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REGULATION OF HEALTH PROFESSIONS:

The Regulation of the Physiotherapy Profession in British Columbia and the changes in regulatory policy implemented with the Health Professions Act (1996).

by

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ABSTRACT

Self-regulation of the professions is established by governments for the purpose of protection of the public and to direct the quality of health care. British Columbia and other provincial jurisdictions are undergoing a period of change in the way health professions are regulated. The current changes are comprehensive and different than policy directions reflected in previous provincial statutes. Traditional regulatory powers granted by government are designed to establish the scope of practice of the profession, to set the standards of qualifications to practice the profession and to enforce minimum standards of practice by a complaints and discipline process. The new regulatory approach includes a change in how scope of practice is defined and adds a new regulatory responsibility of ensuring continued competency of the regulated professional.

The purpose of this study is to increase understanding of the organizational context of professional regulation by identifying the strengths and limits of professional regulation. To do this the structure of health profession self-regulation is provided along with a summary of current forces affecting the regulation of health professions. A detailed and analytical look at the regulation of the physiotherapy profession in British Columbia is then provided. This historical summary sets the basis for detailing and analyzing the current changes in the way professions are regulated with the new legislative framework of the Health Professions Act (1996).

The study identifies that the need for professional regulation is based on the service relationship between the health care provider and the consumer of the services. In this relationship there is an imbalance of knowledge and power between the professional and the consumer. Self-regulation has an effect on this balance by the establishing and enforcing of standards of practice. The characteristics of health professions are analyzed and the purposes

and extent of professional powers that are established by professional self-regulation are described. A consistent criticism of professional self-regulation is the ability of the professions to use these powers to attain dominance and control. Self-regulatory powers have significant effects on the cost, availability and quality of health services.

The findings of this study show that changes in professional dominance and control are occurring with the implementation of the new regulatory framework established by the Health Professions Act (1996). In particular the new approach to defining scope of practices with shared competencies and only a few reserved acts has the potential to change the dynamics of professional dominance and control. Reserved acts are those acts determined to have the potential of significant harm and are given to specific professions. The study finds that there is a probable increased accountability of the professions for public protection through the establishment of a current and uniform regulatory structure. Along with increasing professional accountability the new regulatory responsibility of assurance of continued competency potentially increases the quality of services being delivered by health professionals.

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CHAPTER ONE

INTRODUCTION AND OVERVIEW

British Columbia and other provincial jurisdictions are undergoing a period of change in the way health professions are regulated. The changes in the legal framework for regulating health professions are comprehensive, and different than policy directions reflected in the previous provincial statutes. In 1991, the province of Ontario was the first to enact regulatory changes, with changes in British Columbia occurring with the implementation of the Health Professions Act in 1994.

Self-regulation of the professions is one of the ways governments are able to direct the structure and functions of the health care system. Governments grant self-regulation to the professions based on the overriding objective of public protection. The regulatory powers traditionally granted to the professions are: establishment of the scope of practice of the profession, setting of the standards of qualifications for registration or license to practice the profession, and allowing enforcement of minimum standards of practice by a complaints and discipline process. Although the granting of self-regulatory powers to the professions is done with the overriding objective of public protection, the granting of self-regulatory powers to a profession does enable the profession to potentially make decisions in the best interests of the profession and not the public. There is a need to attain a balance in the powers granted with self-regulation so that the interests of the profession are not served over the protection of and accountability to the public. Current regulatory reform is in response to historical criticism where the interests of the profession have been or are perceived to be served over the protection of the public.

The examination of regulation of health professionals within the overall health system is a complex and multifaceted task although measures of effectiveness can be determined from the reasons why governments have developed regulations. These measures are whether the public is protected from harm, whether there is greater efficiency and accountability in

utilization of health care professionals and whether there are increased mechanisms for the provision of high quality care by regulated health professionals.

The regulation of health care professionals has an effect on the provision of health care by having an impact on the supply, availability and competence of health professionals. Morrison (1996) suggests that most members of the health workforce are regulated, and therefore an unknown, but significant, component of the cost of health care is due to regulatory restrictions on the use of the workforce. Regulation establishes restrictions on the use of health professionals within the workforce by regulatory control of the scope of practice and the qualifications required for providing health services. Kany (1996) proposes that unnecessary barriers to cost-effective, accessible, quality health care, including those set by professional regulation, must be identified and removed if a nation is to reach the important social goals of cost containment, improved access, and maintenance or improvement of quality of care.

Increasing knowledge and complexity of practices, a shortage of health care providers in the traditional professions and demands from consumers for an expanded range of health care services are resulting in the development of a wider range of health care providers. These are, in turn, resulting in an increasing number of health professions requesting self-regulation. This increasing number of requests highlights the criticism of self-regulation being sought by professions as a means to attain professional status and to be self-serving for the profession instead of to protect the public.

