share overlapping scopes of practice and the same or similar controlled acts with other professionals. Non-physician prescribers, including nurses, dentists, midwives and others must work closely with other professionals, including pharmacists.

Issues related to interprofessional collaboration will play a central role when undertaking all of these projects. In doing so, HPRAC will look for common mechanisms that can facilitate collaboration across professions to the extent possible, rather than concentrating exclusively on instruments that are unique to a profession. At the same time, there will be issues that will

⁶ HealthForceOntario (July 2007). *Interprofessional Care: A Blueprint for Action in Ontario*, Interprofessional Care Steering Committee, Government of Ontario, p. 7.

⁷ *Ibid*, p.11.

reflect the skills and scopes of individual professions. Three themes have been identified for consideration as HPRAC begins its work on the remaining questions:

- Interprofessional collaboration at all levels of the health care system is an essential part of health system transformation,
- Legislation and regulations that facilitate collaboration must be identified and adopted, and
- Interprofessional collaboration can be strengthened through a variety of legislative, regulatory, policy or structural mechanisms.

4. HPRAC's Approach to the Minister's Question

In responding to the Minister's request to HPRAC, the Council has taken a two-phased approach.

During phase one, HPRAC:

- sponsored two workshops with representatives from Ontario's health Colleges and associations representing health care practitioners, facilities and providers. The purpose of the workshops was to discuss and assess the scope of interprofessional issues to be addressed, and to identify the challenges that health Colleges, their members and providers face in their collaborative efforts,
- conducted and published a literature review to gather information concerning the evidence for, and progress in, developing interprofessional collaboration,
- conducted and published a jurisdictional review to identify the steps that other jurisdictions are taking and mechanisms that Ontario could adopt or adapt to advance interprofessional collaboration between professions and professionals,
- prepared and published a *Discussion Guide* for broad distribution to members of the public, health care professionals, regulatory bodies, educators, health care providers, associations and others with an interest in the question,
- reviewed options for specific professions, including the new professions of traditional Chinese medicine and psychotherapy where collaboration in the development of standards of practice is expected,
- reviewed the analysis and conclusions reached regarding the scope of practice for nurse practitioners and their applicability to other professions, and
- reviewed interprofessional concerns in professions providing eye care.

Assessments show that clients and patients of interdisciplinary collaborative care have a significant level of satisfaction with the results of this type of care. Studies in various countries show positive results in the quality of life and care with a range of patient and client types.

-HPRAC Jurisdictional Review

The workshops, literature and jurisdictional reviews identified five key themes:

- A growing number and a variety of interprofessional models of clinical care are emerging across the care continuum.
- An increasing amount of research on the benefits of interprofessional patient care is available.
- Commitment and progress in developing interprofessional education, particularly at the post-graduate level, is apparent.
- Few legislative and regulatory initiatives to support interprofessional collaboration, including the appropriate role for health regulatory bodies, have been recorded and evaluated.
- Some developments related to interprofessional collaboration developments in other Canadian jurisdictions and internationally, including the United States, Britain, Denmark, Australia, New Zealand and parts of the European Union, are useful.

The *Discussion Guide* issued in February 2008 summarizes these findings. The *Guide* forms the basis for interested organizations and individuals to make written submissions to HPRAC in response to a series of questions covering four topics:

- defining interprofessional collaboration,
- eliminating barriers to collaboration among the health colleges,
- finding ways to encourage health colleges to collaborate, and
- interprofessional care at the clinical level.

During phase two of its work, HPRAC will synthesize and analyze the submissions it receives in response to the *Discussion Guide's* questions and it will undertake an extensive consultation process seeking further comments, analysis, ideas and opinions. It will also review the scopes of practice of a number of professions whose work fundamentally demands interprofessional relationships to ensure that they have adequate authority and flexibility to meet multidisciplinary obligations.

The purpose of the reviews will be to identify and propose mechanisms to eliminate the barriers to each profession and to professionals in working to their maximum scope in an interdisciplinary environment. This work will be in addition to reviewing the specific, and sometimes problematic, matters relating to those professions who share similar scopes of practice and controlled acts, but do not share either a commitment to the joint development of standards of practice or a common perception of the public interest.

HPRAC's research and consultation findings will form the basis of its advice and recommendations to the Minister in its final report.

4.1 Research and Preliminary Consultations

HPRAC identified six questions as its starting point for consideration:

1. What are the health colleges in Ontario doing to promote interprofessional collaboration?

2. What are the barriers to interprofessional collaboration?
3. How can the barriers be addressed?
4. What do the health Colleges need or want to satisfy the new objects of interprofessional collaboration under the *Health System Improvements Act, 2007*?
5. How can rule-making contribute to interprofessional collaboration?
6. What new requirements are needed to meet interprofessional collaboration goals?

To answer these questions, HPRAC undertook four major information-gathering and analysis activities:

- conducting preliminary consultations with Ontario health care professionals, health provider associations, and representatives from the health Colleges,
- conducting a literature review,
- conducting a jurisdictional review, and
- developing and issuing a *Discussion Guide* inviting submissions from interested organizations and individuals.

The October 2007 Workshops

In preparing its advice, HPRAC seeks knowledgeable information and comment from individuals, the community and special-interest organizations, interest groups, health professional regulatory colleges and associations, and health care facilities and providers. This approach continues with HPRAC's work on interprofessional collaboration.

HPRAC invited health care leaders representing health care professional and health provider associations in Ontario to attend a workshop on October 17, 2007, and representatives from the health colleges, including health professionals, public appointees to health college councils, and health college staff to attend a workshop on October 18, 2007. The format at both workshops included presentations by HPRAC and small and large group discussions with the participants on the above six questions.

The Literature Review

The research objectives of HPRAC's literature review were to:

- identify legislative, regulatory, policy, structural and organizational issues that relate to facilitating and supporting health colleges and their members in advancing interprofessional collaboration, and
- locate studies on regulation and interprofessional collaboration and determine possible linkages or correlations with improvements in patient care.

HPRAC's literature review reflected a wide range of sources: articles from government websites, research institutes and health policy think tanks. In addition, legal, business and industrial search tools found sources from Canada, other Commonwealth countries, the United States, Britain and European Union countries. The complete literature review, including the methodology and citations, is available on HPRAC's website (www.hrpac.org).

The Jurisdictional Review

HPRAC examined 11 jurisdictions (including Ontario) to learn about the mechanisms adopted to enhance interprofessional collaboration. Included in this review were the provinces of Alberta, British Columbia and Quebec; Victoria, Australia; New Zealand; Denmark; Britain and the American states of Nebraska, Virginia and Washington.

HPRAC examined each jurisdiction’s legislative and regulatory framework and identified government policies, strategies and key legislative and regulatory mechanisms. The complete jurisdictional review, including the methodology and sources, is available on HPRAC’s website (www.hprac.org).

Discussion Guide

The knowledge and information that it gained from the preliminary consultations and the literature and jurisdictional reviews enabled HPRAC to consider:

- the challenges health Colleges have faced in their collaborative endeavours,
- the steps taken in other jurisdictions, and
- possible mechanisms for a “made-in-Ontario” solution to advance collaboration among the health colleges.

This provided the basis for HPRAC to develop a *Discussion Guide*. The *Guide* invites interested organizations and individuals to offer their knowledgeable advice for enhancing collaboration among Ontario’s health professions, their regulators and their members to advance safe and effective patient care. It summarizes the background and context for the Minister’s request, and the findings of HPRAC’s research and consultation during the first phase of its work.

Defining Interprofessional Care and Interprofessional Collaboration

While there are many definitions for “interprofessional care”, particularly as it relates to the concept of multidisciplinary collaboration at the clinical level, HPRAC’s literature review did not find any definitions for interprofessional collaboration at the regulatory (college) level.

To focus its response to the Minister’s request, HPRAC has adopted HealthForceOntario’s definition for “interprofessional care”:⁸

Interprofessional care is the provision of comprehensive health services to patients by multiple health caregivers who work collaboratively to deliver quality care within and across settings.

