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REGULATION OF HEALTH PROFESSIONS IN ONTARIO: SELF-REGULATION WITH STATUTORY- BASED PUBLIC ACCOUNTABILITY

*Regulação das profissões de saúde em Ontário: autorregulação
com accountability pública baseada em estatutos legais*

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ABSTRACT

The paper explores the model of regulation of health professionals in Ontario, Canada; a self-regulation model built around a detailed statutory scheme. The core of the paper consists of a discussion of Ontario's Regulated Health Professions Act and of the key components of 26 specific health profession acts that have been enacted under its umbrella. The paper explores the role of the regulatory colleges, the role of the Ministry of Health in determining scope of practice and other components of medical practice, and the disciplinary and appeal procedures. Some other specific issues are also briefly touched upon, such as the integration into the profession of internationally trained physicians, and the government's role in ensuring access to specialists across the province. A final section looks at the challenges and the limitations of the Ontario model, through a number of health professions-related controversies that reveal gaps in self-regulation, including: failure to set and enforce proper educational and practice standards in specific areas; failure to conduct timely investigations into potential misconduct by professionals; and failure to question professionals in a position of power. The paper also discusses briefly the implications of recognizing through legal regulation some alternative and complementary medical practices, and the challenge of regulating indigenous health care practitioners. It concludes that the primary limitations of the regulatory model arise on account of professional self-interest and power-relations impacting procedural issues, and the complexity of the regulatory model that may potentially undermine quality control.

Keywords:

Canada; Health Professions; Health Work Regulation; Public Accountability.

RESUMO

Este artigo explora o modelo de regulação dos profissionais de saúde em Ontário, Canadá, um modelo de autorregulação construído em torno de um regime estatutário específico. O foco central do trabalho é a discussão sobre a Lei de Regulamentação das Profissões de Saúde de Ontário e os principais componentes de 26 leis foram promulgadas sob sua égide para regulamentar profissões de saúde específicas. O artigo explora a função dos colegiados regulatórios, o papel do Ministério da Saúde na determinação de escopos de prática e de outros elementos da atividade médica, e os procedimentos disciplinares e de recurso. Outras questões específicas também são brevemente abordadas como a adequação profissional de médicos treinados no exterior e a atribuição do governo de garantir o acesso a especialistas em toda a província. A seção final analisa os desafios e as limitações do modelo, levantando uma série de controvérsias relacionadas às profissões de saúde que revelam lacunas na autorregulação, incluindo: incapacidade de estabelecer e aplicar padrões educacionais e práticos adequados em áreas específicas; falha na condução de investigações em tempo hábil sobre possíveis desvios de conduta por parte dos profissionais; e falha em questionar profissionais em posições de poder. O artigo também discute brevemente as implicações de reconhecer, por meio de regulamentação legal, algumas profissões alternativas e complementares de saúde; e o desafio de regular os profissionais de saúde indígenas. Conclui-se que as principais limitações do modelo regulatório surgem em razão de interesses profissionais individualistas e de relações de poder que afetam questões processuais, bem como da complexidade do modelo regulatório, que pode potencialmente prejudicar o controle de qualidade.

Palavras-Chave:

Accountability; Canadá; Profissões de Saúde; Regulação das Profissões de Saúde.

Introduction

As in several other industrialized countries, the regulation of the health professions in Canada has undergone significant changes in the last decades. These changes often occurred in conjunction with others in the health care system itself. The changes indicate a growing recognition of the need for a publicly accountable regulatory system, in line with the crucial role of the health professions in Canada's publicly funded health care system. Yet, reflecting political realities, the health professions have largely retained their autonomy and been allowed to organize, albeit under closer state guidance, their own professional regulatory system.

The regulation of professionals in Canada falls under the provincial governments jurisdiction with respect to health care¹. Provincial governments and the territories determine which health professions to regulate and the manner of their regulation². This paper explores the model of regulation of health professionals in Ontario, Canada's most populated province. Ontario was at the forefront in the early 1990s when it developed a detailed model of health professions regulation. The Ontario model has often been seen as an interesting model of self-regulation built around a detailed statutory scheme. The paper aims at sketching a picture of the model of self-regulation that Ontario embraced, and at identifying certain key issues pertaining to its regulatory model.

I. Background leading up to statutory regulation in 1991

Health professions regulation in Ontario underwent a number of changes over the 19th and 20th century³. The early 19th century began with increasing control by the medical profession (primarily physicians) over the division of labor in health care⁴. Through state regulation, medicine became a monopoly that controlled other 'non-physician' health services (such as laboratory technicians)⁵. After the failure of a 'free market' for health care during the Depression of the 1930s, Canadian provinces started introducing doctor and hospital insurance plans⁶.

¹HEALTH Law in Canada. *McMillan LLP*, DBIC-0912, 2010. Available at: <https://mcmillan.ca/files/Health_Law_in_Canada.pdf>; WATTS, Michael. Health law in Canada. *Osler*, 2014. Available at: <<https://www.osler.com/en/resources/cross-border/2014/health-law-in-canada>>; CANADA. Government of Canada. *Canada's health care system*. Available at: <<https://www.canada.ca/en/health-canada/services/health-care-system/reports-publications/health-care-system/canada.html>>.

²ALDRIDGE, Stephanie. The regulation of health professionals: an overview of the British Columbia experience. *J Med Imaging & Radiation Sci*, v. 39, n. 1, p. 4, 2008.

³COBURN, David. State authority, medical dominance, and trends in the regulation of the health professions: the Ontario case. *Social Science Medicine*, v. 37, n. 7, p. 841-842, Oct. 1993

⁴Id., p. 842.

⁵Id., loc. cit.

⁶Id., loc. cit.

Provincial and federal efforts to change health care insurance began in the early 1960s, reducing medicine's control over health care. *Patricia O'Reilly* mentions that one policy that contributed to this change was the halting of the political custom of always having physicians as health ministers. Inter-professional conflicts and growing public interest pressures further contributed to significant changes to health care policy in Canada, and in Ontario in particular⁷. *O'Reilly* provides more detail about how the seeds for specific health professions regulatory reform were sown in that period of overall institutional repositioning of power in the 1960s and 1970s. In 1970, a Report of the Ontario Committee on the Healing Arts already stressed the need for regulatory reform and governmental oversight⁸. Ten years later, in 1980, a Professional Organizations Committee issued another report, which emphasized strongly that the focus of the professional self-regulatory regime should be on the promotion of the public interest. Shortly after, in 1982, the Minister of Health announced an external review of the legislation dealing with Ontario's health professions, which was undertaken by a team led by a Toronto lawyer. This was the start of a formal review process, the "Ontario Health Professions Legislative Review", which took place between 1983 and 1989. The final report of the review consisted of draft legislation, built around an umbrella act that would regulate all health professions with more detailed, specific acts for each profession. The report reflected a desire to promote better coordination of the regulation system of health professions, to enable a more efficient use of health care providers, and to create a more publicly responsive and accountable system⁹. The proposed system clearly embraced, according to *O'Reilly*, an anti-trust or pro-competition model, emphasizing "deregulation or minimal regulation"¹⁰, as well as a focus on the promotion of the public interest.

The Ontario Health Professions Legislative Review was itself a rather remarkable endeavor. It brought together the various interest groups and stakeholders in a formal process involving various rounds of written submissions, workshops, consultation sessions, and meetings. These were aimed at clarifying the respective contributions of the professions to the health care system and at identifying the rationale for professional self-regulation¹¹. The process opened up a dialogue between the various health-related professions, which had been largely absent from Ontario up to that time. The various groups were invited to comment on the submissions other professional groups. At an initial stage, 39

⁷COBURN, David. op. cit., p. 842.

⁸CANADA. Committee on the Healing Arts. *Report of the Committee on the Healing Arts*. Toronto: Queen's Printer, 1970.

⁹O'REILLY, Patricia. *Health care practitioners: an Ontario case study in policy making*. Toronto: University of Toronto Press, 2000. ch 5.

¹⁰Id. Ibid., p. 72.

¹¹Id. Ibid., p. 76.

of them were included in the process of consultation and discussion. Two years into the legislative review process, nine specific criteria were put forward, that were deemed to reflect the suitability for self-regulation of a health profession. These were:

1. Relevance of the proposed self-regulated group to the Ministry of Health (in line with jurisdiction over health);
2. Risk of harm to the public;
3. Sufficiency of supervision (i.e. a significant number of the professionals are not effectively monitored otherwise);
4. Alternative regulatory mechanisms (i.e. absence of different regulatory mechanism);
5. Body of knowledge (professional practice based on distinctive, systematic body of knowledge and core activities constitute a broadly accepted whole);
6. Education requirements for entry to practice;
7. Ability to favor the public interest (i.e. has the profession's leadership shown to be able to focus on public interest);
8. Likelihood of compliance (based on apparent willingness of the profession to comply); and
9. Sufficiency of membership size and willingness of members to contribute to self-regulation¹².

On the basis of the evaluation of the fulfillment of these criteria, the number was subsequently reduced from 39 to 24 professions that were considered to be suitable for self-regulation -- interestingly: naturopathy, which was later added to the list of self-regulated professions, was at this point excluded. It was considered to definitely fail the 'body of knowledge' and the 'sufficient number' criterias, and lack of clarity whether there was a risk to the public. Other exclusions are: opticianry (whereas optometry was included); psychometry and pulmonary and cardiovascular technology¹³. Chiropractic, on the other hand, was included, as was dental hygiene and dental technology.

While this process of consultation and determination of suitability was ongoing, the experts of the Ontario Health Professions Legislative Review also worked on a set of key principles for the procedures of self-regulation. They further developed specific 'scope of practice' statements for all professions, in consultation with the various professions.

¹²O'REILLY, Patricia. op. cit., p. 359-360.

¹³Id. Ibid., p. 77-78.

In 1989, the report of the Ontario Health Professions Legislative Review was presented by Minister of Health in Parliament, in the form of draft legislation. It is this draft legislation, the result of a remarkably open, consultative and inclusive process that is the basis of the 1991 Ontario Regulated Health Professions Act¹⁴ (RHPA)¹⁵.