In order to balance public protection with the effect of regulation on the cost, availability and quality of health services it is important that the public and professionals recognize the purpose of regulating health professionals. Rachlis and Kushner (1994) confirm the need for the provinces to review current laws and regulations for the professions but caution that further evidence is needed as to whether or not the new approaches to regulation will actually serve their intended purposes. The purposes of this study are to increase

understanding of the organizational context of professional regulation by identifying the strengths and limits of professional regulation, and identifying emerging issues that health professions face when implementing the current changes in regulation. This study focuses on how the new regulatory framework has the potential to increase public protection while attaining a balance between public protection and the interests of the profession. The study will consider how the new self-regulatory framework is accountable to the public and provides direction for providing high quality health care.

To provide an in-depth picture of regulation of health care professionals the examination will begin with defining a health professional and the structure of professional regulation. The defining of a health professional and the services the professional delivers are important in developing an understanding of the ongoing tensions that occur in the development of regulatory policies. Illich et al., (1977) illustrates how professionalism is one of the ways professionals have control over their work. Regulation enables professions to gain exclusive right and license to manage their work and thus establishes the ability for professions to control the services provided. In other words the granting of regulation to a profession legitimizes the profession. One of the first health professions to attain regulatory status was the medical profession and thus this group is often used as the sample group when analyzing the effects of regulatory policies. Reviews of self-regulation (eg Coburn et. al., 1983; Illich et.al., 1977)) often use the medical profession to illustrate how a profession attains dominance through regulation.

Following a discussion on various perspectives for defining a health profession and the concepts related to professional controls and dominance a scan of the current environmental forces affecting the regulation of health care professions will be provided. To further assist in understanding the causes and needs for the current regulatory changes, a descriptive case study of the history of regulation for physiotherapists in British Columbia will be provided. The final chapters will describe two significant changes that have occurred

with current regulatory reform. The first change is how scope of practice definitions will now be open and shared. The second is the new regulatory responsibility of ensuring continued competency of regulated health professionals over the life-times of their careers. The study will conclude by summarizing the current status of professional self-regulation and identify recommendations for further exploration.

The analysis will focus on the question: In what ways does the new regulatory framework have the potential to increase public protection and accountability? The potential for greater public protection may be seen by the extent to which the public is protected from harm. Accountability can be defined as the responsibility for the services one provides or makes available. In other words, is there accountability built into the new regulatory framework to ensure regulatory decisions and actions are in the public interest and provide effective mechanisms for the provision of high quality care?

In British Columbia, the physiotherapy profession was one of the first previously regulated health professions to become regulated under the Health Professions Act (1996). Using the experiences of physiotherapists in British Columbia, the final chapters will describe the two significant changes that have occurred with current regulatory reform.

Current Changes in British Columbia

Legislative policy for professional self-regulation in British Columbia started to change with the introduction of an exposure bill, Bill 91, The Health Disciplines Act, July 1989. An exposure bill is a method used by governments to inform the legislature of pending legislation and to allow a process of feedback prior to passing the bill into law. On the basis of comments and suggestions received, changes were made and Bill 31, The Health Professions Act, was introduced to the legislature by John Jensen, Minister of Health, on June 28, 1990. The Minister of Health stated that the new Act would provide a strengthening of public safety by enabling consumers to be even more confident that the care they receive is rendered by health professionals who are governed by enforceable standards of practice (British Columbia

Debates, June 28, 1990,#10642). The bill passed third reading and was proclaimed in July 1990. The Act has continued to evolve and the most current form is the Health Professions Act, R.S.B.C. 1996, c.183.

The objective of the new Act is to attain public protection through an effective and accountable regulatory structure. The professions continue to be self-regulated by the government continuing to delegate the duty and responsibility to regulate the profession to members of the profession. The new regulatory framework introduces the use of umbrella legislation. Umbrella legislation is where the legislation applies to more than one professional group. The B.C. government did not put all regulated professions under the new legislation as occurred in Ontario, but chose to move regulated professions under the new legislation when and if they required updating of their acts. The legislation implements current principles of administrative law to standardize the self-regulatory responsibilities.

The new legislation adopts two significant changes for self-regulating professions in British Columbia. The most innovative and distinctive feature of the current changes is how scope of practice or "who can do what" is regulated. The change recognizes overlapping skills amongst health professions and aims to remove monopolies over areas of practice. Examples of monopoly situations include chiropractors having the exclusive right to use manipulation techniques or physicians being the only ones to prescribe medications. Scope of practice definitions have changed from being restrictive or exclusive, to being open and shared between professions.