⁸ Ibid, p. 44.

To provide a context for its work, HPRAC has developed a statement on interprofessional collaboration to convey its interpretation of what the Minister’s question portends. The Council’s view is that any initiatives should be directed to finding ways to:

Assist health regulatory colleges and their members to work collaboratively, rather than competitively, and to learn from and about each other through a process of mutual respect and shared knowledge to:

- improve patient care and facilitate better results for patients,
- protect the public interest and ensure the highest standards of professional conduct and patient safety,
- regulate the health professions in a manner that maximizes collective resources effectively and efficiently, while protecting the public interest,
- optimize the skills and competencies of diverse health care professionals to enhance access to high quality and safe services,
- ensure access to high quality and safe services no matter which health profession is responsible for delivering care or treatment, and
- enhance scopes of practice to ensure that all regulated health professionals work to their maximum competence and capability.

Strengthening collaboration between and among the health Colleges should be grounded in a series of underlying principles, specifically:

- the responsibility to meet the public’s expectations for improved access to high quality, safe services and patient-centred care,
- optimizing the contribution of all health professionals, and
- maintaining self-regulation.

The *Discussion Guide* asks 43 related questions, covering four topics:

- defining interprofessional collaboration,
- eliminating the barriers to collaboration among the health colleges,
- facilitating collaboration among the health colleges, and
- enhancing interprofessional care at the clinical level.

Defining Interprofessional Collaboration

In this section of the *Guide*, HPRAC has asked for feedback on the above statement elaborating on interprofessional collaboration.

Principles for Strengthening Interprofessional Collaboration:

- ***The responsibility to meet the public’s expectations for improved access to high quality, safe services and patient-centred care,***
- ***Optimizing the contribution of all health professionals, and***
- ***Maintaining self-regulation.***

Eliminating the Barriers to Collaboration among the Health Colleges

The questions on this topic focus on identifying:

- legislative, regulatory, policy and system barriers to collaboration,
- professional, cultural barriers to collaboration and liability issues, and
- possible methods to eliminate these barriers or issues.

Facilitating Collaboration among the Health Colleges

These questions focus on the potential for:

- legislative or regulatory changes,
- collaborative policy or program initiatives to support new health colleges,
- sharing administrative responsibilities between health colleges,
- alternative approaches for addressing complaints, investigations or disciplinary matters arising in an interprofessional care setting,
- alternative approaches to quality assurance activities,
- structural and organizational options to facilitate and support collaboration among the health colleges,
- Minister-directed collaborative initiatives,
- college-wide, consistent guidelines, standards and policies,
- a collaboration toolkit, and
- structural and procedural changes.

Interprofessional Care at the Clinical Level

The questions on this topic focus on:

- the potential for enhanced interprofessional care at the clinical level due to greater collaboration among health colleges,
- identifying any changes to the *RHPA*, the health profession acts or their regulations that are necessary to support interprofessional care at the clinical level, and
- possible policy or legislative initiatives to guarantee patients collaborative, coordinated care.

In the *Discussion Guide*, HPRAC stresses that it wants to know not only the ideal but also what is workable, and how any legislative or regulatory initiatives will advance safe and effective patient care.

The speed of change, [the] volume of work arising from the change process makes it impossible for Colleges to “keep up” and requires new ways of doing business. Professional groups need to collaborate in addressing some of these issues. It is time to look at implementing some form of ‘rolling incorporation’ process.

- October 2007 workshop participant

5. What HPRAC Learned and Heard

5.1 What People Told HPRAC

At the October workshops, participants confirmed that there is growing interest among health care associations, health Colleges, health professionals and other providers in advancing interprofessional collaboration. Current clinical, teaching, research and policy setting activities demonstrating this are:

There is a strong desire for and commitment to promoting more collaboration among professions.

- October 2007 workshop participants

- Strategic planning sessions and documents support the philosophy of interprofessional collaboration,
- Some health colleges identify “collaboration” as a core competency,
- Some professions seek to share standards or solicit comments from other professions when establishing revised and new standards,
- There is interest in the development of templates or tools that regulators could use to facilitate collaboration,
- A guideline to delegation and medical directives has been developed,
- There are a few cross-appointments and cross-college representation on professional committees,
- Interprofessional teams in clinical settings, including hospitals, Community Health Centres, Family Health Teams and long-term care settings are expanding,
- In some team-based settings, there may be sharing of electronic health records between professionals,
- There is renewed focus on interprofessional education and training at universities and colleges, including changes in curriculum content and research on interprofessional education, and
- Interprofessional collaboration conferences and think tanks are increasingly involving numerous participants.

Barriers to Interprofessional Collaboration

The workshop participants said:

- Professionals and health colleges are often not aware of, do not understand each other’s roles or are reluctant to acknowledge each other’s competencies and scopes of practice. This is a key barrier to making changes that would support interprofessional care.
- There is insufficient or inadequate terminology for talking about interprofessional collaboration (e.g., What is collaborative care? What is interprofessional collaboration? What makes collaboration successful?). This results in ambiguity.
- Different standards for shared or similar controlled acts can be barriers. There are often different interpretations and different standards of practice among professions whose members perform the same or similar controlled acts. This has the potential to

create competition and turf protection issues among professions that are often difficult to resolve, and raise concerns about the quality of care provided.

- There is a lack of time, resources, guidance and support to move forward with interprofessional collaboration models; a lack of collaboration guidelines; and a lack of guidance and support in interprofessional team development.
- Different remuneration methods and incentives lead to turf protection and power imbalances at the clinical level.
- Regulatory challenges, including the regulation approval process, delays in approvals, and rigid, limiting standards inhibit change.
- Health colleges duplicate regulations that have the same intent, instead of sharing them.
- Organizational and government policies and structures often reinforce silos.

What is frustrating is the big black hole within the Ministry relating to regulation/rule making. The “75 day rule” used by the OSC is, therefore, attractive and could be very useful for regulated health professional groups.

- October 2007 workshop participant

Addressing the Barriers

The workshop participants identified possible ways to address some of these barriers. HPRAC grouped the participants’ suggestions into the following five categories: clinical, education and teaching, research and policy, legislative and regulatory issues, and structural.

Clinical

- Revisit and revise professional scopes of practice as necessary,
- Clarify overlapping scopes of practice and shared controlled acts,
- Recognize that clinical practice and standards are evolutionary, and
- Change funding models that conflict with interprofessional collaboration.

Education is necessary at the foundation levels to include major changes to the current programs. However there must be an incentive for the programs to change.

- October 2007 workshop participant

Education and Teaching

- Address the practice of silos and segregation in educating health professionals,
- Provide more education opportunities across professions to promote interprofessional collaboration,
- Establish mentoring programs,
- Learn from and build on successful interprofessional education models,
- Improve the integration of interprofessional collaboration into educational and training programs, and
- Strengthen collaboration between the Ministry of Health and Long-Term Care and the Ministry of Training, Colleges and Universities.

Research and Policy

- Clarify the definition of interprofessional collaboration and controlled acts,
- Learn from and apply what other professions and/or jurisdictions have done to advance interprofessional collaboration,
- Create common resource repositories, and
- Review practices that are common to all health Colleges to understand the similarities.

Legislative and Regulatory Issues

- Address issues arising from conflicting legislation and regulations, such as inconsistencies in matters that are common to the various professions such as codes of ethics, quality assurance, business practices and similar issues,
- Clarify the distinction among bylaws, regulations, rules, guidelines and standards,
- Confirm the degree of regulatory authority that individual health Colleges have to regulate and enforce the adoption of best practice standards,
- Promote joint quality assurance and quality improvement processes and continuing competency,
- Enhance opportunities for joint investigations when professionals from more than one health College are involved in a complaint or report,
- Address differences in standards on record-keeping, competencies, guidelines and expectations,
- Introduce and strengthen the conflict resolution process, and
- Revise the *Public Hospitals Act* to address barriers and amend other legislation where it is necessary to facilitate interprofessional collaboration.