1. Statutorily regulated health professions in Ontario & the RHPA

The 1991 RHPA introduced originally 21 Health Professions Acts, while six regulated health professions were later added.¹⁶ The health professions originally regulated under the system were: audiology and speech language pathology; chiropody and podiatry; chiropractic; dental hygiene; dental technology; dentistry; denturism; dietetics; massage therapy; medical laboratory technology; medical radiation technology; medicine; midwifery; nursing; occupational therapy; opticianry; optometry; pharmacy; physiotherapy; psychology; and respiratory therapy. Traditional chinese medicine became regulated in 2006, and homeopathy, kinesiology, naturopathy, and psychotherapy were added in 2007 to the list of self-regulated professions. The Health Professions Regulatory Advisory Council, an advisory body set up under the legislation to advise the Minister about all issues related to the regulation of the various professions, including whether a profession should be or not regulated, rejected paramedics, sonographers, and dental assistants applications to become regulated professions under the system¹⁷. Although one rationale for rejection may be that these professions are already under supervision of other regulated professions, political reasons may in the end determine what profession is recognized in the system.

Health care professionals other than physicians and nurses are grouped under the category of 'allied health professionals'¹⁸.

The 28 health professions are regulated by their own statute, which exist under the umbrella legislation, the RHPA¹⁹ that is purposed to:

- better protect and serve the public interest;
- be a more open and accountable system of self-governance;

¹⁴Regulated Health Professions Act (RHPA), 1991, S.O. 1991, c. 18.

¹⁵For a discussion of the background and debates preceding the promulgation of the RHPA, see O'REILLY, Patricia. *op. cit.*, ch 4-5.

¹⁶ONTARIO. Ministry of Health and Long-term Care. *Regulated health professions*. Available at: <http://www.health.gov.on.ca/en/pro/programs/hhrsd/about/regulated_professions.aspx#kinesiology>; HEALTH PROFESSIONS REGULATORY ADVISORY COUNCIL. *Key legislation: regulation of health professions*. Available at: <<https://www.hprac.org/en/keylegislation/keylegislation.asp>>; HEALTH FORCE ONTARIO. *Health providers: regulated health professions*. Available at: <http://www.healthforceontario.ca/en/Home/Health_Providers>.

¹⁷PERSONAL communication Bonni Ellis, Partner, Lerner LLP. Oct. 2018.

¹⁸CANADA. Government of Canada. *Canada's health care system*. *op. cit.*

¹⁹COUGHLAN. Anne. *Regulation of health professionals in Ontario*. College of Nurses of Ontario, 2010. [power point presentation]; ONTARIO BAR ASSOCIATION. *The regulation of health professionals and professional discipline*. Apr 2018. Available at: <<https://www.oba.org/Sections/Health-Law/Resources/Resources/The-Regulation-of-Health-Professionals-and-Profess>>.

- provide a more modern framework for the work of health professionals;
- provide consumers with freedom of choice; and
- provide mechanisms to improve quality of care²⁰.

The RHPA was recently amended by the 2017 **Protecting Patients Act**. This act increases oversight of health professionals and alters the process for dealing with cases of sexual misconduct²¹.

2. Model of statutory regulation: self-regulation

In respect of all 28 health professions, the model of regulation adopted is that of self-regulation, pursuant to the RHPA²². The idea behind the regulatory delegation from the government to the professions is, according to the Ontario Bar Association, “that health professionals have specialized knowledge about their practice which makes them more adept at regulating their profession than would be the case with government”²³.

Self-regulation is a privilege that the legislature grants to a profession when it is in the public interest to have that profession self-regulate²⁴. Benefits gained by self-regulatory status include “[...] professional prestige, greater autonomy to set entry requirements and standards of practice, financial advantages, and potentially greater access to government”²⁵. In bestowing self-regulatory status on a profession, the legislature grants it the power to “[...] act in the public interest [...] exercise delegated law-making powers [...] and [...] exercise “public law” powers of enforcement over its members.”²⁶ The decision to regulate particular health professions rests according to the Ontario regime on the “risk of harm threshold.”²⁷ This threshold is met when it is in the public interest to regulate a profession because lack of proper regulation and oversight puts the public at risk²⁸.

²⁰ONTARIO. Health workforce planning and regulatory affairs division. *Regulated Health Professions Act, 1991*. Ministry of Health and Long-Term Care (Queen’s Printer for Ontario, 2016).

²¹ONTARIO. The Protecting Patients Act, 2017 (30 May 2017). *Newsroom*, 30 May. 2017. Available at: <<https://news.ontario.ca/mohltc/en/2017/05/the-protecting-patients-act-2017.html>>.

²²COUGHLAN. Anne. op. cit.; ZELISKO, Debra et al. Ensuring accountability through health professional regulatory bodies: the case of conflict of interest. *Healthcare Policy*, n. 10, spec. issue, p. 110, Sept. 2014.

²³ONTARIO BAR ASSOCIATION. The regulation of health professionals and professional discipline, cit.

²⁴SCHULTZE, Robert. What does it mean to be a self-governing regulated profession? *Journal of Property Tax Assessment & Administration*, v. 4, n. 3, p. 41-42, 2007. Available at: <https://professional.sauder.ubc.ca/re_creditprogram/course_resources/courses/content/112/self-governing_regulated_profession.pdf>.

²⁵Id. *Ibid.* p. 44.

²⁶Id. *Ibid.* p. 45.

²⁷HEALTH PROFESSIONS REGULATORY ADVISORY COUNCIL. *Paramedicine in Ontario: Consideration of the Application for the Regulation of Paramedics under the Regulated Health Professions Act, 1991*. Dec. 2013. Chair: Thomas Corcoran.

²⁸Id. *Ibid.*

Concretely, the model of self-regulation embraced by Ontario permits the professions to have oversight over a number of key issues, from determining who becomes a member of the profession, to the determination of standard of practice; to quality control, and to professional discipline and enforcement. The Health Professions Regulatory Advisory Council enumerates the following roles of the professional colleges:

- determining entrance requirements
- providing a system of registration to determine required applicant qualifications
- licensing professional practitioners
- establishing and maintaining levels of competency
- establishing and maintaining codes of conduct (ethics and standards)
- receiving, investigating, and adjudicating complaints
- administering a disciplinary process to sanction members who fail to maintain established standards and practices²⁹.

3. Regulation through profession-specific Acts

The Ontario model is built around the RHPA as the umbrella legislation, which lays out the framework and also contains a procedural code that applies to all of the various health professions; 26 specific Acts for 28 health professions³⁰.

List of acts: Audiology & Speech-Language Pathology Act, 1991; Chiropody Act, 1991; Chiropractic Act, 1991; Dental Hygiene Act, 1991; Dental Technology Act, 1991; Dentistry Act, 1991; Denturism Act, 1991; Dietetics Act, 1991; Homeopath Act, 2007; Kinesiology Act, 2007; Massage Therapy Act, 1991; Medical Laboratory Technology Act, 1991; Medical Radiation Technology Act, 1991; Medicine Act, 1991; Midwifery Act, 1991; Naturopathy Act, 2007; Nursing Act, 1991; Occupational Therapy Act, 1991; Opticianry Act, 1991; Optometry Act, 1991; Pharmacy Act, 1991; Physiotherapy Act, 1991; Psychology Act, 1991; Psychotherapy Act, 2007; Respiratory Therapy Act, 1991; and Traditional Chinese Medicine Act, 2006.

List of professions: audiology and speech-language pathology; chiropody and podiatry; chiropractic; dental hygiene; dental technology; dentistry; denturism; dietetics; homeopathy; kinesiology; massage therapy; medical laboratory technology; medical radiation technology; medicine; midwifery; naturopathy; nursing; occupational therapy; opticianry; optometry; pharmacy; physiotherapy; psychology; psychotherapy; respiratory therapy; and traditional chinese medicine and acupuncture.

²⁹HEALTH PROFESSIONS REGULATORY ADVISORY COUNCIL. op. cit. p. 45-46.

³⁰ONTARIO. Ministry of Health and Long-term Care. *Regulated health professions*, cit.

The profession-specific Acts set out the scope of practice for their respective professions³¹. The RHPA and the profession-specific Acts together provide a common framework for the regulation of health professions in Ontario, based upon shared key principles, including:

advancing the public interest; protecting the public from harm and unqualified, incompetent or unfit providers; promoting high quality health care services and accountability of health care professionals; providing patients/clients access to health care professionals of their choice; achieving equality and consistency by requiring all regulated health professions to adhere to the same purposes, objects, duties, procedures and public interest principles; treating individual patients/clients and health professionals in an equitable manner; providing flexibility in roles of individual professions and room for evolution of professions through broad scopes of practice provisions³².

4. Regulatory bodies: profession-specific Colleges & Ministry

4.1 Profession-specific Colleges

Each profession-specific statute establishes a regulatory college for that profession: College of Audiology & Speech-Language Pathologists of Ontario; College of Chiropractors of Ontario; College of Chiropractors of Ontario; College of Dental Hygienists of Ontario; College of Dental Technologists of Ontario; Royal College of Dental Surgeons of Ontario; College of Denturists of Ontario; College of Dietitians of Ontario; College of Homeopaths of Ontario; College of Kinesiologists of Ontario; College of Massage Therapists of Ontario; College of Medical Laboratory Technologists of Ontario; College of Medical Radiation Technologists of Ontario; College of Physicians & Surgeons of Ontario; College of Midwives of Ontario; College of Naturopaths of Ontario; College of Nurses of Ontario; College of Occupational Therapists of Ontario; College of Opticians of Ontario; College of Optometrists of Ontario; Ontario College of Pharmacists; College of Physiotherapists of Ontario; College of Psychologists of Ontario; College of Registered Psychotherapists and Registered Mental Health Therapists of Ontario; College of Respiratory Therapists of Ontario; and College of Traditional Chinese Medicine Practitioners & Acupuncturists of Ontario³³. The colleges are responsible for setting standards of practice for the regulated profession, and also for investigating complaints and disciplining

³¹COUGHLAN. Anne. op. cit.

³²Id. Ibid.