A second innovative feature of the new Act is how it expands regulatory responsibilities to ensure the continued competence of health professionals throughout their careers. The responsibility for continuing competence was delegated to all regulated health professions in British Columbia, not just those regulated under the Health Professions Act (1996). The responsibility for ensuring continued competence is added to the traditional regulatory responsibilities for setting the entry-to-practice requirements and enforcing

standards of practice.

Study Approach

In this study I used current personal involvement and past experience to access the relevant information. My exposure to regulatory issues began in 1987 when I was elected as a member of the regulatory board of the Association of Physiotherapists and Massage Practitioners of British Columbia (APMP). I held several executive positions on this board until the new legislation was accepted in 1994. Between 1994 and 1999 I was the chair of the College of Physical Therapists of British Columbia (CPTBC). Currently, I chair the Canadian Alliance of Regulatory Boards (the Alliance). The Alliance is the national association of regulatory boards of the provinces of Canada. Both the regulatory CPTBC and the Alliance were informed of this thesis topic and that the author would be using information from direct observation and from the review of relevant literature and archival materials. The author has signed, and respects, the code of ethics and confidentiality policies established by both groups.

The study approach included obtaining and analyzing information from a range of sources including a literature review on regulatory issues and the use of archival materials from regulation of physical therapists in British Columbia. During the years of involvement on the regulatory boards I have been immersed in the process of the regulatory changes and thus it was important to systematically reflect on and re-confirm the regulatory issues being considered. Lofland and Lofland (1995), in discussing the relationship of the researcher to the research field state, "The moral is this: be neither discouraged nor overconfident about your relationship to the setting. Whatever the relationship, it is simultaneously an advantage and a drawback" (p.23).

There are several advantages to being so closely involved over the years. These include the ability to make direct observations and to collect the relevant literature and archival materials, including minutes of meetings, newsletters, correspondence and personal

notes taken. This study allows me to reflect on the issues and provides me with the chance to pose new questions and consider new perspectives. The challenge or drawback, however, is to ensure that personal biases do not unduly influence the scope of the examination. During the process of reflection on the changes and issues one must acknowledge the personal and professional perceptions affecting the memory of the actions taken. Attempts must be made to verify the facts, to weigh the factors influencing a perspective, and to allow new perspectives to emerge. This thesis reflects my attempt at achieving an accurate, balanced and reflective account of regulatory changes and their implications.

CHAPTER TWO

REGULATION OF HEALTH PROFESSIONS

A profession may be defined from differing sociological, political and economic perspectives; however, this chapter will emphasize how a profession is defined for regulatory purposes using the physiotherapy profession in British Columbia as an example group. A review of the structure and forms of professional regulation will be given. The conclusion of this chapter will provide an historical outline of professional regulation and note the current changes occurring in Canada.

Defining a Health Profession and a Health Professional

When the privilege of regulation is granted to a profession by government, the profession achieves legal recognition of its professional status. According to the Health Professions Act R.S.B.C.1996, c.183, the legislated definition of a health profession:

> ...means a profession in which a person exercises skill or judgment or provides a service related to
> (a) the preservation or improvement of the health of individuals, or
> (b) the treatment or care of individuals who are injured, sick, disabled or infirm.

Understanding the characteristics of a profession helps in explaining the need for health professional regulation. One of the earliest reports that defined characteristics of a profession in the context of regulatory policies was by McLeod (1973) in the Special Report, Public Regulation of the Professions prepared for Foulkes, R.G. (1973), Health Security for British Columbians (the Foulkes Report). McLeod's report outlines the following characteristics of a profession:

- a profession is an organized group of individuals providing a specific service, a service based on a body of knowledge which can be applied to human needs and a social purpose.
- practitioners are highly educated and have a common body of knowledge.
- standards of ethical practice and conduct must prevail.
- considerable public confidence is given to the practitioner.

- members must achieve and maintain high quality standards and competence. (p.2,3)

Professionals have organized into groups that have specific roles and responsibilities. For physiotherapists in B.C. these groups include the regulatory body (The College of Physical Therapists of British Columbia, CPTBC), the professional association (The Physical Therapy Association of British Columbia, PABC) and the educators (The Association of Academic Educators and the Faculty of the School of Rehabilitation at the University of British Columbia). Understanding the division between the roles and functions of the professional association and the regulatory colleges can be confusing. The professional association promotes the professional interests, and the regulatory colleges act in the interests of the public. A criticism of professional self-regulation is that the powers granted with regulation can be misused for professional self-interests, control and power within the health care system. In the new regulatory structure established by the Health Professions Act (1996) there is a clear separation of professional membership promotion functions from regulatory responsibilities of registration/licensing and discipline functions. Prior to the Health Professions Act (1996) it was possible for one board to have both regulatory and professional association roles and responsibilities. The separation of regulatory colleges from professional associations reduces the potential for interests of the profession taking precedence over interests of the public.