Structural

- Clarify the level of support and accountability of existing structures, such as the Federation of Health Regulatory Colleges of Ontario,
- Enhance formal and informal communication among health colleges and professions,
- Use current professions and their role in meeting population needs as leverage to make changes,
- Amend existing laws and regulations so they can apply to multidisciplinary teams,
- Adopt the electronic health record as a mechanism for change, and
- Move toward binding arbitration by addressing long-standing turf issues.

Workshop participants said that identifying and responding to some of the barriers in the current system is a key starting point for improving the status quo.

5.2 What Others Are Saying and Doing About Interprofessional Collaboration

HPRAC's literature and jurisdictional reviews confirm that the issues related to interprofessional collaboration are not unique to Ontario.

Literature Review Summary

The literature review found a renewed interest in interprofessional collaboration and interprofessional care models, variations in the terminology for describing interprofessional

care, a growing body of research related to interprofessional care and a need for strategic change to facilitate interprofessional collaboration. The key findings are:

- Growing interest in interprofessional collaboration and interprofessional care models.
- The theme of interprofessional collaboration has emerged in a number of contexts. Many recent reports recommend a greater focus on interprofessional collaboration in education, research, clinical practice, legislation and regulation.
- Many patients, caregivers, health professionals, and decision-makers are ready to adopt collaborative health care. However, current policies often present barriers that get in the way of achieving team-based health care. These barriers include inconsistent government policies and approaches, limited health human resource planning, regulatory and legislative frameworks that create silos, and funding and remuneration models that discourage collaboration.
- New questions about managing professional boundaries, especially the relationship of professional care providers with one another and among those responsible for regulating health professionals.

Locally, nationally and internationally, there is:

- ***growing interest in interprofessional collaboration and interprofessional care models,***
 - ***varied terminology for describing interprofessional care,***
 - ***a growing body of research, and***
 - ***agreement that strategic changes are necessary to facilitate interprofessional collaboration.***
- HPRAC Literature Review

Variations in the Terminology for Describing Interprofessional Care

- Words used to describe interprofessional care include: “collaborative care”, “collaborative practice”, “interdisciplinary care”, “interprofessional care”, “multidisciplinary care”, “team” and “teamwork.”
- HPRAC found no definitions for interprofessional collaboration in the regulatory context.

A Growing Body of Research on Interprofessional Care

- Much of the literature describes past and current experiences with interprofessional care models and comments on their successes and barriers. Recent literature has started to look more closely at some of the current policy and system issues that have helped or hindered collaborative-based health care.

- There is a general sense that teamwork produces better patient outcomes. However, there are difficulties in demonstrating this relationship through research. Evidence nonetheless tends to support the value of interprofessional care models, increasing patient and provider satisfaction, and decreasing health care costs when employed in a variety of practice settings.
- There are a limited number of published studies on interdisciplinary collaborative care outcomes. However, the existing assessments show that clients and patients of interdisciplinary collaborative care have a significant level of satisfaction with the results of this type of care. Studies in various countries show positive results in the quality of life and care with a range of patient and client types. These include veterans with complex care needs, children with special needs, geriatric patients, users of mental health services and the general patient population.
- There is not much in the literature supporting the value of interprofessional education. This is especially true for published reports of pre-licensure interprofessional education. A body of knowledge that defines the frequency and nature of interprofessional experience must be created to ensure that health care professionals have the requisite knowledge, attitudes and skills to engage in collaborative practice.

***The EMRxtra Project:
Pharmacist and Physician
Collaboration***

***In a pilot project launched in August 2006, pharmacists in Sault Ste. Marie are the first in Canada to access lab test results, allergies and other vital data from consenting patients' electronic medical records. Working collaboratively with primary care physicians at the Group Health Centre, pharmacists are now able to fully collaborate with physicians and the rest of the provider team to resolve drug-related issues more effectively and efficiently for their patients. EMRxtra is supported by a \$2 million investment from Canada Health Infoway (CHI).
- Source: Canada Health Infoway (www.infoway-inforoute.ca)***

A Need for Strategic Change

- There is a need for mechanisms that will help regulators of various health professions to work together to build effective interprofessional collaborative arrangements within and across the health care continuum.
- Momentum for increased interprofessional collaboration requires supportive structures. This includes legislative, regulatory and legal frameworks. While momentum for change seems to be emerging in legislative and regulatory frameworks, some of the literature concludes that, overall, the current legislative and regulatory frameworks are still not sufficient to encourage interdisciplinary collaboration.
- At the system level, legislative and regulatory reforms need to keep up with changes and trends in the practice environment. Existing legislative and regulatory frameworks in Canada are inconsistent in the way they define the scopes of practice

of the health professions. Barriers that prevent practitioners from functioning to their full scope of practice mean that health human resources are not being fully utilized.

- Further legislative and regulatory action is required to encourage interdisciplinary collaboration by, for example, recognizing the validity of collective practice, clearly setting out and redefining scopes of practice, establishing accountability expectations for teams, and permitting collaboration agreements among members of different professions that clearly define roles, responsibilities and relationships.
- Collaborative care has not traditionally been a main objective of legislation and regulation. Current legislation and regulation do not prohibit collaborative practice, nor do they encourage, require, facilitate or enable collaborative practice. Legislation and regulations should be updated and amended to expressly support collaboration.
- In Canada, legislation and regulations lack consistency and clarity concerning collaboration. When these flaws exist, regulators and health care professionals tend to err on the side of caution. Therefore, legislators and regulators must be clear and consistent in emphasizing the importance of collaboration.
- Regulators have an important role to play in supporting collaborative practice by developing partnerships between themselves and educators, government and the public. Encouraging regulators to work together in the areas of quality assurance, complaints and discipline would signal the importance of collaboration to health professionals.

In Canada, legislation and regulations lack consistency and clarity concerning collaboration. When these flaws exist, regulators and health care professionals tend to err on the side of caution. Therefore, legislators and regulators must be clear and consistent in emphasizing the importance of collaboration.
- HPRAC Literature Review

Jurisdictional Review Summary

In its review of eleven selected jurisdictions, HPRAC found:

- legislative reforms that focus on facilitating the ability of health care practitioners to collaborate with one another (the provinces of Alberta, British Columbia, and Quebec; Victoria, Australia and New Zealand),
- specific frameworks dedicated to enhancing collaboration among health professions regulators (Quebec, Britain), and
- some common processes or systems for all health profession regulators for handling complaints, investigations, disciplinary processes and procedures (Quebec, Victoria, New Zealand, Denmark, Nebraska, Virginia and Washington).

Other key findings of the jurisdictional review were:

- There are some innovative and emerging approaches to interprofessional collaboration in other jurisdictions. However, collaboration among regulatory bodies

does not appear to be as well developed as interprofessional initiatives at the clinical and educational levels.

- Through legislative and regulatory reform, Alberta, British Columbia, New Zealand and Victoria (Australia) have created a legislative framework similar to that in Ontario.
- The most common initiative (present in seven of the jurisdictions) is the introduction of common complaints, investigations or disciplinary processes and procedures for all health regulators.
- Britain has taken significant steps towards modernizing the regulation of its health professions with the publication of a White Paper in 2007 on the regulation of health professionals. Among the White Paper's proposals is the consideration of areas for harmonizing regulatory practice and legislative provisions across regulatory bodies to ensure that each has the most up-to-date and comprehensive duties and powers.
- New Zealand's *Code of Health and Disability Services Consumers' Rights* explicitly guarantees every health care consumer the right to expect cooperation among providers to ensure quality and continuity of services – it is the only jurisdiction to do so.