³³ONTARIO BAR ASSOCIATION. The regulation of health professionals and professional discipline, cit.; ONTARIO. Ministry of Health and Long-term Care. *Regulated health professions*, cit.

members³⁴. It is the responsibility of the college that the regulated health professions provides health services “in a safe, professional and ethical manner”,³⁵ and that they “serve and protect the public interest.”³⁶

The Health Professions Procedural Code (Code), which is included in the RHPA as “Schedule 2”, stipulates procedural rules that all health regulatory colleges are required to comply with³⁷. These rules govern registration of new members, investigation of complaints, and disciplining of members by the colleges³⁸. The objective of the Code is to ensure that health professional regulation in Ontario is “open, transparent, accessible and fair”³⁹, for regulated health professionals, patients and the public⁴⁰. This Code is thus a core foundation of all the various self-regulatory colleges and is included in each health profession specific Act.

4.2 The Ministry of Health and Long Term Care

The RHPA is administered by the Ontario Ministry of Health and Long Term Care (MOHLTC)⁴¹, a provincial Ministry responsible for administering and providing for Medicare services, prescription drug coverage, long-term care, and for regulating hospitals, nursing homes, and other health care services in Ontario⁴². MOHLTC derives its power from the **Ministry of Health and Long-Term Care Act**⁴³ that allows the Minister of Health to delegate authority to other people, including public servants, employees of the Ministry, and members of other agencies⁴⁴. The Minister is empowered by the Act to:

- advise the government on health issues;
- oversee and promote the health of the people of Ontario;
- develop and maintain the services and facilities of the health care system;
- control the charges made by hospitals and health facilities;
- make payments related to health care services⁴⁵.

³⁴ONTARIO. Ministry of Health and Long-term Care. *Regulated health professions*, cit.; ONTARIO BAR ASSOCIATION. *The regulation of health professionals and professional discipline*, cit.

³⁵ONTARIO. Ministry of Health and Long-term Care. *Regulated health professions*, cit.

³⁶ZELISKO, Debra et al. op. cit.

³⁷COUGHLAN. Anne. op. cit.; ONTARIO. Ministry of Health and Long-term Care. *Regulated health professions*, cit.; ONTARIO BAR ASSOCIATION. *The regulation of health professionals and professional discipline*, cit.

³⁸ONTARIO. Ministry of Health and Long-term Care. *Regulated health professions*, cit.

³⁹Ibid.

⁴⁰Ibid.

⁴¹ONTARIO. Ministry of Health and Long-Term Care. *Legislation*. Available at: <<http://www.health.gov.on.ca/en/common/legislation/default.aspx>>.

⁴²Ibid.

⁴³*Ministry of Health and Long-Term Care Act*, R.S.O. 1990, c. M.26.

⁴⁴Ibid.

⁴⁵Ibid.

The MOHLTC is also responsible for the administration of 60 healthcare statutes, and the 26 regulated healthcare profession-specific Acts under the RHPA⁴⁶.

Under the RHPA the Minister of Health, in his capacity, has significant regulating powers applying to each health care professional College. The Ministry of Health is empowered to require a College to do anything necessary to carry out the intent of the RHPA⁴⁷. For example: the Ministry requires the Colleges to maintain patient-relation and quality assurance programs, and also imposes a reporting obligation. Colleges have to report annually to the Minister on the effectiveness of these programs⁴⁸.

5. Scope of practice

A key component of the health professional regulatory system, introduced by the RHPA, is the determination of the scope of practice that varies across health care professionals depending on their selected specialty, level of experience, and education. For example, primary care physicians have a wide scope of practice, often involving numerous fields of medicine, whereas an ophthalmologist may have a more restricted and highly specialized scope of practice. Further, patients may interact with various health care professionals other than doctors, such as nurses, pharmacists, naturopaths, nutritionists, etc. Overlap between the skills and roles of these health care professionals is prevalent. For example, childbirth may involve the care of primary care physicians, specialists, nurses, and midwives⁴⁹. The various agencies and colleges representing interests of health care professionals are generally supportive of collaboration between health providers with the aim of improving patient care⁵⁰. This increased focus on collaboration is also reflected in statements by interest-groups associated with the health professions. For example, the Canadian Medical Association, a pan-Canadian advocacy organization for physicians, promotes “patient-centered” care, and encourages collaboration among health care providers⁵¹.

The scope of practice for each profession is outlined by the RHPA along with profession-specific Acts. Each regulated health profession has a “scope of practice statement” that describes the scope in a general manner. The statement of scope is not intended to exclude or prevent other health care professionals from performing

⁴⁶Ministry of Health and Long-Term Care Act, R.S.O. 1990, c. M.26, cit.

⁴⁷RHPA, 1991, S.O. 1991, C. 18, s. 3.

⁴⁸Ibid.

⁴⁹CANADIAN INSTITUTE FOR HEALTH INFORMATION. *Canada's health care providers*. Available at: <https://secure.cihi.ca/free_products/hctenglish.pdf>.

⁵⁰CANADIAN MEDICAL PROTECTIVE ASSOCIATION. *Physicians and Nurse practitioners: working collaboratively as independent health professionals*. Jan. 2014. Available at: <<https://www.cmpa-acpm.ca/en/advice-publications/browse-articles/2014/physicians-and-nurse-practitioners-working-collaboratively-as-independent-health-professionals>>.

⁵¹CANADIAN MEDICAL ASSOCIATION. *CMA Policy. Achieving patient-centred collaborative care*. 2008. Available at: <<https://www.cma.ca/Assets/assets-library/document/en/PD08-02-e.pdf>>.

the same functions. The scope of practice for physicians in Ontario is defined in the **Medicine Act**, as follows:

The practice of medicine is the assessment of the physical or mental condition of an individual and the diagnosis, treatment and prevention of any disease, disorder or dysfunction⁵².

The **Nursing Act** defines the nursing scope of practice as follows:

The practice of nursing is the promotion of health and the assessment of, the provision of care for and the treatment of health conditions by supportive, preventive, therapeutic, palliative and rehabilitative means in order to attain or maintain optimal function⁵³.

However, the scope of practice for nurses in the province varies widely depending on several factors including their location, work setting, and education.⁵⁴ For example, nurses may work in hospital emergency rooms practicing acute care, or as public health officials promoting policy. Within the broad umbrella of ‘nursing’ (as a regulated profession) three types of nursing positions are recognized, and they are dependent upon education and training: (a) Registered Practical Nurse (RPN) must earn a diploma in Practical Nursing from an accredited college program. RPN work is generally less complex, and they work with patients with predictable conditions; (b) Registered Nurses (RNs) must obtain a baccalaureate degree in a four-year nursing program. They have greater degree of responsibility, and can care for patients with complex needs; and (c) a Nurse Practitioner (NP) is the most advanced nursing specialty in Ontario. NPs have advanced university education and can specialize in areas such as: primary health care, adult, pediatric care and anesthesia. Most nurses in Ontario are RNs but their individual scope of practice varies, as they can work in areas such as cardiovascular nursing, critical care nursing, oncology nursing, and medical-surgical nursing.

NPs and primary health physicians often perform overlapping functions. A report from the Ontario College of Family Physicians⁵⁵ suggested that some functions should be shared between physicians and nurses including: physical examinations, monitoring patients with chronic illnesses, and health education. Interestingly, in the context of the new Canadian legislation with respect to ‘Medical Assistance in

⁵²*Medicine Act*, 1991, S.O. 1991, c. 30.

⁵³*Ibid.*

⁵⁴*Ibid.*

⁵⁵ONTARIO COLLEGE OF FAMILY PHYSICIANS. *Implementation strategies: ‘collaboration in primary care – family doctors & nurse practitioners delivering shared care.* (2000). Available at: <<https://ocfp.on.ca/docs/public-policy-documents/implementation-strategies-collaboration-in-primary-care--family-doctors-nurse-practitioners-delivering-shared-care.pdf?sfvrsn=3>>.

Dying⁵⁶, NPs have received the authority to provide this life-ending service. Canada is the only country where nurses can be directly involved in this practice.

The roles of various health care professionals evolve over time and may encroach on functions associated exclusively with medical doctors. For example, the role of pharmacists has slowly evolved from purely dispensing drugs to more interaction with the patients, and to providing important drug education to physicians⁵⁷.

In 2003 the Canadian Medical Association issued a joint statement endorsed by both the Canadian Pharmacists Association and the Canadian Nurses Association with respect to the determination of scopes of practice for health care professionals⁵⁸. The statement emphasized that policy decisions taken to expand the scope of practice must put patient safety first. The professional code of ethics set out by the Canadian Medical Associations states that physicians have a responsibility to maintain professionalism and congeniality with other health care professionals. Physicians are encouraged to collaborate with nurses and pharmacists in patient management. For example, physicians are permitted to bill for telephone consultations with pharmacists subject to meeting certain conditions.

6. Controlled Acts

Although the scope of work of physicians and other health care professionals overlaps, and they are encouraged to collaborate with one another as described above, there are nevertheless certain duties that fall exclusively within the scope of physicians.

The RHPA refers to acts that can only be performed by authorized health care professionals as 'controlled acts'⁵⁹:

27 (1) No person shall perform a controlled act set out in subsection (2) in the course of providing health care services to an individual unless,

(a) the person is a member authorized by a health profession Act to perform the controlled act; or

(b) the performance of the controlled act has been delegated to the person by a member described in clause (a)⁶⁰.

⁵⁶Bill C-14, *An Act to amend the Criminal Code and to make related amendments to other Acts (medical assistance in dying)*, 1st Sess., 42nd Parl., 2016, S.O. 2016, c. 3 (assented to June 17, 2016).

⁵⁷TANNENBAUM, Cara; TSUYUKI, Ross T. The expanding scope of pharmacists' practice: implications for physicians. *CMAJ*, v. 185, n. 14, p. 1228-1232, Oct. 2013. <https://doi.org/10.1503/cmaj.121990>.

⁵⁸CANADIAN MEDICAL PROTECTIVE ASSOCIATION et al. *Joint position statement*. 2003. Available at: <https://www.cna-aiic.ca/-/media/cna/page-content/pdf-en/ps66_scopes_of_practice_june_2003_e.pdf?la=en&hash=F346C4473B0C8154811834EEB34BC551805B6154>.

⁵⁹RHPA, 1991, S.O. 1991, c. 18.

⁶⁰Id. Ibid. s27.

The statutory authority to perform a controlled act is then found in the relevant profession-specific Act.