A primary responsibility of regulatory colleges is protection of the public by setting standards for education, training and practice of the professional. With regard to physiotherapists, Atkinson (1988) developed criteria of professionalism and documented how the expertise and education of physical therapists met these criteria and in particular, achieved the highest professional level, autonomy of judgment. Atkinson used the British Rules of Professional Conduct of the Chartered Society of Physiotherapists in 1987 to substantiate her analysis on professionalism. Atkinson used the following criteria of professionalism developed by Moore (1970):

1. Strong motivation and lifetime commitment towards the chosen career.
2. Membership of an established organization committed to defining, protecting and enhancing the represented profession.
3. Completion of a prolonged period of specialized education and training.
4. Orientation towards serving clients through the competent application of specialized knowledge and skills to individual needs.
5. Autonomy of judgment within the realm of the given profession.

The ability of a health care professional to use autonomous judgment in the application of specialized knowledge and skills is reinforced by the establishment of self-regulation of a health profession. Coburn (1999), in examining professional autonomy, states

> Professional self-regulation, the measure of autonomy, implies not only that occupational organizations represent the profession externally and are not subject to outside control, but the occupation itself and no one else controls the work of individual practitioners (p. 28).

Graddy (1991) discussed how researchers and policy makers are increasingly scrutinizing the acceptance of obtaining self-regulation as a natural progression of professionalization of an occupation. Attaining self-regulation grants the profession the power to set and enforce the qualifications required for entry to practicing the profession and the standards of practice that occur in the service relationship between the client and the health professional. These regulatory powers have an influence on the costs of services, the number of qualified professionals and the availability of services.

Because health care involves people, a mark of a health professional is service through relationships. The relationship between a health professional and the consumer is unequal in power and knowledge. Professional knowledge establishes a power relationship between the health professional and the patient. The relationship inequity between the professional and the consumer is used in justifying the need for regulation to protect the public. Fulford (1996) states: "Medical knowledge has too often been used, not to empower the patient, but as a power base for the doctor" (p. 15). Fulford and others (Friedson, 1970; Starr, 1982) describe,

usually using physicians as the sample group, how medical power can be used for commercial gain and for a controlling attitude of " I know best". The powers of the professional are affected by the profession's regulatory ability to establish its scope of practice and by defining professional standards required in the provision of services.

Professional's can use their knowledge not only in direct patient relationships but also for influencing social and political processes. Airaksinen (1994) presents a sociological view of professional service by comparing the professions of engineering and medicine. In comparing the professions Airaksinen describes the differences in the value and purposes of the service being provided. In medicine the value and purpose of the service is to be healthy and one cannot refute that there is a wish to be healthy except in unusual circumstances where a person will use ill health for personal gain such as avoiding work. Whereas the services provided in engineering are based on determining a need to provide the service. For example there is a need to build a bridge. This difference in the purpose of the service being provided and the value of the service affects the power and relationship the professions have with the public they serve.

Physiotherapists have the type of service relationship where there is a direct effect on the public. A direct effect is when a health professional applies a treatment to an individual and the individual is directly affected by the treatment. This direct effect justifies the need to protect the public by enforcing the standards of practice for the profession. An indirect effect is when the decision or action of the professional is not applied directly to the consumer. If the relationship is one of an indirect effect then public protection may be accomplished by means other than by professional regulation. The engineering and accounting professions are two examples of professions where application of professional skills may be regulated and the

public protected through legislation such as building codes and taxation laws.

Educational qualifications or specialized training are part of defining a profession. Regulation of a profession gives the profession the power to establish entry-level practice qualifications. Professions have been moving away from using graduation from an education program as the primary criterion for entry to practice and moving towards the requirement of competency based assessments. Physiotherapists in Canada started to implement a national competency based examination in 1994. The purpose of the examination is to determine that the candidate has acquired the minimal entry-level standard prior to being granted a license to practice physiotherapy. Both Canadian and non-Canadian educated physiotherapists must successfully complete the examination. Eligibility for a candidate to take the competency examination is established through a credentialing process. For Canadian educated applicants, credentialing criteria include having attained a Canadian baccalaureate degree in physical therapy from an accredited program, completion of the required hours of supervised clinical practice and proficiency in the English or French language. For the non-Canadian-educated, the credentialing process evaluates the applicant's education and determines if it is substantially equivalent to the Canadian baccalaureate degree in physiotherapy. In the regulatory framework of the Health Professions Act (1996) responsibility for determining entry-level standards is retained as a responsibility of the regulating College.