5.3 Emerging Themes

The October workshops and the literature and jurisdictional reviews identified five key themes:

- A growing number and variety of interprofessional models of clinical care are emerging across the care continuum.
- More research on the benefits of interprofessional care to patient care is available.
- Commitment and progress in the development of interprofessional education, particularly at the post-graduate level, is apparent.
- A limited number of legislative and regulatory framework initiatives to support interprofessional collaboration, including the appropriate role for health regulatory bodies, have been recorded and evaluated.
- Some developments related to interprofessional collaboration in other Canadian jurisdictions and internationally, including in the United States, Britain, Denmark, Australia, New Zealand and parts of the European Union are useful.

An influential Canadian project also points to the value of a collaborative approach to health care, although it is more of a policy initiative than a strictly regulatory proposal. A strong argument for collaborative care, in the context of persons living with mental illness, has been set out by the Standing Senate Committee on Social Affairs, Science and Technology in its Final Report, titled *Out of the Shadows At Last: Transforming Mental Health, Mental Illness and Addiction Services in Canada*. In its proposal for a recovery-based, and community-based approach, it stresses the need for a model in which the individual is “situated within a complex set of social determinants of health” at the centre of a circle which is itself framed by various forms of mental health care, including friends and family, community groups and

services, and formal mental health care services.⁹ In short, it is patient-centred, both graphically and in the real world of the delivery of health care.

In section 5.6.3, “Promoting Collaborative Care”, *Out of the Shadows at Last*, it is stated that:

The Committee believes it is important to encourage implementation of collaborative care initiatives in the development of an integrated, community-based continuum of care. Collaborative care is the most promising strategy to improve both access to, and the quality of, treatment and services at the first-line level.¹⁰

It then cites a U.S. study reporting evidence of effectiveness of collaborative care projects:

For example, the evaluation of one model of collaborative care using non-physician mental health specialists shows that patients with depression treated with the collaborative care model in primary care settings experienced a significantly greater reduction in symptoms over a one-year period than did patients treated with usual primary care.¹¹

The report goes on to recommend two sources of future funding for collaborative care initiatives in the mental health field. It is possible that this model and these recommendations for the care of persons living with mental illness can be applied to other forms of health and illness, including complex conditions which require several forms of professional care at the same time.

6. Collaboration in Setting Standards of Practice

Possible mechanisms to achieve the fullest interprofessional collaboration in setting standards of practice can be seen to lie along a sliding scale, ranging from those that are most protective of the autonomy of the regulatory colleges through those that offer strong incentives, to those that are more directive, to those most restrictive of the freedom of professions to self-regulate. In the second phase of this review, HPRAC will explore those mechanisms in greater depth.

In *New Directions*, HPRAC recognized the importance of greater information-sharing and collaboration among health Colleges in setting standards of practice. More recently, HPRAC advised the Minister on the scope of practice of nurse practitioners, in which protocols and mechanisms for interprofessional involvement in setting standards of practice are highlighted as features of a flexible, dynamic approach to professional regulation.

⁹ Standing Senate Committee on Social Affairs, Science and Technology (May 2006). *Out of the Shadows At Last: Transforming Mental Health, Mental Illness and Addiction Services in Canada*, p. 53.

¹⁰ Ibid, p. 125.

¹¹ Ibid, p. 125, referencing Lehman, A., Goldman, H., Dixon, L., and Churchill, R. (June 2004) *Evidence-based mental health treatments and services: Examples to inform public policy*. Millbank Memorial Fund, p. 14.

Drawing on its earlier work and its interim findings related to interprofessional collaboration, HPRAC has noted the challenges that the new professions of traditional Chinese medicine and psychotherapy are encountering and has specific recommendations for interprofessional collaboration to assist them in their efforts. HPRAC also comments on the difficult relationship among the eye care professions in Ontario, where there has been a longstanding history of discord.

6.1 Traditional Chinese Medicine

Background

Traditional Chinese medicine (TCM) is a holistic system of health care that originated in China several thousand years ago. Therapies include acupuncture, herbal therapy, tuina (or Tui Na) massage, and therapeutic exercise. TCM views the body as a whole and addresses how illness manifests itself in a patient. It assesses the whole patient, not just the specific disease.

The road to regulation of traditional Chinese medicine and acupuncture has been a long one in Ontario. In 1984, the Health Professions Legislative Review recommended that acupuncture not be regulated, citing deficiencies in meeting regulatory criteria such as risk of harm, educational qualifications, likelihood of compliance and willingness of the profession to accept self-regulation.

In 1991, as part of the *RHPA*, procedures below the dermis were designated as controlled acts; the Regulations under the Act created an exemption for acupuncture. Members of a number of regulated professions, including dentists, physicians, naturopaths, chiropractors and physiotherapists practise acupuncture, often as an adjunct, or a complementary treatment, or as a tool in pain management.

In 1996, in the course of its work following a request for advice from the Minister on whether acupuncture should itself be a controlled act, HPRAC reported on evidence that there was a risk of both direct and indirect harm inherent in the practice, noting that there is a distinctly different approach to diagnosis in traditional Chinese and western medicine. HPRAC described the historical differences in the application of acupuncture by a range of professional practitioners who use the modality for patient care.

“Anatomical acupuncture” (is) a form of acupuncture based on an understanding of anatomy, the locations and uses of a relatively small number of classical acupuncture points and a western-based diagnosis.¹²

HPRAC compared this western approach to the concept of acupuncture used in traditional Chinese medicine, which

...is premised on the belief that ill health results when energy, or Qi, becomes unbalanced in the human body. Insertion of acupuncture needles is one way

¹² HPRAC (December 1996). *Advice to the Minister of Health: Acupuncture Referral*, p. 16.

to stimulate the flow of energy from surplus to deficit areas of the body and thereby restore health to the patient/client.¹³

In its subsequent April 2001 report to the Minister, HPRAC stated:

Acupuncture is currently practiced by a range of health care professions within their scope of practice usually as an adjunct to other forms of treatment. Acupuncture is also an integral part of the practice of TCM. It is difficult to define a body of acupuncture knowledge that is distinct from TCM theory when practiced in the context of TCM. Similarly in relation to an anatomical approach to acupuncture as practiced by a range of professions, it is difficult to define a body of knowledge sufficiently distinct from the body of knowledge associated with professions' scopes of practice.¹⁴

The Council also determined that:

Acupuncture should be considered a treatment modality and not a separate profession. This conclusion is in appreciation of the nature of the procedure of acupuncture, the absence of a distinct acupuncture body of knowledge separate from TCM or bio-medical theory, and the undesired implications of separating the regulation of acupuncture from the regulation of professions which provide acupuncture treatments as part of their scopes of practice.

Therefore, HPRAC recommended the inclusion of acupuncture in the meaning of the controlled act of performing a procedure on the tissue below the dermis and below the surface of a mucous membrane. The Council said that the professions of dentistry, medicine, naturopathy, nursing and traditional Chinese medicine should be authorized to perform acupuncture as a procedure below the dermis, and that these colleges should identify the specific acupuncture applications that are within the profession's scope of practice, the competencies required, and the appropriate educational standard needed to provide safe and effective acupuncture treatment.

HPRAC also said that other regulated professions seeking to perform acupuncture should request an expansion to their scope of practice, and indicate the specific acupuncture applications for the profession, the competencies required, and the educational standards that would be required for members in order to perform acupuncture as part of their practice.¹⁵

Following the HPRAC report, a government caucus committee, chaired by MPP Tony Wong, further investigated the regulation of traditional Chinese medicine and acupuncture. Subsequently, the *Traditional Chinese Medicine Act, 2006*, was passed by the Legislature, receiving Royal Assent in December 2006. It authorized members of this new profession to perform the controlled act of "performing a procedure on tissue below the dermis and below

¹³ Ibid, p. 13.

¹⁴ HPRAC (April 2001). *Advice to the Minister of Health and Long-Term Care: Traditional Chinese Medicine and Acupuncture*, Executive Summary.

¹⁵ Ibid, pp. 21-23.

the surface of a mucous membrane for the purpose of performing acupuncture.” This provision will come into force in 2009.