The RHPA identifies 14 “controlled acts”⁶¹, 13 of them are to be performed by physicians⁶². This reflects the dominant position physicians maintain within the health regulatory system. Physicians may, in certain circumstances, delegate the performance of a controlled act to another health care professional⁶³. The College of Physicians and Surgeons of Ontario notes delegation does not occur when a physician authorizes a controlled act to another health care professional, if that act is already within the scope of practice of said professional⁶⁴. It only occurs when a physician directs the performance of a controlled act to an individual with no statutory authority.

The prohibitions applicable on controlled acts do not apply if done to render first aid, or provide assistance in an emergency, in which cases the RHPA specifically carves out an exemption⁶⁵.

7. How does a health profession become regulated?

As mentioned, the RHPA has established the Health Professions Regulatory Advisory Council (HPRAC Council), with the primary statutory duty to advise the MOHLTC on health professions regulatory matters in Ontario⁶⁶. These regulatory matters include proposed amendments that should be made to the RHPA or specific acts under the RHPA, the recognition of new professions, and matters concerning quality assurance programs in the health colleges⁶⁷.

Among its core duties, the HPRAC Council is responsible for determining whether unregulated health professions should be regulated, and whether those which already are, should no longer be regulated⁶⁸. It performs the function of an independent advisor providing evidence-informed advice, as it is independent from

the Minister of Health and Long-Term Care, the Ministry of Health and Long-Term Care, the regulated health colleges, regulated health professional and provider associations, and stakeholders who have an interest in issues on which it provides advice⁶⁹.

⁶¹RHPA, 1991, s. 27(2).

⁶²Id. Ibid. s27.

⁶³Id. Ibid. s28(1).

⁶⁴COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO - CPSO. *Delegation of controlled acts*. Available at: <<https://www.cpso.on.ca/Policies-Publications/Policy/Delegation-of-Controlled-Acts#toc5>>.

⁶⁵RHPA, 1991, S.O. 1991, c. 18 at s. 29(1)(a,b).

⁶⁶HEALTH PROFESSIONS REGULATORY ADVISORY COUNCIL. *Mandate: about the Health Professions Regulatory Advisory Council (HPRAC)*. Available at: <<https://www.hprac.org/en/about/mandate.asp>>.

⁶⁷Id. Ibid.

⁶⁸Id. Ibid.

⁶⁹Id. Ibid.

The emphasis on independence seeks to ensure that the HPRAC Council's advice be free from conflict of interest and bias⁷⁰.

The advice provided by the HPRAC Council constitutes recommendations that may be relied upon by the Minister, but they are not binding⁷¹. The advice is taken into consideration when formulating policy in relation to health professional regulation in Ontario⁷². The HPRAC Council submits its report to the Minister for consideration, and the report remains confidential until the Minister releases it at own discretion⁷³, if the Minister chooses to implement the recommendation provided by the HPRAC Council, the implementation is undertaken based upon the directions of the government⁷⁴. The decision to regulate may take decades to implement⁷⁵.

When evaluating whether a profession should be regulated, the HPRAC Council explores the question through the following key principles:

- Meeting public expectations for improved access to high quality and safe care;
- Supporting interprofessional care and optimizing the contribution of all health professionals;
- Applying standards for the regulation of health professionals;
- Ensuring a shared accountability agenda that encourages and values collaboration and trust;
- Using resources efficiently;
- Sustaining the health care system; and,
- Maintaining self-regulation⁷⁶.

During the process of preparing recommendations, in addition to undertaking extensive research, the HPRAC Council undertakes consultations, which may include written submissions, public hearings, focus groups, research projects and community meetings⁷⁷. The HPRAC Council takes into consideration feedback provided from “the public, community organizations, interest groups, and health professionals regulatory colleges and associations”⁷⁸.

⁷⁰HEALTH PROFESSIONS REGULATORY ADVISORY COUNCIL. *Mandate: about the Health Professions Regulatory Advisory Council (HPRAC)*, cit.

⁷¹Id. Ibid.

⁷²Id. Ibid.

⁷³Id. Ibid.

⁷⁴Id. Ibid.

⁷⁵ONTARIO OSTEOPATHIC ASSOCIATION. *Understanding the process in becoming a regulated health profession in Ontario*. Available at: <<http://www.ontarioosteopathy.com/wp-content/uploads/2018/02/How-Health-Professions-Become-Regulated.pdf>>.

⁷⁶Id. Ibid.

⁷⁷Id. Ibid.

⁷⁸Id. Ibid.

To illustrate the process and factors involved in the achievement or denial of statutory regulatory status, consider three examples.

First, the traditional Chinese medicine came under regulation in the 2000s, when the **Traditional Chinese Medicine Act** (2006) initiated the College of Traditional Chinese Medicine Practitioners and Acupuncturists of Ontario⁷⁹. The College was officially established in April 2013⁸⁰.

Traditional Chinese Medicine practitioners' request for self-regulation was successful due to factors such as practitioner lobbying, increased public acceptance of alternative medicine, and concern over patient safety⁸¹. In part, an incident in Quebec where improper sterilization of acupuncture needles resulted in class action lawsuits also encouraged support for self-regulation of the profession in Ontario⁸².

Second, paramedic services are neither self-regulated nor subject to direct government oversight. In 2007, the Minister of Health and Long-Term Care initiated an inquiry into whether or not paramedics ought to be regulated under the RHPA. The HPPA Council decided that it was not in the public interest to regulate paramedics as these services failed to meet the "risk of harm threshold".

8. Qualification & membership requirements

In order to practice a regulated profession, an individual is required to become a member of the regulatory College in the province he/she wishes to practice⁸³. The individual must obtain a certificate of registration from the College⁸⁴. Each College has its own minimum educational and training requirements that need to be fulfilled in order for the individual to be able to qualify and apply to become a member⁸⁵. This section describes the education and membership requirements for physicians, nurses and dentists in Ontario, and the national accreditation by regulatory colleges. This section also describes the funding and accreditation of medical colleges, and qualification requirements of International Medical Graduates, i.e. individuals wishing to practice as physicians who have completed their education outside Canada.

⁷⁹COLLEGE OF TRADITIONAL CHINESE MEDICINE. Practitioners and acupuncturists of Ontario. *Regulations*. Available at: <<http://www.ctcmpao.on.ca/regulation/>>.

⁸⁰RANDALL, Glen E.; EMBRETT, Mark G.; BARR, Neil G.; VANIA, Diana K. Regulating traditional chinese medicine practitioners and acupuncturists in Ontario, Canada. *Health Reform Observer*, v. 3, n. 2, p. 1, 2015. Available at: <<https://mulpress.mcmaster.ca/hro-ors/article/view/2441>>. <https://doi.org/10.13162/hro-ors.v3i2.2441>.

⁸¹Id. Ibid. p. 1.

⁸²Id. Ibid. p. 5.

⁸³REGULATED Health Professions in Ontario. *Working Centre*. Available at: <<https://www.theworkingcentre.org/regulated-health-careers/1404-regulated-health-professions-ontario>>.

⁸⁴Id. Ibid.

⁸⁵Id. Ibid.

8.1 Becoming a member of the College of Physicians and Surgeons of Ontario

The process of becoming a physician in Canada is the same across the provinces. To become a physician in Canada, an applicant must first complete at least three years of undergraduate education⁸⁶. Subsequently, they must be admitted to and complete a four-year undergraduate medical education program⁸⁷. This program involves two years of basic medical science education and two years of clinical clerkship. Upon completion, graduates must complete supervised practice and training, referred to as residency. Residency can vary in length from 2-4 years depending on the type of specialty selected⁸⁸. A certificate from a certifying body, either the College of Family Physicians of Canada (a professional regulatory body responsible for training and certification of family physicians⁸⁹), or the Royal College of Physicians and Surgeons of Canada (responsible for certifying medical specialists in Canada), and then registration to practice in a particular province completes the accreditation process for physicians.

The College of Physicians and Surgeons of Ontario (CPSO) is a self-regulating professional college of which all physicians in Ontario must be members⁹⁰. It issues certificates of registration to physicians, which allows them to practice in the province of Ontario⁹¹ and grants memberships based on a detailed set of requirements. First, applicants to the CPSO must have a degree in medicine from an accredited medical school or an “acceptable uncredited medical school”⁹². An accredited medical school is described by the CPSO as a medical school that has been accredited by either the Committee on Accreditation of Canadian Medical Schools or by the Liaison Committee on Medical Education of the United States of America⁹³. Further, the graduate must also have successfully completed a clerkship that complies with regulations under the **Medicine Act**⁹⁴. An “acceptable uncredited medical school” is defined by the college as an undergraduate program in allopathic medicine that:

1. Teaches medical principles, knowledge and skills similar to those taught in undergraduate programs of medical education at accredited medical schools in Canada or the United States of America,

⁸⁶CANADIAN MEDICAL ASSOCIATION. *Becoming a physician*. Available at: <<https://www.cma.ca/En/Pages/becoming-a-physician.aspx>>.

⁸⁷Id. Ibid.

⁸⁸Id. Ibid.

⁸⁹COLLEGE OF PHYSICIANS AND SURGEONS OF BRITISH COLUMBIA. *Understanding your physician's credentials*. Available at: <https://www.cpsbc.ca/physician_search/credentials>.

⁹⁰COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO - CPSO. *About the college*. Available at: <<https://www.cpso.on.ca/About-Us>>.

⁹¹Id. Ibid.

⁹²COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO - CPSO. *Registration requirements*. Available at: <<https://www.cpso.on.ca/Applicant-Information/Registration-Requirements>>.

⁹³Id. Ibid.

⁹⁴*Medicine Act*, 1991, S.O. 1991, c. 30.

2. includes at least 130 weeks of instruction over a minimum of thirty-six months, and was, at the time of graduation, listed in the World Directory of Medical Schools published by the World Health Organization⁹⁵.

Further, acceptance into the CPSO is contingent on the requirement that the applicant's conduct gives reasonable grounds for belief that the applicant:

1. Is mentally competent to practice medicine;
2. Will practice medicine with decency, integrity and honesty and in accordance with the law;
3. Has sufficient knowledge, skill and judgment to engage in the medical practice authorized by the Certificate, and
4. Can communicate effectively and will display an appropriately professional attitude⁹⁶.

The CPSO's Registration Committee reviews any issues that may arise in connection with any of the aforementioned requirements⁹⁷.