Structure and Forms of Professional Regulation

The World Health Organization (WHO) categorizes health laws into twenty-two categories. Legislation implementing health policies for health manpower is one of the largest areas of legislation as so many aspects of the health systems depend on the qualifications of health providers. Roemer (1993) defines three main forms of health profession licensure laws in which a central authority exercises some control over the activities of the open market as:

Form One:
Authority is invested in the Ministry of Health (e.g. in Sweden and Japan).

Form Two:
Authority is invested in independent quasi-governmental groups recognized by the law (e.g. Medical Council in Great Britain, National Council of the Order of Physicians in France, the various agencies or colleges established by States and Provinces in the United States and Canada).

Form Three:
Authority is invested in judicial decisions on controversial matters, often involving interpretation of a statute (e.g. a court decision on what is informed consent for treatment.)

Each of these forms of occupational regulation has a different effect on the service market, incurs different social costs and has different benefits to practitioners and consumers. It is Form Two where the authority is delegated to a profession to be self-regulated, under which health professions are regulated in Canada.

Administrative Law

While it is beyond the scope of this study to discuss in detail the types of law enacted by governments in Canada, some basic definitions will assist in understanding the form of law under which health professions are regulated. In Canada, parliament is responsible for representing the popular will and does so by enacting legislation that sets general principles into law. Constitutional law establishes the rules that determine which institutions have the right to make laws that govern our society. Administrative law is a branch of civil law that governs the administrative and adjudicative functions of the government and quasi-governmental bodies and tribunals.

The form of regulation used to establish the self-regulating colleges for health professionals falls under the purview of administrative law. The functions of administrative law include setting the scope of the powers and duties delegated to administrative bodies, setting the principles of how the powers are to be exercised, and providing legal remedies for those aggrieved by administrative actions. Statutes enacted by the government delegate

powers and duties to the administrative or regulatory bodies. In other words there must be lawful authority for the actions of the administrative bodies. The principles of "natural justice" or "procedural fairness" are an essential part of administrative law. The foundation of these principles is the duty to act fairly in administering the powers and duties specified by the statute. Statutes are difficult to amend as they can only be amended by the legislature. Regulations set the details of how the statutory functions are to be administered. Regulations can be changed by an Order in Council or a Minister of the government.

In Canada, federal and provincial governments are increasingly using template, umbrella or skeleton legislation to establish administrative laws, where the administration of the law applies to more than one professional group. One example of "umbrella" legislation is the British Columbia Health Professions Act (1996). Use of umbrella legislation eliminates the need for parliament to debate the complex and technical details of every professional group. Regulatory authorities have greater flexibility and more immediate ability to adapt the law in response to social or economic changes. However there is concern that governments are allowing an erosion of legislative power by negating their direct responsibility for the laws. To balance this concern, umbrella legislation needs to be consistent with public policy, and incorporate methods of accountability. It is necessary to clearly define the purposes and methods of regulation and establish regular legislation reviews.

Self-regulation

A government often delegates authority for administering the regulation to those with the expertise and the ability to effectively deal with issues requiring technical and scientific expertise. This is called "self-regulation". It is important to understand that statutory authority for self-regulation is a privilege given by the government to a health profession and is often referred to as delegated legislation.

Reviews of federal and provincial reports on health care show that there has been repeated consideration of the issue of whether or not self-governance should be granted as an

effective way to protect the public. Federally, the Hall Commission (1964) report stated that free and self-governing professions means the right of the members of health professions to practice within the law, to free choice of location and type of practice and to professional self-government. Other provincial reports (The McRuer ,1968 report in Ontario; The Castonguay Report released August 29, 1967 in Quebec) agreed with the Hall Commission's concept that to achieve high quality service, professionals need to work with integrity, independence and freedom from controls to allow the application of their knowledge and skills. The 1991 report, Closer to Home. The Report of The British Columbia Royal Commission on Health Care and Costs (the Seaton Report) endorsed self-governance as the chosen means for regulating health professions in British Columbia. However, the report points out that there are evolving levels of self-governance being granted by governments.

The new regulatory structure set by the Health Professions Act (1996) in British Columbia is based on the principles of self-governance with the objective of obtaining a balance of essential regulation to safeguard the public with the autonomy (or advantages) that self-regulation gives to the professions.

Defining Levels of Regulation

Different levels of regulation have been developed to provide public protection and yet apply a policy of using the least restrictive level of regulation. Regulation can occur in three ways: licensure, certification, and registration. There is a lack of clarity and consistency in the everyday use of these terms.