At the same time, Ontario Regulation 107/96 (Controlled Acts) under the *Regulated Health Professions Act, 1991* was amended by revoking the provisions allowing anyone to perform acupuncture. A revised regulation will allow acupuncture to be performed by a member of the College of Chiropractors of Ontario, the College of Chiropractors of Ontario, the College of Nurses of Ontario, the College of Occupational Therapists of Ontario, the College of Physiotherapists of Ontario, and the Royal College of Dental Surgeons of Ontario, in accordance with the standard of practice and within the scope of practice of the respective health profession. Individuals who are registered to practise under the *Drugless Practitioners Act, 1990* (naturopaths), and those who perform acupuncture as part of an addiction treatment program within a health facility, will also be permitted to perform the procedure.

The Wong committee report, the public hearings of the Legislature’s Standing Committee on Social Policy during consideration of *The Traditional Chinese Medicine Act, 2006*, and HPRAC’s workshops on collaboration in October 2007 provided opportunities for participation by practitioners who are likely to seek membership in the new health College under the *Traditional Chinese Medicine Act, 2006*. It was evident that many who practice acupuncture as an integral part of traditional Chinese medicine, and who are new to professional regulation, do not have a clear understanding of the concept of overlapping scopes of practice and shared controlled acts that is central to the *RHPA*. Many contend that acupuncture services must always be provided in accordance with the College of Traditional Chinese Medicine and Acupuncturists of Ontario’s standards, although such services are part of the scope of practice and have been provided safely by members of other regulated professions for decades.

During the Standing Committee hearings on the *Traditional Chinese Medicine Act*, the Minister wrote to the Committee Chair, indicating that he would seek further advice from HPRAC on these matters, including a recommendation on how best to facilitate collaboration in setting standards of practice among all of the professions who are authorized to perform acupuncture.

In reviewing the Minister’s recent request for advice, HPRAC is aware of the Council’s 2001 recommendations that health colleges whose members seek to perform acupuncture should identify:

- the specific applications that are within the profession’s scope of practice,
- the competencies required to perform the act, and
- the appropriate educational standard needed to provide safe and effective acupuncture treatment.

The Council is also aware of the fundamentally different historical approaches to this modality by western and traditional Chinese medicine practitioners. Nonetheless, HPRAC insists that the patient must have confidence in the safe application of the treatment, whether

the practitioner subscribes to western or TCM theory. Council notes that, no matter who provides the treatment:

- The fundamental action or procedure involved in acupuncture, whether rooted in TCM theory or anatomical theory, is the insertion of needles under the skin (dermis),
- There are risks of harm in the practice of acupuncture,
- There are some consistencies in the body of knowledge relied on by both western and TCM practitioners, and
- There are matters that need to be addressed by the new College of Traditional Chinese Medicine Practitioners and Acupuncturists of Ontario, and that should be addressed at the same time by existing health Colleges whose members practice acupuncture, including:
 - the development of prior-learning and competency assessments,
 - the elements of an educational program that should include training in anatomy, physiology and pathophysiology,
 - matters respecting ethical practice, conflict of interest, business, billing and advertising requirements, and rules for relationships with regulated or unregulated practitioners,
 - referral process and requirements,
 - continuing quality assurance and improvement, including practice assessments, and
 - evaluation of continuing competency.

Some Barriers to Collaboration

It is instructive to review the experience of HPRAC with questions concerning the regulation of acupuncture. From its first encounter with the issue in the 1990s, in meetings with stakeholders prior to its report in 2001, and in the hearings of the Standing Committee on Social Policy in 2006, HPRAC is conscious of many different and complex views of the matter, both within the TCM community and outside of it. Nevertheless, traditional Chinese medicine is now regulated as a profession, and the decision has been made, after many years of consideration, that acupuncture is one form of the controlled act of performing a procedure below the dermis and below the surface of a mucous membrane. As such, it is now enshrined in the law as a treatment modality. The authority to perform the act is shared by several professions. The barriers to collaboration between these professions are largely grounded in lack of knowledge and trust between the new and existing professions, and include:

- Lack of information and understanding of the “overlapping scope of practice” construct of the *RHPA* by those who are likely to become members of the new profession,
- Lack of experience among existing professions in co-developing standards of practice,
- A fear that collaboration will diminish self-regulation and professional autonomy,
- A strongly held view by some TCM practitioners that acupuncture cannot be separated from TCM, and must be based only on traditional theory - an ancient Taoist metaphysical philosophy, involving the concept of the basic bodily energy (Qi or

- ch'i), the meridians or pathways in which it travels, acupuncture points, Yin and Yang, the effort to achieve a balance of these, the five elements, and other matters,
- Lack of appreciation by western practitioners of the traditional theories of TCM acupuncture,
 - Fear that the legitimacy of both the TCM and the western approaches to acupuncture will be compromised or that one approach will be paramount,
 - Few, if any, credentialled educational and training programs featuring common course content, learning outcomes and competencies on which to base entry to practice requirements and scope of practice descriptions for both the TCM and western approaches,
 - No previous efforts leading to joint identification of matters common to both approaches, including common patient safety measures, infection control, referral protocols, record-keeping and similar issues, and
 - Uncertainty and dispute over the process of setting standards for the practice of acupuncture. Would the new college set the standards for all? If not, would each of the colleges whose members practice acupuncture set their own standards? Is it appropriate that there should be many different standards? Would the TCM College have any input in the standards of other colleges?

There are many distinct issues and different perspectives on those issues, some held with great force and conviction. Many of these must be addressed in the operation of the Transitional Council of the new College which will have the initial responsibility of developing entry to practice qualifications, and establishing the standards of practice for the profession.

Opportunities for Collaboration

The very newness of the College of Traditional Chinese Medicine Practitioners and Acupuncturists of Ontario provides singular opportunities, both for the new college and existing professions whose members practice acupuncture to work together to reach solutions that further the public interest.

To borrow from another field of thought - political philosophy - the democratic form of government can be derived from different theoretical sources; but what counts in practice is agreement on the merits of the democratic system itself.

By analogy, acupuncture can be grounded in two different medical philosophies, the Taoist metaphysics of TCM, or western neurological science. What counts is agreement in practice on outcomes, standards and safety. The legislation effectively settled this matter. There are, in fact, two forms of acupuncture regulated in Ontario. It is now time to move on to develop interprofessional mechanisms to set standards of education and practice for those who perform the procedure.

The emergence of the new profession provides an opportunity for existing colleges to review their own standards for acupuncture to be certain that they demand the highest level of safety and quality from their members who perform this controlled act. This does not need to be

done in isolation, one from the other; in fact, to build public trust and provide clarity, an interdisciplinary approach is the most satisfactory one.

It also provides an opportunity for the new TCM college to benefit from the experience of those who have been regulated for a much longer period of time, and to jointly identify those specific areas where mutual benefits can be achieved, whether in developing similar standards for business practices, referrals, record-keeping, conflict of interest, registration requirements, infection control or in other matters.

While there will be standards that can be applied to both forms of acupuncture, it should be clearly understood that there will be aspects in the practice of TCM acupuncture and in the practice of western acupuncture that will remain discrete and different because of decidedly different approaches to the modality. There should be respect for both, and neither approach should be subsumed by the other.

Options that HPRAC Considered

In formulating its advice to the Minister, HPRAC considered several options to assist in ensuring that patients who choose to be treated by an acupuncturist receive safe services, and that the professions work together to establish standards that best reflect their own competencies and professional obligations. They included:

- the establishment of an expert panel to make recommendations to the Minister on common standards of practice and professional practice guidelines for all acupuncture practitioners,
- a Ministerial directive requiring the various parties to undergo mediation leading to the establishment of common standards of practice and professional practice guidelines for all acupuncture practitioners, and
- a Ministerial directive requiring the various parties to participate in an arbitration where common standards of practice and professional practice guidelines for the practice of acupuncture would ultimately be imposed if agreement could not be reached.