The CPSO maintains a Quality Assurance Program through peer and practice assessments that is a requirement under the RHPA⁹⁸. Participation in the College's peer and practice assessment is a required component of the CPSO⁹⁹. Any member of the CPSO may be required to participate, and the selection of physicians for participation in the program may be random, "age-related" or related to another aspect of the physician's practice¹⁰⁰. A physician may be randomly selected for assessment every 10 years if she practices independently and is under 70 years of age. All physicians aged 70 and over are assessed through the program every 5 years¹⁰¹. Further, physicians who practice in long term care facilities, physicians who change their scope of practice or re-enter practice, and physicians who prescribe methadone, may be subject to additional peer assessment¹⁰².

8.2. Becoming a member of the College of Nurses of Ontario

The College of Nurses of Ontario is a provincial self-regulating college of which every practicing nurse in Ontario must be a member¹⁰³. Membership in the

⁹⁵COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO - CPSO. *Registration requirements*, cit.

⁹⁶*Ibid.*

⁹⁷*Ibid.*

⁹⁸COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO - CPSO. Assessments. Available at: <<https://www.cpso.on.ca/Member-Information/Assessments>>.

⁹⁹*Ibid.*

¹⁰⁰*Ibid.*

¹⁰¹*Ibid.*

¹⁰²*Ibid.*

¹⁰³COLLEGE OF NURSES OF ONTARIO. *About the College of Nurses of Ontario*. Available at: <<http://www.cno.org/en/what-is-cno/>>.

college consists of several requirements including successful completion of a nursing education program and examinations¹⁰⁴.

To become a member of the College of Nurses of Ontario, applicants must meet the following requirements. First, they must successfully complete a nursing education program, and show that they have recent experience practicing as a nurse¹⁰⁵. All nursing programs approved by the College of Nurses of Ontario provide graduates with the required practical nursing experience¹⁰⁶.

Applicants must also complete the Registration Examination and the Jurisprudence Examination (NCLEX-RN)¹⁰⁷. This examination is administered by the National Council Licensure Examination and is used to examine nursing graduates in both Canada and the United States¹⁰⁸. The Jurisprudence Examination tests the applicants' knowledge of the "laws, regulations, College by-laws, and practice standards and guidelines that govern the nursing profession in Ontario."¹⁰⁹ Further, admission to the College of Nurses of Ontario is contingent to demonstrated proficiency in English or French, and satisfying the citizenship requirements.

Lastly, applicants must submit a criminal record check; declare if they suffer from any physical or mental disorder that could affect their practice¹¹⁰. Quality assurance in the College is maintained through a mandatory yearly self-assessment, and through a random peer assessment program¹¹¹.

8.3. Becoming a member of the College of Dental Surgeons of Ontario

Membership requirements in the College of Dental Surgeons of Ontario vary depending on dental specialty. For general dental practitioners, the College mandates that applicants have a degree in dentistry from a dental school of at least four years' duration, and successful completion of the National Dental Examining Board examinations¹¹². Applicants must demonstrate fluency in English or French,

¹⁰⁴COLLEGE OF NURSES OF ONTARIO. *About the College of Nurses of Ontario*, cit.; COLLEGE OF NURSES OF ONTARIO. *Registration requirements*. Available at: <<http://www.cno.org/en/become-a-nurse/new-applicants1/ontario/registration-requirements-for-rns-and-rpns/>>.

¹⁰⁵Id. Ibid.

¹⁰⁶COLLEGE OF NURSES OF ONTARIO. *Evidence of practice*. Available at: <<http://www.cno.org/en/become-a-nurse/registration-requirements/evidence-of-practice/>>.

¹⁰⁷Id. Ibid.

¹⁰⁸COLLEGE OF NURSES OF ONTARIO. *Registration examination*. Available at: <<http://www.cno.org/en/become-a-nurse/registration-requirements/registration-examination/>>.

¹⁰⁹COLLEGE OF NURSES OF ONTARIO. *Jurisprudence examination*. Available at: <<http://www.cno.org/en/become-a-nurse/registration-requirements/jurisprudence-examination/>>.

¹¹⁰Id. Ibid.

¹¹¹COLLEGE OF NURSES OF ONTARIO. *Quality assurance*. Available at: <<http://www.cno.org/en/myqa/quality-assurance-page-2/>>.

¹¹²ROYAL COLLEGE OF DENTAL SURGEONS OF ONTARIO. *Registration information - general certificate (licence)*. Available at: <http://www.rcdso.org/Assets/DOCUMENTS/Registration/Information_Sheets/RCDSO_General_Info_Sheet.pdf>.

and fulfill the membership requirements of the College¹¹³. Lastly, the applicant must successfully complete examinations in Ethics and Jurisprudence¹¹⁴.

8.4. National level accreditation by regulatory colleges

Regulatory colleges can also accredit their members on a national level. For example, the Royal College of Physicians and Surgeons of Canada (Royal College), provides accreditation for physicians in Canada who wish to become specialists¹¹⁵. Those individuals must be assessed by the Royal College, prior to completing the requisite examinations to become certified as specialists¹¹⁶. The process of accreditation varies depending on where the medical school graduate has completed his/her training (whether in Canada, or overseas)¹¹⁷. Medical school graduates, who are completing their residency requirements, must apply for a training assessment for their chosen specialty. For example, residents wishing to become surgeons must complete a “Surgical Foundations” examination administered by the Royal College that stipulates different training requirements depending on one’s chosen field of specialization. For example, to become a dermatologist, one must complete five years of an approved residency in dermatology, successfully complete the certification in dermatology examination, and participate in a relevant scholarly research project¹¹⁸.

8.5. Medical Colleges

There are 17 medical schools in Canada, all of them public. They are partially funded by the provinces; nevertheless, the total cost of medical education for students in Canada can exceed \$100,000.

The Association of Faculties of Medicine in Canada (AFMC) and the Committee on Accreditation of Canadian Medical Schools (CACMS) manage together the accreditation of Canadian medical schools. Accreditation is aimed at ensuring that the education meets “reasonable, generally-accepted, and appropriate national standards for educational quality”, and that graduates have completed the proper educational experience to prepare them for their next stage of training¹¹⁹.

¹¹³ROYAL COLLEGE OF DENTAL SURGEONS OF ONTARIO. *Registration information - general certificate (licence)*, cit.

¹¹⁴Ibid.

¹¹⁵ROYAL COLLEGE OF PHYSICIANS AND SURGEONS OF CANADA. *Credentials and exams – eligibility*. Available at: <<http://www.royalcollege.ca/rcsite/credentials-exams/exam-eligibility-e>>.

¹¹⁶Ibid.

¹¹⁷Ibid.

¹¹⁸Ibid. ROYAL COLLEGE OF PHYSICIANS AND SURGEONS OF CANADA. *Specialty training requirements in dermatology: minimum training requirements*. 2012. Available at: <<http://www.royalcollege.ca/cs/groups/public/documents/document/y2vk/mdaw/~edisp/tztest3rcpsced000614.pdf>>.

¹¹⁹CANADIAN MEDICAL ASSOCIATION. *Medical education and the CMA*. Available at: <<https://www.cma.ca/En/Pages/medical-education.aspx>>.

Canadian medical schools also tend to be accredited by the Liaison Committee on Medical Education (LCME)¹²⁰, the USA department of education-recognized accreditation body for medical schools. Accreditation visits are often organized jointly by the CACMS and the LCME. During these visits, the accreditation agencies assess whether a large number of criteria are respected in the context of the educational program. If not, the educational program can be put on probation and ultimately see its accreditation removed. In 2015, for example, a joint accreditation visit resulted in an imposition of a probationary period on McGill University's undergraduate medical program, the oldest program in the country with a stellar international reputation, when about 24 criteria out of 132 were deemed not to be fulfilled¹²¹. The probation was lifted two years later, even though the accreditation body remained critical of the underrepresentation of minority students¹²². Other Canadian medical schools have also been put on probation in the past.

8.6. International Medical Graduates

To practice a regulated profession in Canada, international medical graduates (IMGs) must register with the relevant provincial or territorial licensing body and meet all requirements particular to each profession¹²³. In Ontario, IMGs who wish to practice medicine as a family practitioner or specialist must obtain an Independent Practice certificate of registration from CPSO. Reception of this certificate rests upon fulfillment of all required Canadian postgraduate qualifications. These requirements include¹²⁴:

1. Degree in medicine from an acceptable medical school.
2. Part 1 and Part 2 of the Medical Council of Canada Qualifying Examination (MCCQE) or one of the acceptable alternative examinations.
3. Certification by examination, by the Royal College of Physicians and Surgeons of Canada (RCPSC) or the College of Family Physicians of Canada (CFPC).

¹²⁰For more information, see ASSOCIATION OF AMERICAN MEDICAL COLLEGES. Liaison Committee on Medical Education (LCME). Available at: <https://www.aamc.org/members/osr/committees/48814/reports_lcme.html>.

¹²¹PERITZ, Ingrid. McGill University takes a hit to prestige as Medical School put on probation. *Globe & Mail*, 17 June 2015. Available at: <<https://www.theglobeandmail.com/news/national/education/mcgill-universitys-medical-school-put-on-probation-following-investigation/article25012146/>>.

¹²²MCKENNA, Kate. Probation lifted at McGill's med school, but accreditation body slams program's diversity. *CBC News*, June 16, 2017. Available at: <<https://www.cbc.ca/news/canada/montreal/mcgill-medical-school-probation-lifted-1.4163794>>.

¹²³ONTARIO. Ministry of Health and Long-Term Care. *Health Workforce Planning and Regulatory Affairs Division*. Available at: <<http://www.health.gov.on.ca/en/pro/programs/hhrsd/>>.

¹²⁴COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO - CPSO. *Qualifying to practice medicine in Ontario*. Available at: <<https://www.cpso.on.ca/Applicant-Information/International-Medical-Graduates/Qualifying-to-Practice-Medicine-in-Ontario>>.

4. Completion in Canada of one year of postgraduate training or active medical practice with pertinent clinical experience.
5. Canadian citizenship or permanent resident status.