Licensure is the highest form of regulation since it provides the highest level of public protection. Generally governments must perceive a significant risk of harm to the public before a profession meets this requirement. Licensure defines a particular scope of practice making it illegal to perform a service unless one has the specific qualifications. Licensure protects the use of a title and allows certain activities to be done only by members who hold certain qualifications. Licensure defines standards of practice to be controlled and establishes

power for complaint and discipline processes. In Canada, the licensure of health professions is a provincial regulatory responsibility. In British Columbia, prior to implementation of the Health Professions Act (1994) the recognized health professions with regulatory statutes included Optometrists, Naturopaths, Dentists, Chiropractors, Medical Practitioners (Physicians), Nurses, Pharmacists, Podiatrists, Psychologists and Physiotherapists (the Physiotherapy statute also covered Massage Therapists). Under the new Health Professions Act (1996) new professional groups can apply for regulation. Examples of occupational groups applying for self-regulation include midwives, acupuncturists, laboratory technicians, occupational therapists and social workers.

Certification restricts the use of a particular title to individuals who meet specific requirements but does not restrict practice to only those that attain certification. The purpose of certification is to help the public to identify providers who have met certain defined criteria of knowledge, skills and abilities. Certification is used in both public and private sector industries. Certification can be attained by statutory (regulatory law) or non-statutory (volunteer) processes and may include meeting a certain level of education, experience and/or an examination process. An example of voluntary certification is when a person is certified after a course in reflexology; an example of government certification is certifying a mechanic to repair specific machinery. Certification can also be used for facilities such as laboratories.

Registration is the least restrictive form of regulation, and provides a register of people with certain qualifications permitting the use of a certain title. It does not restrict others from performing similar activities. Registration is used when there is a low probability that the provider could cause harm to the public and it provides no guarantee of competence or assurance that the individual has met educational or experiential standards. An example of registration currently being used in health care is that of an exercise therapist.

Structure of Health Regulation

A statute is an act of the legislature that sets the type and amount of authority to be

granted. When proposed legislation is first placed in the legislature it is called a bill; once passed by the legislature it is called an act. The terms statute, act and law are often used interchangeably in discussing legal frameworks.

By-laws are ancillary legislation to a statute and are generally administrative and explanatory in nature. They expand the powers of an act by providing the framework for applying the regulatory statute. A by-law is highly enforceable but can be changed more easily than a statute. A by-law is changed by approval of the cabinet of the government and passed by the Lieutenant Governor in Council.

A rule does not have the same status as a by-law or a provision in the statute and has less authority. A rule passed by the relevant regulatory board is enforceable as law, providing that the making of the rule is specifically authorized within the statute. It is difficult to determine what should be a by-law or a rule. The common process for determining this is to evaluate the level of importance of the subject matter, the level of risk, and the need for evolving changes to occur within appropriate time frames. By-laws potentially take longer to change because they require approval of cabinet. Although the Provincial Cabinet in B.C. usually meets once a week, accepting a bylaw onto the Cabinet agenda can be a slow process dependent on the prioritization of items to be included on the agenda. Agenda changes can occur to deal with emergent or crisis items.

Standards guide the practice of a profession and outline the minimal level of performance expected. They relate to the core areas of practice and are not subject to frequent changes. Standards are used for many functions including the evaluation by individual practitioners of their own performance, the education of members of the public, or other health-care providers, about the expected performance levels of care and the regulatory enforcement (discipline) of a professional's practice performance. A standard can be formalized, such as those relating to ethical considerations, by being included in a rule or a by-law. This is done to give the regulatory body greater powers of enforcement. The Code of

Ethics for the profession and standards for record-keeping are examples of standards that are usually placed into rules or bylaws. The Code of Ethics or Codes of Professional Responsibilities are used to guide everyday decisions in the delivery of care. They establish that a professional is accountable for his or her actions, including the responsibility to practice within his or her own level of competency. A Professional Code of Ethics provides a standard of professional conduct based on principles of competence, integrity, professional responsibility, respect for people's rights and dignity, concern for the welfare of others and social responsibility. Professions may also use clinical practice statements and advisory statements to guide the practice of the profession. Physical therapists in British Columbia use clinical practice statements and advisory statements approved at the College Board level. The advisory statements provide interpretation of the standards and the clinical practice statements. The structure of regulation has developed over time and continues to evolve with the implementation of the new regulatory structures set by the Health Professions Act (1996).

Historical Summary of Early Regulation

A review of the history of regulation shows its consistent purpose has been to protect the public from harm. This has been attained by setting standards of education and practice. Wiessert (1996) noted the first licensing for health personnel was for healers in Bagdad in 931 A.D. By 1225 A.D., Frederick II, Holy Roman Emperor, presided over what was probably the first medical practice law. The law forbade the practice of medicine without a license, included examination by teachers of medicine, required five years of academic study (three devoted to the study of logic), and one year of practice under the direction of an experienced physician. It also required physicians to provide free care for the poor and prohibited them from running apothecary shops.