While these options were considered, HPRAC rejected them since they rely on external determination of professional regulation. Rather, HPRAC is recommending an approach that is most consistent with the *RHPA*'s central principles of professional self-regulation and the obligation of regulated health professions to establish standards of high quality that are most appropriate to the profession. The recommendations also reflect the new mandate for colleges to:

- promote and enhance relations between the College and its members, other health profession Colleges, key stakeholders and the public,
- promote interprofessional collaboration with other health profession Colleges, and
- develop, establish and maintain standards and programs to promote the ability of members to respond to changes in practice environments, advances in technology and other emerging issues.

Recommendations

A template for interprofessional collaboration in acupuncture already exists, albeit initially conceived for a different issue and context. In *New Directions*, HPRAC recommended that the Council of the College of Psychotherapy should establish an interprofessional advisory committee to include representatives of health colleges whose members practise psychotherapy. It also recommended that the transitional Council of the new college include representatives nominated by the specific colleges whose members practise psychotherapy. HPRAC said that those health colleges, other than the College of Psychotherapy, should also establish high minimum qualifications and develop general standards for the practice of psychotherapy in their professions.

A variation on this approach is a practical solution to challenges in the regulation of individuals who practise acupuncture. In this way, the experience and expertise of existing health colleges whose members practise acupuncture can assist the new college as it establishes its practice standards, and initiate a pattern of interprofessional collaboration for the future. As well, those existing health colleges whose members practise acupuncture will be expected to prepare high minimum qualifications and standards to assure the safe practice of the modality within their own professions.

Section 13 (1) of the *Traditional Chinese Medicine Act, 2006* requires the Lieutenant Governor in Council to appoint a transitional Council for the College of Traditional Chinese Medicine Practitioners and Acupuncturists of Ontario. It does not stipulate the specific composition for the transitional Council nor any requirement to have interprofessional representation. HPRAC is convinced that collaboration among professions is pertinent when regulated professions share the same or similar controlled acts, and may apply different standards of practice for the performance of the same acts. It is particularly relevant when one profession is making the transition to self-regulation, and the experience of mature colleges respecting regulatory matters can be of benefit to the new regulator.

HPRAC recommends to the Minister:

- 1. That the Lieutenant Governor in Council appointments to the transitional Council of the College of Traditional Chinese Medicine Practitioners and Acupuncturists of Ontario include a total of three representatives selected from and recommended by the College of Chiropodists of Ontario, the College of Chiropractors of Ontario, the College of Nurses of Ontario, the College of Occupational Therapists of Ontario, the College of Physiotherapists of Ontario, the Board of Directors of Drugless Therapy (Naturopathy) and the Royal College of Dental Surgeons of Ontario.**

The Traditional Chinese Medicine Act, 2006 did not provide a mechanism to encourage interprofessional collaboration in the establishment of qualifications, the development of common standards of practice, or the identification of a core body of common knowledge for the professions that share overlapping scopes of practice and the controlled act of performing a procedure on tissue below the dermis for the purpose of performing acupuncture.

The continuing involvement of members of the existing health Colleges with the new College of Traditional Chinese Medicine Practitioners and Acupuncturists of Ontario could enhance interprofessional collaboration among the various regulators while respecting the principles of professional self-regulation. Existing health colleges will have similar responsibilities with respect to the regulation of acupuncture as those of the new college. The Councils of all the colleges could benefit from the expert advice of an advisory committee. Regrettably, HPRAC is not confident that, in the absence of an explicit Ministerial direction, voluntary initiatives would proceed satisfactorily.

HPRAC recommends to the Minister:

2. **That the Minister direct the College of Chiropractors of Ontario, the College of Chiropractors of Ontario, the College of Nurses of Ontario, the College of Occupational Therapists of Ontario, the College of Physiotherapists of Ontario, the College of Traditional Chinese Medicine Practitioners and Acupuncturists of Ontario, the Board of Directors of Drugless Therapy (Naturopathy) and the Royal College of Dental Surgeons of Ontario to establish a continuing interprofessional Advisory Committee on Acupuncture, the mandate of which is to provide advice to the Colleges, and to promote the development, either jointly or individually of:**
 - a) **High minimum qualifications for the practice of acupuncture;**
 - b) **General standards of practice for acupuncture;**
 - c) **Quality assurance and continuing competence programs for acupuncture;**
 - d) **Educational qualifications and equivalency standards for members to practise acupuncture; and**
 - e) **Any other matter relevant to the practice of acupuncture.**

6.2 Psychotherapy

Background

In February 2005, HPRAC received a request from the Minister in which he asked for advice on:

whether psychotherapy should be an additional controlled act under the *Regulated Health Professions Act, 1991 (RHPA)*, and if so, which regulated professions should have psychotherapy in their scopes of practice and how standards should be set and measured; and whether psychotherapists should be regulated under the *RHPA* as a profession, what their scope of practice should be and what controlled acts they should be authorized to perform, as well as any protected titles, and whether it is appropriate that psychotherapists be regulated under an existing profession-specific act.¹⁶

¹⁶ HPRAC (April 2006). Op. cit., Appendix A.

In response to the Minister's request, HPRAC undertook a multi-stage consultation process to seek the views of interested organizations and individuals, and examine issues related to the possible regulation of psychotherapy. The findings and conclusions of the consultations were presented in *New Directions*¹⁷.

HPRAC's central response was that psychotherapists and psychotherapy should be regulated in Ontario under the *Regulated Health Professions Act, 1991*, with a new profession-specific statute, the *Psychotherapy Act*. Those health colleges whose members practice psychotherapy should develop standards of practice for their members comparable to those required of members in the new College of Psychotherapy.¹⁸

HPRAC also recommended that the Transitional Council for the new college include members of other professions that are authorized to practise psychotherapy, and that the College Council, when established, should have an advisory committee including representatives of other professions whose members practise psychotherapy. These recommendations were based on the view that existing colleges have regulatory expertise to contribute to the development of the new college, and would also be tasked with developing standards for the practice of psychotherapy within their own professions. The collaborative work that ensued, HPRAC argued, would lead to enhanced protection of the public interest.

The Minister proceeded with some of HPRAC's recommendations concerning the regulation of psychotherapy; specifically, the establishment of the *Psychotherapy Act, 2007* that regulates psychotherapy and psychotherapists under the *RHPA* and establishes a new College of Psychotherapists and Registered Mental Health Therapists of Ontario.

Sections 1, 2 and 12 of the Act are now in effect. Respectively, they establish the name of the new College, make the Health Professions Procedural Code part of the Act and provide for the appointment of a transitional Council. The Act also restricts the use of the title "psychotherapist" or "registered mental health therapist" to members of the new health college.

The *Psychotherapy Act* authorized the new controlled act of the practice of psychotherapy to members of the College, and amendments to the *RHPA* allowed members of the College of Psychologists of Ontario, the College of Occupational Therapists of Ontario, the College of Physicians and Surgeons of Ontario, and the College of Nurses of Ontario to practice psychotherapy. The amendment to the *RHPA* also included an exception to the Act, authorizing a member of the Ontario College of Social Workers and Social Service Workers to perform the controlled act in compliance with the *Social Work and Social Service Work Act, 1998* its regulations and by-laws.

The Opportunity to Advance Interprofessional Collaboration

The Minister did not proceed with HPRAC's recommendations concerning a new Advisory Committee to the new College, the composition of its transitional Council, title protection

¹⁷ Ibid, pp. 206 to 228.

¹⁸ Ibid, p. 206.

and the establishment of high minimum qualifications and standards by the existing health Colleges that have psychotherapy within their scope of practice.

HPRAC has reviewed its recommendations on these matters in the context of its current work on interprofessional collaboration. It has reached the conclusion that its earlier recommendations support collaboration among the health colleges and further the public interest.