Medical licensing authorities are specific to each province and territory and there are two routes to practice in Canada for IMGs. On the one hand, IMGs who are certified at an accepted jurisdiction and have completed all certification requirements for that jurisdiction (e.g., graduates of U.S. schools) can register directly with the CPSO. On the other hand, IMGs who did not attend an accredited university must participate in a ministry-funded training or assessment program. These students apply for an entry level training position to complete a family medicine or specialty residency¹²⁵. Successful candidates must attend a Pre-Residency Program (PRP) at the Touchstone Institute and commit to a Return of Service (ROS) Agreement system that is used to promote access to medical services outside of the urban medical centers. Under a ROS Agreement, those accepting a resident position must provide five years of full-time service in communities outside the urban centers of the greater Toronto region and Ottawa. This is one of the significant challenges Canada, and Ontario in particular, faces, with respect to its goal to offer access to quality medical care across a very large territory. Due to the low density of the population in some regions, the remoteness and difficulty of access, but also simply the preference of qualified professionals to live in the urban centers, there is a scarcity of qualified medical professionals in some regions. Ontario currently offers 200 entry-level training positions for post-graduate IMGs¹²⁶.

8.7. Ensuring fairness in immigrant access to regulated professions

It is worth discussing briefly here, an interesting legislative initiative in Ontario, which aims at fostering immigrants' access to a number of health professions. **The Fair Access to Regulated Professions Act (FARPA)** was passed in Ontario in 2006 with the aim of facilitating immigrant access to regulated professions¹²⁷. Specifically, the FARPA's objective is to "ensure that regulated professions and individuals applying for registration are governed by registration practices that are transparent, objective, impartial and fair."¹²⁸ The FARPA initially only applied to 13 non-health professions and 21 health professions, however today the FARPA applies to 15 non-health, 28 health professions, and 22 compulsory trades¹²⁹.

¹²⁵ONTARIO. Ministry of Health and Long-Term Care. *Health Workforce Planning and Regulatory Affairs Division: International Medical Graduates (IMG)*. Available at: <http://www.health.gov.on.ca/en/pro/programs/hhrsd/physicians/international_medical_graduates.aspx>.

¹²⁶Ibid.

¹²⁷*Fair Access to Regulated Professions and Compulsory Trades Act*, 2006.

¹²⁸Ibid.

¹²⁹Ibid.

The FARPA created five tools for the fulfillment of its stated purpose: (a) Fair Registration Practices Code; (b) Fairness Commissioner and Office of the Fairness Commissioner; (c) Access Center for Internationally Trained Individuals; (d) Reporting and auditing requirements, and (e) Sanctions.

The Fair Registration Practices Code provides that regulated professions must meet two requirements. First, they must provide the public with information about their registration practices, and second, regulated professions must improve their registration practices¹³⁰. For example, the Code imposes requirements such as communicating and justifying all decisions, providing applicants with a review procedure or appeal, and providing alternative ways of fulfilling requirements.¹³¹

The Office of the Fairness Commissioner is responsible for implementing the FARPA¹³². It must assess registration practices, administrate audits, and report to the Minister of Citizenship and Immigration¹³³.

The Access Center for Internationally Trained Individuals provides information and guidance to applicants on registration requirements¹³⁴. The Center's services also include facilitating document translation, technical language support, and referrals for training opportunities¹³⁵.

Each regulated profession covered by the FARPA is required to review their registration practices and provide a report to the Office of the Fairness Commissioner¹³⁶. The regulated professions are also required to undergo an audit of their registration practices every three years. The Commissioner can make an order requiring compliance with the Fair Registration Practices Code¹³⁷.

9. Appointment of specialists in medicine

The question of how many medical specialists are required in a particular area or the types of specialists required, are determined through workforce planning. Workforce planning is governed separately by each Canadian province and territory. For example, in Ontario, beginning in March 2006, workforce planning is undertaken by regional Local Health Integration Networks (LHINs)¹³⁸, crown agencies, created by the provincial government via the 2006 Local Health System

¹³⁰Fair Access to Regulated Professions and Compulsory Trades Act, 2006, cit..

¹³¹Id. Ibid.

¹³²Id. Ibid.

¹³³Id. Ibid.

¹³⁴ACCESS CENTRE FOR INTERNATIONALLY TRAINED INDIVIDUALS. *Our services*. Available at: <<http://www.accesscentre.ca/services>>.

¹³⁵Id. Ibid.

¹³⁶Fair Access to Regulated Professions and Compulsory Trades Act, 2006.

¹³⁷Id. Ibid.

¹³⁸MOAT, Kaelan A.; CIUREA, Ileana; WADDELL, Kerry et al. *Citizen brief: planning for the future health workforce of Ontario*. McMaster Health Forum, 2016.

Integration Act (LHSIA), that determine the health needs of particular regions by working with local health providers and community members¹³⁹. There are fourteen LHINs in Ontario¹⁴⁰.

There are three common approaches to health workforce planning. First, 'utilization-based planning' bases future health workforce numbers on the needs of the present population. Second, 'needs-based planning' considers estimates of health needs for particular populations. Third, 'effective demand-based planning' considers economic factors as well as the needs of the population¹⁴¹. Ontario relies on 'utilization-based planning,' taking into consideration which health care services were used over a defined time period and by how many residents¹⁴².

The 2016 McMaster Health Forum and other reports argue changes in workforce planning are needed to address current and future health care challenges.¹⁴³ Specific to Ontario, the Forum notes health planning challenges include,

[...] a rapidly aging population; an increase in the number of people living with one or more chronic conditions; an increase in demand for intensive (and expensive) acute care services, as well as expensive cutting-edge technologies and drugs; and a growing need and demand for services provided in home and community settings¹⁴⁴.

Indeed, across Canada, planning the workforce represents challenges such as insufficient accessibility to health care and long waits¹⁴⁵.

Suggested improvements include changes such a shift in focus from individual professionals to team-based care and greater focus on resident needs.¹⁴⁶ As the Ontario health system develops, a number of factors are expected to improve workforce planning. These factors include:

¹³⁹ONTARIO. Local Health Integration Network. *About Toronto Central LHIN*. Available at: <<http://www.torontocentrallhin.on.ca/aboutus.aspx>>. In January 2019, the newly elected conservative government announced that they would dissolve these regional health agencies, although it was not clear whether they would simply be abolished or replaced by a smaller number of agencies. CRAWLEY, Mike. Ford government poised to dissolve regional health agencies, sources say. *CBC News*, 17 Jan. 2019. Available at: <<https://www.cbc.ca/news/canada/toronto/lhin-ontario-doug-ford-local-health-integration-networks-1.4980509>>.

¹⁴⁰ONTARIO. Local Health Integration Network. *Ontario's LHINs* (queen's printer for Ontario, 2014). Available at: <<http://www.lhins.on.ca>>.

¹⁴¹MOAT, Kaelan A.; CIUREA, Ileana; WADDELL, Kerry et al. op. cit., p. 5.

¹⁴²Id. Ibid. p. 7.

¹⁴³Id. Ibid p. 5.

¹⁴⁴Id., loc. cit. CANADIAN INSTITUTE FOR HEALTH INFORMATION. *Seniors and the health care system: what is the impact of multiple chronic conditions?* 2011. Available at: <https://secure.cihi.ca/free_products/air-chronic_disease_aib_en.pdf>; NELSON, S. et al. *Optimizing scopes of practice: new models for a new health care system*. Ottawa: Canadian Academy of Health Sciences, 2014. Available at: <https://www.caahs-acss.ca/wp-content/uploads/2014/08/Optimizing-Scopes-of-Practice_REPORT-English.pdf>.

¹⁴⁵NOSMITH, L. et al. *Transforming care for Canadians with chronic health conditions: put people first, expect the best, manage for results*. Ottawa: Canadian Academy of Health Sciences, 2010.

¹⁴⁶Id. Ibid.

- The establishment of regional, population-based planning processes in primary care, home and community care, long-term care, and public health;
- The shifting of many services from acute-care settings (i.e., hospitals) to home and community settings;
- The integration of a wider range of healthcare professionals (e.g., dietitians, midwives and physiotherapists working alongside doctors and nurses) into teams to provide comprehensive primary-care services, supported by a range of technologies (e.g., electronic health records, online referral systems, telehealth and telemedicine);
- A focus on treating only the most ill and complex patients in hospitals, and the shifting of low-risk, routine specialty care services (e.g., cataract surgeries) to community-based facilities; and
- An increasing level of integration across sectors that means health workers will be involved in providing care in more diverse settings (e.g., long-term care facilities may draw on health workers, such as nurses, who traditionally work in primary care)¹⁴⁷.

10. Disciplining of professionals: Colleges, Review Board & Courts

The RHPA provides a statutory outline for Colleges for handling complaints and investigations surrounding professional misconduct¹⁴⁸. Each College in Ontario has its own by-laws detailing procedures on complaints and discipline but they have to respect the general outline provided by the RHPA¹⁴⁹. Typically, Colleges will begin by conducting a confidential review of the facts¹⁵⁰. Simple complaints may be resolved without a hearing, through correspondence with the parties involved¹⁵¹. Regarding physicians, the College of Physicians and Surgeons of Ontario is given broad powers and may inspect administrative and patient record, and examine the physical premises¹⁵². More serious complaints require formal reviews by special committees within the College¹⁵³.

The Health Professions Procedural Code (Code) states that each College must have an Inquiries, Complaints and Reports Committee; a Discipline Committee;

¹⁴⁷MOAT, Kaelan A.; CIUREA, Ileana; WADDELL, Kerry et al. op. cit., p. 11.

¹⁴⁸RHPA, 1991, S.O. 1991, c. 18 at Schedule 2 "Health Professions Procedural Code".

¹⁴⁹CANADIAN MEDICAL PROTECTIVE ASSOCIATION. *Understanding how colleges handle complaints or allegations of professional misconduct*. Available at: <<https://www.cmpa-acpm.ca/en/advice-publications/browse-articles/2012/understanding-how-colleges-handle-complaints-or-allegations-of-professional-misconduct>>.

¹⁵⁰Id. Ibid.

¹⁵¹Id. Ibid.

¹⁵²Id. Ibid.

¹⁵³Id. Ibid.

a Fitness to Practise Committee; and a Quality Assurance Committee¹⁵⁴. While the larger regulatory colleges such as those of the physicians are capable of conducting any investigations with its own staff, smaller regulatory colleges may appoint investigators, such as legal professionals, to conduct the investigation on their behalf.