Roemer (1993) notes that early in the history of western civilization, Norman King Roger II in 1140 ordered that physicians could not practice medicine without being found fit to practice by the Salernitan masters. This was the start of policy that spread through Europe

for training and examinations to be administered by professors in universities. The government also had a representative on the examination board. In Europe occupational regulation became more prevalent with the development of crafts and guilds and the establishing of standards for producing goods and services of high quality in order to maintain and increase the market share of producing groups. Protecting the market share and the standards of quality of goods and services continues to be a component of occupational regulation today.

Physicians, lawyers and notaries were the first professions to convince governments of the need to protect the public and be granted self-regulating licensing laws. The Royal College of Physicians was chartered in 1518 and authorized to grant licenses. The Medical Act (1858) is reported to be of major importance in the development of medicine in Britain. This Act established the General Medical Council and required this council to publish a register of qualified practitioners and to protect the public from incompetent practitioners. "This act was framed as protecting the public but critics at that time argued that the profession derived significant monopolistic advantages from registration and the profession knew this from the beginning of their campaign for registration." (Waddington, 1994, p.152).

In Canada, the first occupational regulation was enacted in the Quebec Ordinance of 1788 "to prevent persons practicing physic and surgery in the province of Quebec or midwifery in the towns of Quebec and Montreal without a license" (MacDermot, 1975, p.12). When Canada became a nation, the Constitution Act (1867) gave the provinces the responsibility for providing their own health care services. In British Columbia, the Medical Act (1886) established the College of Physicians and Surgeons of British Columbia. Other Acts allowing professions to attain early regulation include the British Columbia Registered Nurses Act, passed in 1918; the Chiropody Act of 1929; the Chiropractic Act of 1934; and the Naturopathic Physicians Act of 1936. Regulating physiotherapists in British Columbia began in 1936, under the Naturopathic Physicians Act.

In the United States, regulating occupations began in 1639 in Virginia, with regulating fees charged by physicians (Berry & Brineger, 1990 in Weissert (1996). The first legislation requiring medical practitioners to take licensure exams was passed in the 1760's in New York and New Jersey. Over the next few years most other states followed their lead. In 1889, a U.S. Supreme Court decision, Dent v. West Virginia, upheld that state's right to deny a practice license to a physician without state approved credentials. The court's decision summarized the rationale for state regulation of health professionals. "The power of the state to provide for the general welfare of its people authorizes it to prescribe all such regulation as in its judgment will secure or tend to secure them against the consequences of ignorance and incapacity as well as of deception and fraud" (Gross as cited in Weissert, 1996, p86).

Review of Provincial Regulatory Changes

A review of the current regulatory changes occurring in Canada reveals that all provinces are moving towards the implementation of a uniform regulatory structure.

Ontario

Ontario's public policy implemented with the Regulated Health Professions Act (1991) and the profession-specific acts that are its companion pieces set many precedents now seen in other Canadian provinces. A major impact on public policy relating to the regulation of professionals in Ontario was the 1968 McRuer Royal Commission Inquiry into Civil Rights. Volume Three, Section Four was devoted to the professions. The purpose of regulating a health professional was reaffirmed as:

> The granting of self-government is a delegation of legislative and judicial functions and can only be justified as a safeguard to the public interest. The power of self-governance must not be extended beyond the present limitations unless it is clearly established that the public interest demands it and that the public interest could not be adequately safeguarded by other means. (p.1209)

The Commission recommended the inclusion of lay representation on the boards, Lieutenant-Governor-in-Council approval of professional regulations and establishment of due process in the procedures and actions of professional governing bodies.

The McRuer Report, the Committee on Healing Arts, and the Ontario Law Reform Commission, which later became the Professional Organization Committee (POC), influenced the Minister of Health in 1983 to establish the Health Professions Legislation Review. The 1980 report of the Professional Organizations Committee did not deal specifically with health professions but covered the structure and processes required for public accountability for self-regulating professions. The report covered what should be in a statute, what should be in regulations subject to Lieutenant-Governor-in-Council approval, and what should be in a rule set by the regulated profession. The review recommendations were put forth in the report Striking a New Balance: A Blueprint for the Regulation of Ontario's Health Professions (1990). This report led to the Regulated Health Professions Act (1991), an Act that is a departure from the previous patterns of self-regulation in Ontario. Bohen (1994) states that the intent of the Regulated Health Professions Act (1991), proclaimed in 1993, is to make more efficient use of all health professions without compromising public protection. The Act strongly recognized that the purpose of professional regulation is the protection of the public and not the interests of the profession. The Ontario regulatory reform significantly changed the way in which a scope of practice was defined. The scope of practice definitions are now designed to allow more freedom of choice for the consumer, to recognize overlapping scopes of practice and to reduce exclusive control by any profession. Other changes included public representation on the boards and three new statutory committees of Quality Assurance, Patient Relations and Fitness to Practice. The responsibilities of the statutory committees are to ensure continuing competency of the regulated professional and to prevent patient abuse.