Transitional Council Composition and Activities to Support Interprofessional Collaboration

The *Psychotherapy Act, 2007* provides for the appointment of a transitional Council by the Lieutenant Governor in Council. To support interprofessional collaboration among the health Colleges that share the controlled act, HPRAC previously recommended that the transitional Council include representation from existing health colleges whose members practice psychotherapy. This recommendation was based on its conclusions that the existing colleges have regulatory expertise to contribute to the transition of the new college as it is established, particularly in the development of professional standards.

Representatives of these colleges would have similar responsibilities with respect to the practice of psychotherapy in their own professions, including the development of psychotherapy qualifications and standards for their respective colleges. Their participation on the transitional Council would ensure their involvement in and support for ongoing cooperation in the development of qualifications and general standards for the practice of psychotherapy. It would also avoid duplication and ensure consistency among all the health colleges that have the controlled act of psychotherapy in their scope of practice. These appointments to the transitional Council would terminate when the new College is officially established; however, it was anticipated that the colleges would continue to work together through an Advisory Committee, once the permanent council was in place.

Title Restriction and Representation

In *New Directions*, HPRAC concluded that the competency and capacity of members of several professions who practice psychotherapy should be apparent to the public, who should be able to recognize qualified practitioners by a restricted title. Title restriction protects the public interest by providing patients with a clear way to identify whether a practitioner has the educational and other qualifications to practice under the purview of an appropriate regulatory body. Given the wide use and acceptance of the title “psychotherapist” by practitioners, other health care professionals, patients, clients and members of the public, HPRAC recommended in *New Directions* that “psychotherapist” be the protected title and this is reflected in the *Psychotherapy Act, 2007*.

Section 8(1) of the Act restricts the use of the title, “psychotherapist” to members of the College of Psychotherapists and Registered Mental Health Therapists of Ontario. Section 8(2) states, “No person other than a member (of the College) shall hold himself or herself out as a person who is qualified to practise in Ontario as a psychotherapist or a registered mental health therapist.” These sections of the Act have an unintended negative consequence.

Members of the College of Psychotherapists and Registered Mental Health Therapists of Ontario, the College of Physicians and Surgeons of Ontario, the College of Occupational Therapists of Ontario, the College of Psychologists of Ontario, the Ontario College of Social Workers and Social Service Workers and the College of Nurses of Ontario share the controlled act of psychotherapy. Collaboration among these health Colleges is essential. In practice, many members of these various colleges work together in providing mental health services to patients. However, given the *Psychotherapy Act, 2007*'s restrictions on the use of the title “psychotherapist” to members of the new health College, no other person who is authorized to practice psychotherapy can be called a psychotherapist or call him or herself a psychotherapist. This will create confusion among the public regarding the qualifications and experience of those who are authorized to perform the controlled act, and among those who work in the profession.

HPRAC recommends that, just as the controlled act is shared, the title of “psychotherapist” should also be shared by professions.

Recommendations

HPRAC recommends to the Minister:

- 3. That the transitional Council of the College of Psychotherapists and Registered Mental Health Therapists of Ontario should include persons who are nominated jointly by the College of Psychologists of Ontario, the College of Physicians and Surgeons of Ontario, the College of Occupational Therapists of Ontario, the College of Social Workers and Social Service Workers, and the College of Nurses of Ontario.**
- 4. That the use of the title “psychotherapist” should be restricted to members of the College of Psychotherapists and Registered Mental Health Therapists of Ontario, the College of Psychologists of Ontario, the College of Physicians and Surgeons of Ontario, the College of Occupational Therapists of Ontario, the College of Social Workers and Social Service Workers, and the College of Nurses of Ontario who have the controlled act of psychotherapy within the scope of their practice.**
- 5. That a person who is not a member of the College of Psychotherapists and Registered Mental Health Therapists of Ontario, a member of the College of Psychologists of Ontario, the College of Physicians and Surgeons of Ontario, the College of Occupational Therapists of Ontario, the Ontario College of Social Workers and Social Service Workers or the College of Nurses of Ontario who practices psychotherapy should not hold himself or herself out as a person who is qualified to practice psychotherapy in Ontario.**

6.3 Eye Care Professions

In Ontario, eye care services are provided by members of three regulated health colleges: the College of Physicians and Surgeons of Ontario, the College of Opticians of Ontario, and the

College of Optometrists of Ontario. These professions have overlapping scopes of practice, and share certain authorities to provide services. For example, opticians and optometrists have the right to dispense eyewear; only optometrists and physicians can conduct complete vision tests and prescribe eyewear.

In *New Directions*, in the context of its discussion respecting refractometry by opticians, HPRAC recommended that there be collaboration among professionals in the field of eye care: optometrists, opticians, and physicians, who are more frequently specialists in ophthalmology. In its 2006 report, HPRAC noted that barriers existed to such collaboration, but was optimistic that there would be changes that could reduce those barriers:

Current conflict of interest regulations that disallow optometrists from associating with opticians must be addressed to facilitate this collaboration. The College of Optometrists is in the process of preparing a revised regulation to reduce these barriers between the professions, and is expected to forward it to the Minister for review following completion of a consultative process and Council scrutiny. A new regulation should take into account the ability of opticians to perform refractions as part of a complete eye examination performed by an optometrist.¹⁹

In 2008, disappointingly, the barriers not only persist, but have increased. While representatives of other colleges have categorized the disputes as “destructive”, or have remarked that “interprofessional *non*-collaboration” is the hallmark of the relationship between two colleges whose members provide eye care, HPRAC is deeply concerned as to the degree to which either college is seeking to safeguard the public interest.

Optometry

The College of Optometry’s Conflict of Interest regulations are found in RRO 1990, Reg 550 of the *Drug and Pharmacies Regulation Act*. The current regulation states that conflicts of interest exist when optometrists:

engage in the practice of optometry where any of the public entrances or exits of the member's premises are within the premises of a retail merchant, optical company or ophthalmic dispenser or interconnecting therewith²⁰.

This has led to a situation over the years, whereby patients, if they choose not to have the optometrist fill the prescription or if the optometrist chooses not to dispense eyewear, must leave the optometrist’s premises, eyewear prescription in hand, and enter through a separate door, the premises of an optician who will fill the prescription.

HPRAC has reviewed the College of Optometrists’ proposed new regulation which was submitted to the Minister of Health and Long-Term Care in June 2007. It no longer deems it a conflict of interest for a member to engage in the practice of optometry where any of the public entrances or exits of the members’ premises are within or connect with, the premises of a retail merchant, optical company or ophthalmic dispenser (optician). However, the

¹⁹ Ibid, p.291.

²⁰ *Drug and Pharmacies Regulation Act* - R.R.O. 1990, Reg. 550 s. 26. (4) (c).

proposed regulation still classifies it as a conflict of interest to practice optometry, with some exceptions, in any kind of association with certain other persons or corporations. The exceptions do not apparently include opticians, other than in certain specific circumstances that are difficult to define.²¹

The regulation also provides that:

- (3) Clause 3(2)(d) shall not apply to a member or an optometry professional corporation where a reasonable person knowing the relevant facts would conclude that the member or an optometry professional corporation was engaging in the practice of optometry as an independent contractor.

Thus, it seems that if an optometrist were to be recognized as an independent contractor, and not as an employee of an eye care company, he or she could associate as such with an optician. This looks promising, but the new regulation imposes restrictions on the association of an optometrist with other regulated professionals.

Moreover, it does not address the situation of the optometrist who is an employee of a company offering multi-professional, integrated eye care services with an interdisciplinary approach to patient care.

In the meantime, under the current regulation that is still in force, a member of the College can face disciplinary action by the College for failure to abide by the existing conflict of interest provisions, at risk of suspension or cancellation of registration with the College.

Although the original intent of the conflict of interest provisions might have been to resist pressure of a financial nature on the practitioner, they are also being viewed as an attempt to reimpose a monopoly and to limit competition.