10.1 Inquiries, Complaints and Reports Committee

For physicians in Ontario, the Inquiries, Complaints and Reports Committee of the College is responsible for investigating complaints or concerns about physicians' care and conduct¹⁵⁵. They are also responsible for investigating complaints regarding a physician's capacity to practice¹⁵⁶. The quorum of the Committee comprises of three members, including at least one public member¹⁵⁷.

10.2. The Discipline Committee

After the Inquiries, Complaints and Reports Committee completes its investigation, it can refer allegations of misconduct to the Discipline Committee¹⁵⁸. The Act stipulates that the Discipline Committee must have a panel composed of at least three and no more than five people¹⁵⁹; two must be public members and one must be a physician member of Council¹⁶⁰. The Lieutenant Governor in Council (also known as the Cabinet) appoints members to the Committee¹⁶¹.

The purpose of the Discipline Committee is to hold hearings of allegations of professional misconduct or incompetence. If professional misconduct or incompetence is found, the Committee is required to make a disciplinary order such as for a reprimand, revocation of a certificate of registration, suspension, imposition of terms, conditions and limitations on practice, and payment of a fine¹⁶². Further, if the misconduct was the sexual abuse of a patient, the Committee may require the member to reimburse the College for funding provided for the victim¹⁶³.

The Code identifies four instances in which the Discipline Committee must find professional misconduct:

1. the member has been found guilty of an offence that is relevant to the member's suitability to practise;

¹⁵⁴RHPA, 1991, S.O. 1991, c. 18.

¹⁵⁵COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO - CPSO. *Committees*. Available at: <<https://www.cpso.on.ca/About-Us/Council-Committees/Committees>>.

¹⁵⁶*Id.* Ibid.

¹⁵⁷*Id.* Ibid.

¹⁵⁸*Id.* Ibid.

¹⁵⁹*Id.* Ibid.

¹⁶⁰*Id.* Ibid.

¹⁶¹*Id.* Ibid.

¹⁶²*Id.* Ibid.

¹⁶³*Id.* Ibid.

2. the governing body of another health profession in Ontario, or the governing body of a health profession in a jurisdiction other than Ontario, has found that the member committed an act of professional misconduct that would, in the opinion of the panel, be an act of professional misconduct under this section or an act of professional misconduct as defined in the regulations and the member has failed to co-operate with the Quality Assurance Committee or any assessor appointed by that committee;
3. if a member has sexually abused a patient; or
4. the member has committed an act of professional misconduct as defined in the regulations¹⁶⁴.

Decisions from the Discipline Committee, like most administrative decisions, can be appealed in a provincial court. Section 70 of the RHPA outlines the procedures for appealing College committee decisions to a court¹⁶⁵. Given that committees within colleges are administrative tribunals, the standard of review for their decisions is reasonableness¹⁶⁶. Court will typically give a high degree of deference to a decision made by an administrative tribunal¹⁶⁷.

10.3. The Health Professions Appeal and Review Board

Decisions made by the Inquiries, Complaints and Reports Committee may be appealed to the Health Professions Appeal and Review Board (Review Board), an adjudicative body established in 1998 by the Ministry of Health and Long-Term Care Appeal and Review Boards Act¹⁶⁸, under the RHPA¹⁶⁹. The Review Board conducts hearings and reviews regarding registration decisions of Colleges and regarding decisions of the Inquiries, Complaints and Reports Committees of one of the registered colleges¹⁷⁰. After conducting a review, the Review Board may affirm a Committee's decision, require remedial action of the member against whom the complaint is made, or refer the member under investigation to the College's Discipline Committee¹⁷¹.

The Review Board also ensures that the Inquiries, Complaints and Reports Committees of each College, as well as the Registration Committees, fulfill their duties under the RHPA¹⁷².

¹⁶⁴COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO - CPSO. *Committees*, cit.

¹⁶⁵Id. Ibid.

¹⁶⁶*College of Physicians and Surgeons of Ontario versus Peirovy*, 2018 ONCA 420.

¹⁶⁷Id. Ibid.

¹⁶⁸HEALTH PROFESSIONS APPEAL AND REVIEW BOARD. *About Us*. Available at: <<http://www.hparb.on.ca/scripts/english/about.asp>>.

¹⁶⁹RHPA, 1991, S.O. 1991, c. 18.

¹⁷⁰HEALTH PROFESSIONS APPEAL AND REVIEW BOARD. *About Us*, cit.

¹⁷¹Id. Ibid.

¹⁷²Id. Ibid.

When the Review Board reviews a College decision about a complaint against a health professional, it looks at the appropriateness and adequacy of the investigation, and the reasonableness of the final decision. Following hearings, in which the parties may represent themselves or be represented by the Council, the Review Board can confirm or rescind all or part of the College's committee decision, make specific recommendations (such as conducting a further inquiry) or require the College's committee to take further action.

With respect to registration decisions, the Review Board has the authority to refer a case back to the registration committee of a college with specific recommendations or require that the college issue a certificate of registration. It can obviously also simply confirm an order.

The Review Board is independent from government¹⁷³; although their members are appointed based on recommendations from the Minister of Health and Long-Term Care, they are not government employees and are not permitted to have ever been members of a regulated health profession or College¹⁷⁴. The Review Board consists of at least 12 members, and one of its members is designated as the Chair, and two as Vice-Chairs¹⁷⁵. Proceedings are determined by a panel of one or three members, one of them must be the Chair, a Vice-Chair (or a Vice-Chair designated by the Chair)¹⁷⁶.

The MOHLTC funds the Review Board, and provides administrative services¹⁷⁷.

II. Challenges of Ontario's Health Professions Regulatory System

As mentioned, the Ontario legislation-based system of self-governing health professions has often been touted as an interesting model that embraces public accountability while respecting the traditional self-regulatory nature of some of the key health professions. Its development has also been studied as an interesting example of deliberative health policy making, involving in an exemplary way the various stakeholders, the government, as well as the public¹⁷⁸.

Yet, particularly in the last decade, a number of controversies related to different health professions have exposed key shortcomings of Ontario's self-regulatory regime. These controversies reveal failures by some of the health professions to set and enforce proper educational and practice standards in specific areas; and

¹⁷³HEALTH PROFESSIONS APPEAL AND REVIEW BOARD. *About Us*, cit.

¹⁷⁴*Ibid.*

¹⁷⁵*Ibid.*

¹⁷⁶*Ibid.*

¹⁷⁷*Ibid.*

¹⁷⁸See in general O'REILLY, Patricia. *op. cit.*

to conduct timely investigations into potential misconduct by professionals. For example, investigations following the death of a woman undergoing a liposuction procedure revealed problematic cosmetic surgery practices by general practitioners and the absence of clear criteria for qualification of cosmetic surgeons¹⁷⁹. In response, the regulatory college, in collaboration with the government, took a number of steps, including changing the scope of practice, improving public information, and introducing monitoring of the practice¹⁸⁰.

A public inquiry into another high-profile controversy, involving the former chief child pathologist of Ontario, Charles Smith¹⁸¹, highlighted the gaps in self-regulation arising on account of lack of formal and explicit quality standards governing pathology. It also revealed the professional regulatory system's failure to challenge at times the practice of incompetent professionals with significant authority within their area of practice. The case further highlighted the potentially devastating consequences of poor quality control, in this case with tragic consequences for individuals who were wrongfully convicted based on flawed pathology expert reports¹⁸².

Lack of timely regulatory intervention and problems with communication of professional misconduct have also been revealed within the context of the nursing profession, in the wake of the murder conviction of a nurse practitioner, Elizabeth Wettlaufer, who killed over a 10-year time span 8 of her patients and attempted to murder many others¹⁸³. The murder trial revealed that she had been fired for medication errors and behavioral problems, yet future employers were not warned about her behavior, which was not further investigated by the profession¹⁸⁴. A public inquiry

¹⁷⁹See FLOOD, Colleen M.; THOMAS, Bryan; HARRISON WILSON, Leigh. Cosmetic surgery regulation and regulation enforcement in Ontario. *Queen's Law Journal*, v. 36, p. 31-70, 2010. Available at: <https://papers.ssrn.com/sol3/papers.cfm?abstract_id=2307196>.

¹⁸⁰COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO - CPSO. *Action taken by the college to improve patient safety with respect to cosmetic procedures*. Available at: <https://www.cpsc.on.ca/uploadedFiles/policies/positions/cosmetic/cosmetic-procedures-initiative_may11.pdf>; COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO - CPSO. *Out-of-Hospital Premises Inspection Program (OHP/IP): Program standards* (2013). Available at: <http://www.cpsc.on.ca/uploadedFiles/policies/guidelines/office/ohp_standards.pdf>.

¹⁸¹GOUDGE, Stephen T. Commissioner, *inquiry into pediatric forensic pathology in Ontario* – report. Toronto: Ministry of the Attorney General, 2008.

¹⁸²For a good discussion, see COLLINS, Kim A.; BYNARD, Roger W. Forensic pathology of infancy and childhood (New York: Springer, 2014). In: UBERLAKER, Douglas H. (Ed.). *The global practice of forensic science*. West Sussex, UK: Wiley-Blackwell, 2015. p. 37.

¹⁸³GOFFIN, Peter. 'Gap' existed between watchdog and wettlaufer care home: inquiry commissioner. *CTV News*, 25 Jul. 2018. Available at: <<https://www.ctvnews.ca/canada/gap-existed-between-watchdog-and-wettlaufer-care-home-inquiry-commissioner-1.4028006>>; LORETO, Nora. Vulnerable patients were easy prey for Ontario serial killer. *Canada's National Observer*, 4 Jul. 2018. Available at: <<https://www.nationalobserver.com/2018/07/04/opinion/vulnerable-patients-were-easy-prey-ontario-serial-killer>>.

¹⁸⁴DUBINSKI, Kate. Nursing home didn't 'paint full picture' of Wettlaufer, inquiry hears. *CBC News*, 25 July 2018. Available at: <<https://www.cbc.ca/news/canada/london/long-term-care-inquiry-elizabeth-wettlaufer-college-of-nurses-of-ontario-1.4760740>>; CASEY, Liam. Serial killer guilty of professional misconduct by nursing college. *Canada's National Observer*, 25 Jul. 2017. Available at: <<https://www.nationalobserver.com/2017/07/25/news/serial-killer-guilty-professional-misconduct-nursing-college>>.

by a commissioner is exploring the role and shortcomings in the functioning of the Ontario College of Nurses and the MOHLTC¹⁸⁵.