The federal Competition Bureau recently notes that in view of the complementarities between the activities of the two professions of opticianry and optometry, it would be “natural for members of both professions to work under the same roof”, likely resulting in greater efficiency and lower costs for consumers. The present restrictions are forcing optometrists into the same business model, making it less likely that meaningful competition will develop. Its recent recommendation in this regard is that the:

Colleges of Optometry should remove restrictions that prohibit or discourage optometrists from working in multidisciplinary arrangements with opticians²².

²¹ College of Optometrists of Ontario, *Proposed Conflict of Interest Regulation* (Available at www.collegeoptom.on.ca).

²² Competition Bureau (2007). *Self-regulated professions: Balancing competition and regulation*, pp.96-97.

Opticianry

In February 2001, the Minister of Health (Ms. Elizabeth Witmer) directed the College of Opticians to require its members who had been performing refractions, to stop doing so, citing concerns about safety.

In *New Directions*, at the request of the Minister, HPRAC examined whether refractometry, or automated sight testing, is within the scope of practice of opticianry. After examining this question, HPRAC concluded:

The Advisory Council concludes that qualified opticians should be permitted to perform refractometry only for the purpose of informing a comprehensive ocular assessment and in conjunction with members of other professions who are authorized to prescribe eye wear, including an optometrist or a physician. Members of the College of Opticians should not be authorized to dispense eye wear solely on the basis of a refraction test.

In other words, performing refractions by opticians must be done only in a collaborative context; it cannot lead to prescription or dispensing solely on the basis of a refraction test²³.

HPRAC further recommended that, with respect to eye care services:

That the College of Opticians of Ontario, the College of Optometrists of Ontario and the College of Physicians and Surgeons of Ontario collaborate on standards of practice and guidelines for members of their respective professions²⁴.

A standard of practice respecting refractions was developed by the College of Opticians and approved September 25, 2007. HPRAC is uncertain whether other pertinent stakeholders were involved in the process, or whether it was done unilaterally. The standard states that an optician may only perform refractions based on a clearance from an authorized prescriber, presumably a physician or an optometrist. The clearance may take three forms, all requiring the patient to have had a full eye examination within 365 days: the prescriber has issued a prescription; or has determined that the health of a patient meets certain predetermined health standards; or a referral is made, the refraction is performed, followed by a prescription from the authorized prescriber.²⁵

Members of the voluntary advocacy organization, the Ontario Opticians Association, while welcoming what they perceive to be overdue action on the part of the College, nevertheless have voiced the opinion in their newsletter that the standard does not go far enough, have

²³ HPRAC (April 2006). Op. cit., p. 290.

²⁴ Ibid, p. 292.

²⁵ College of Opticians of Ontario (October 2007). *Standard of Practice: Refraction* (available at www.copton.org).

sharply criticized the 365 day requirement as “ridiculous” and have found the three forms of clearance confusing.²⁶

Despite the action of the College, the Minister’s Directive of February 2001 to the College requiring opticians not to conduct refractions remains in effect.

It appears then, that there are two issues over which opticians have concerns. One is the continuing effective exclusion of opticians from associating with optometrists, which, it is reported, has led to some members resigning from their College in order to continue to work with other eye care professionals or to avoid exposing those partners to disciplinary action by the College of Optometrists. The other, for some at least, is the necessity of receiving prescriptions or permission for refractions from other professionals, including the very optometrists with whom they are forbidden to associate.

These controversies do not bode well for constructive collaboration; it discourages it.

HPRAC’s Next Steps

HPRAC has not engaged in a formal consultative process on matters relating to eye care professionals, and until that occurs, will not make recommendations to the Minister. It intends to engage the Colleges of Optometry, Opticians and Physicians and Surgeons in a dialogue in the spring of 2008, as part of phase two of its review of interprofessional collaboration. HPRAC’s recommendations to the Minister will follow that consultation.

²⁶ Ontario Opticians Association (February 2008). *Focus*, p. 2.

7. Conclusions

HPRAC is strongly committed to the further development of interprofessional collaboration among the health professions in Ontario. This includes collaboration between the regulatory colleges themselves, between the professions generally, and between individual professionals in clinical practice.

- The review of the principles grounding the regulation of the health professions, namely the public interest, which translates in practice to protecting individual patients from harm and advancing the quality of their care, indicates a strong case for interprofessional collaboration between health regulatory colleges, between the professions themselves, and between individual practitioners. As individuals benefit, so the greater good of society in Ontario will benefit from having a health care system that is more patient-centred and collaborative in nature.
- The Literature and Jurisdictional Reviews provide empirical evidence that there is a trend toward such collaboration in many jurisdictions, and that there are successful efforts and programs in place elsewhere to achieve this. The public interest in Ontario can be advanced by learning from such developments, and implementing them.
- There are already such initiatives in place in Ontario, and interprofessional care of high quality is provided in many institutions and through a number of delivery systems. These can be held out as examples of best practices or models.
- Scope of practice reviews, most particularly for those professions who deal directly with patients and whose work fundamentally demands interprofessional relationships are needed so that professionals can work to their fullest competence without undue or inappropriate constraints. Existing professions can take on new or altered roles in a collaborative environment when barriers are removed.
- The best results for patients, and efficiency in the health system, are the product of professionals who work to the fullest range of their scopes of practice.
- The time has come to maintain and develop the direction further. To fail in this is to fail to promote the public interest. Ontario, having brought into being an exemplary system of health professional regulation, must not lag behind other jurisdictions in the effort to initiate, maintain, and improve interprofessional collaboration in health care.

8. Summary of Recommendations

Acupuncture

HPRAC recommends to the Minister:

- 1. That the Lieutenant Governor in Council appointments to the transitional Council of the College of Traditional Chinese Medicine Practitioners and Acupuncturists of Ontario include a total of three representatives selected from and recommended by the College of Chiropodists of Ontario, the College of Chiropractors of Ontario, the College of Nurses of Ontario, the College of Occupational Therapists of Ontario, the College of Physiotherapists of Ontario, the Board of Directors of Drugless Therapy (Naturopathy) and the Royal College of Dental Surgeons of Ontario.**
- 2. That the Minister direct the College of Chiropodists of Ontario, the College of Chiropractors of Ontario, the College of Nurses of Ontario, the College of Occupational Therapists of Ontario, the College of Physiotherapists of Ontario, the College of Traditional Chinese Medicine Practitioners and Acupuncturists of Ontario, the Board of Directors of Drugless Therapy (Naturopathy) and the Royal College of Dental Surgeons of Ontario to establish a continuing interprofessional Advisory Committee on Acupuncture, the mandate of which is to provide advice to the Colleges, and to promote the development, either jointly or individually of:**
 - a) High minimum qualifications for the practice of acupuncture;**
 - b) General standards of practice for acupuncture;**
 - c) Quality assurance and continuing competence programs for acupuncture;**
 - d) Educational qualifications and equivalency standards for members to practise acupuncture; and**
 - e) Any other matter relevant to the practice of acupuncture.**

Psychotherapy

- 3. That the transitional Council of the College of Psychotherapists and Registered Mental Health Therapists of Ontario should include persons who are nominated jointly by the College of Psychologists of Ontario, the College of Physicians and Surgeons of Ontario, the College of Occupational Therapists of Ontario, the College of Social Workers and Social Service Workers, and the College of Nurses of Ontario.**

- 4. That the use of the title “psychotherapist” should be restricted to members of the College of Psychotherapists and Registered Mental Health Therapists of Ontario, the College of Psychologists of Ontario, the College of Physicians and Surgeons of Ontario, the College of Occupational Therapists of Ontario, the College of Social Workers and Social Service Workers, and the College of Nurses of Ontario who have the controlled act of psychotherapy within the scope of their practice.**

- 5. That a person who is not a member of the College of Psychotherapists and Registered Mental Health Therapists of Ontario, a member of the College of Psychologists of Ontario, the College of Physicians and Surgeons of Ontario, the College of Occupational Therapists of Ontario, the Ontario College of Social Workers and Social Service Workers or the College of Nurses of Ontario who practices psychotherapy should not hold himself or herself out as a person who is qualified to practice psychotherapy in Ontario.**

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