There has also been increasing discussion around the question whether it is appropriate to submit all health professions to a similar overarching regulatory regime, based on self-regulation but with statutory recognition and some level of governmental oversight. Two very different issues are worth discussing briefly here, as they are issues that will likely come up in other jurisdictions in the Americas. The first is that the recognition of a health profession by the issuing of self-regulatory powers through a statute may be seen as a governmental endorsement of questionable health care practice. This raises questions with respect to the potential negative impact of such recognition on public health¹⁸⁶. The statutory recognition of health professions associated with homeopathy, naturopathy, chiropractic, and other forms of alternative medicine have in recent years been particularly criticized in this context¹⁸⁷.

The second issue relates to the creation of a self-governing regime in the context of indigenous health care practitioners. There is a growing recognition in Canada, to a large extent as a result of the work of the Truth and Reconciliation Commission, of the devastating impact of past treatment of indigenous communities across Canada, particularly also the impact on the health and wellbeing of indigenous people. The Truth and Reconciliation Commission of Canada (TRC) was set up to address, in a unique way, the historical injustice caused by the Canadian State on the indigenous people primarily through forceful removal of indigenous children to residential schools between 1830s and mid 1900s. The TRC's mandate was premised on the need for acknowledging the injustices of past events to overcome existing conflict, so as to foster a stronger and healthier relationship between the indigenous and non-indigenous going forward. The TRC's primary duty was to gather and record peoples' experiences focusing on the victims, and sharing these experiences with and educating the public. The TRC completed its work by December 2015, and the archives are now maintained by the National Centre for Truth and Reconciliation¹⁸⁸.

¹⁸⁵The final report is expected by 31 July 2019. GOFFIN, Peter. op. cit.; AUDETTE-LONGO, Trish. Advocates warn against treating nursing home murders as an isolated case. *Canada's National Observer*, 26 June 2017. Available at: <<https://www.nationalobserver.com/2017/06/26/news/advocates-warn-against-treating-nursing-home-murders-isolated-case>>.

¹⁸⁶See e.g. the critique in WEEKS, C. Are we being served by the regulation of naturopaths? not if patients are still being misled. *The Globe and Mail*, 28 Apr. 2016. Available at: <<http://www.theglobeandmail.com/life/health-and-fitness/health/canadian-naturopaths-need-to-follow-the-rules-if-they-wantregulation/article29785140/>>. See also KELNER, Merrijoy et al. Responses of established healthcare to the professionalization of complementary and alternative medicine in Ontario. *Social Science & Medicine*, v. 59, n. 5, p. 915, Sept. 2004. 10.1016/j.socscimed.2003.12.017.

¹⁸⁷For a broad overview of critiques placed against CAM see TREBILCOCK, Michael J.; GHIMIRE, Kanksha M. *Regulating alternative medicines: disorder in the borderlands*. (Forthcoming 2019) C D Howe Institute Commentary.

¹⁸⁸TRUTH AND RECONCILIATION COMMISSION OF CANADA - TRC. *Findings: TRC Final Report*. Available at: <<http://www.trc.ca/websites/trcinstitution/index.php?p=890>>.

There is also a push for the recognition of self-governance of indigenous people, including in the context of health care. This raises questions about how to deal with indigenous health care practitioners and potentially quite distinct approaches to health care and well-being embraced by indigenous people. Is it desirable to recognize indigenous health practitioners under the general system of health professional self-governance? Or would it rather perpetuate injustice associated with post-colonialism? How can professional regulation and the enforcement of such regulation be reconciled with growing recognition of indigenous self-governance, including with respect to health care.

The Truth and Reconciliation Commission explicitly recommends recognition and acceptance of indigenous healing practices by mainstream health practitioners: “[to] recognize the value of Aboriginal healing practices and use them in the treatment of Aboriginal patients in collaboration with Aboriginal healers and Elders where requested by Aboriginal patients.”¹⁸⁹

In Ontario, the RHPA specifically states that the Act does not apply to “(a) Aboriginal healers providing traditional healing services or (b) Aboriginal midwives providing traditional midwifery services to Aboriginal persons or to members of an Aboriginal community.”¹⁹⁰ This language has been interpreted to mean that the exemption applies to health services provided to all indigenous people, whether on or off the reserves, as well as non-indigenous people inside an indigenous community¹⁹¹.

But questions have also been raised on the extent to which *ex post* regulation through courts, i.e. under torts and criminal negligence, applicable to all allopathic and CAM practitioners, should apply to aboriginal healers. This has been particularly controversial when children have been involved, as in a 2015 case of **Hamilton Health Sciences vs DH case**¹⁹². Although the hospital, the Child and welfare services, and the parents later came to an agreement with a joint submission in which all parties agreed that the “best interest of the child” has priority over other considerations, the judge originally rejected a hospital’s application under the **Child and Family Services Act** to oblige an indigenous mother to have her child undergo

¹⁸⁹TRUTH AND RECONCILIATION COMMISSION OF CANADA - TRC. *Truth and Reconciliation Commission of Canada: calls to action*. p. 3. Available at: <http://www.trc.ca/websites/trcinstitution/File/2015/Findings/Calls_to_Action_English2.pdf>.

¹⁹⁰CROUCH, Robert; ELLIOTT, Richard; LEMMENS, Trudo; CHARLAND, Louis. *Complementary/alternative health care and HIV/AIDS: legal, ethical & policy issues in regulation*. Canadian HIV/AIDS Legal Network, 2001, p. 89. Available at: <<http://www.aidslaw.ca/site/wp-content/uploads/2013/04/Complimentary+Alternative+Healthcare+-+ENG.pdf>>; CARROLL, Dena; BENOIT, Cecilia. *Aboriginal midwifery in Canada: merging traditional practices and modern science*. In: BOURGEOULT, Ivy Lynn; BENOIT, Cecilia; DAVIS-FLOYD, Robbie (Eds.). *Reconceiving midwifery*. Montréal: McGill-Queen’s University Press, 2004. p. 274-277.

¹⁹¹CARROLL, Dena; BENOIT, Cecilia. op. cit., p. 274-277.

¹⁹²*Hamilton Health Sciences Corp. versus D.H., P.L.J., Six Nations of the Grand River Child and Family Services Department and Brant Family and Children’s Services, 2014 ONCJ 603 (CanLII)*. See also CHARTRAND, Larry. *Deciding medical treatment for a first nation’s child: is it six nations or Ontario authority that should govern?* Paper presented at University of Toronto Health Law Seminar Series, on file with authors, 2018.

further chemotherapy for her cancer. The judge invoked the mother's "constitutionally protected right to pursue their traditional medicine over the applicant's stated course of treatment of chemotherapy."¹⁹³

Conclusions

The model of state-organized self-regulation of health professionals in Ontario offers an interesting middle ground between fully autonomous professional self-regulation, and state supervised regulation of health professionals. It offers a level of public accountability that was lacking prior to the enactment of the 1991 statutory regime, while the profession itself is still predominantly in charge. Interesting features of the regulatory regime include the statutorily required presence of community members at various levels of professional regulation and discipline; a level of state oversight through a statutory regime with some regulatory powers over all the different professions; a state imposed scope of practice which has been developed in the early 1990s in an exemplary inclusive and deliberative process involving all the different health professions; and with respect to disciplinary proceedings and decisions to delist or register professionals, also an appeal procedure before an independent administrative appeal board that is independent from the professions themselves.

Yet, the system also suffers from several inadequacies. Several of these inadequacies can, in our view, be connected to two primary limitations of the regulatory model, which arise on account of power-relations impacting on procedural issues, and the complexity of the regulatory model that may potentially undermine quality control.

The complexity of the regulatory system has exacerbated its drawbacks. The statutory health professions regulated across Canada, and within Ontario, are governed through different statutory/regulatory regimes, accreditation systems, and by different regulatory & advisory bodies depending on type of health, facilities and professions involved. Although there are efforts to streamline the process, severe coordination problems occur as various health-professional colleges are in charge of investigations and disciplining health professionals.

At a time when there is a growing integration of health care practices in complex institutional settings, where there is an increased emphasis on collaboration among the various health professions, a model that reflects the notion of insulated health professions, with clearly delineated professional roles that do not overlap, appears outdated. Even though it has often been suggested, for example, that disciplinary proceedings in relation to complex procedures in which various professions

¹⁹³*Hamilton Health Sciences Corp. versus D.H., P.L.J., Six Nations of the Grand River Child and Family Services Department and Brant Family and Children's Services, 2014 ONCJ 603 (CanLII), cit.*

were involved would better be coordinated, concrete steps to streamline different disciplinary proceedings has not yet been taken.

Furthermore, while the regulatory regime in Ontario developed with a public interest focus, inherent tensions because of professional self-interest and power relations remain an issue. Self-interest and power imbalance are key points of contention in the debate surrounding regulation of complementary and alternative medicines, as well as in the regulation of aboriginal healers. Procedural issues also arise on account of the power-relations between the medical profession and the patients. Notwithstanding public representation at all levels of regulatory college decision-making, the medical profession still dominates within the system. The Inquiry into the Dr. Smith controversy related to child pathology concluded that in several cases the interest of the professional or college – in some cases the reputation of the college – was prioritized over the interests of the patient. Procedural issues resulted in lack of transparency, public accountability, and a gap in information sharing; controversies expose remarkable gaps in regulatory and the control system of health professional practice. In the wake of some of the recent controversies, there are ongoing changes to the system of health professions regulation in Ontario. Whether these changes will constitute a sufficient response to the continuing call for more governmental oversight remains to be seen.

Recent political developments in Ontario may also have significant consequences for the health professions regulatory system in the province. In 2018, the liberal majority, which had dominated Ontario politics and law-making for 15 years, was decimated and replaced by a conservative government led by a populist ‘small government’ style premier. It has embarked on a dismantling of government support and government oversight in a variety of areas. One of its first decisions was to cut back the government’s operational grant to the regulatory College of Midwives, which covered one-third of its annual budget. There is concern that this is the first step towards a significantly diminished role of the government in providing oversight over the health professions. Time will tell how Ontario’s system further evolves.

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