Quebec and Other Canadian Provinces

In Quebec, corporations are given the privilege of self-regulation. Corporations are

equivalent in duties and functions to Colleges/ Regulatory Boards and Registration Boards in the other provinces. The first corporations were created in the mid-eighteenth century for notaries, doctors and lawyers. Reform of the professional system in Quebec began in the 1960s as a means to provide protection for the public, establish standards of quality in professional practice and identify certain professional groups by statute. In 1966 the Quebec government set up a Commission of Inquiry on Health and Social Welfare (the Castonquay-Nepvue Commission) and this commission identified the need for changes in the framework of professional regulation. The initial Castonquay Report was released August 29, 1967. The subsequent report, the Report of the Commission of Inquiry on Health and Social Welfare (The Castonquay Report, Quebec, 1970) was devoted to the examination of "The Professions and Society". The report identified the problems of accountability and of multiple professions being regulated with no consistency in their laws. The report identified the need for professional regulation to come under closer state supervision. However the report also recognized the essential role that professional regulatory bodies performed in protecting the public. It was recommended that government develop a mixed system that was neither totally independent nor state managed, where the privileges and powers accorded to the professions were balanced and managed under a new structure. This structural change included a minister responsible for application of professional laws, a new inter-professional council, and the appointment to the corporations of directors to represent the public. In 1973, a professional code and 21 related bills identifying 38 professional Corporations were enacted.

Protection of the public is the overriding goal for establishing Corporations in Quebec. Corporations are assigned reserved titles, and have the power to draw up regulations respecting the conduct of business, the training required of members, and the criteria for acceptance into the profession. The professional code (the law) requires Corporations to make annual reports; carry out periodic assessments by inspectors to make sure their members are competent; and have discipline committees to hear complaints from consumers such as

complaints on fees, misconduct and professional secrecy. The corporations are monitored by government, and are public agencies answerable to society. The overseeing body is the Office of the Professions.

Other Canadian provinces are also undergoing regulatory reform similar to what has occurred in Quebec, Ontario and British Columbia. In Alberta, the Special Committee of the Legislative Assembly of Alberta on Professions and Occupations, Report 1, April, 1973 and Report 11, December, 1973 (Alberta, Government of, 1973) and Government of Alberta, Policy Governing Future Legislation for the Professions and Occupations (Alberta: Government of, 1978) recommended the formation of a Health Workforce Rebalancing Committee. The committee mandate is to recommend to the government regulation that is consumer focused, affordable, accountable and to apply principles of public protection similar to the policy directions established in Ontario, British Columbia and Quebec.

Other provinces are in various stages of regulatory reform. The direction of change is consistent with the changes that have occurred in Ontario and British Columbia. The territories, including Nunavut, do not currently have legislation to regulate the licensure of physiotherapists. The Health Professions Act was passed in Alberta in May 1999. The College of Physical Therapists of Alberta will fall under the Health Professions Act by December 31, 2002. The Manitoba Law Reform Commission, in October 1994, recommended the establishment of a delegated common legislative framework focused solely on public protection; the Task Force also recommended that the "traditional occupation-based approach to delineating scopes of practice should be replaced by a task based model...in which tasks and services are regulated, rather than practitioners or occupations" (p.8). The Manitoba report referred to the need to do a cost benefit analysis as part of the decision-making process on whether or not a profession should be regulated. The analysis was to determine whether the costs of regulating a profession were justifiable in relation to the benefits attained in public protection.

Summary

This chapter defined a health profession from a regulatory perspective, defined the structure of professional self-regulation and provided a historical and current summary of self-regulation of health professionals. The next chapter will provide a summary of current forces influencing the regulation of physiotherapists in Canada in general and British Columbia in particular. An understanding of the forces influencing the implementation of regulation assists in identifying why the new regulation is being implemented and whether the new structure has the potential to be accountable in meeting the objective of public protection.

CHAPTER THREE

ENVIRONMENTAL SCAN

This chapter provides a summary of the forces perceived as influencing the regulation of health care professionals, specifically physiotherapists. In particular the chapter will illustrate the interplay between regulation and social, financial, professional, educational and legal influences on policy directions for self-regulation of the professions. The summary is compiled from a range of sources, including workshop discussions, press and journal articles, and discussions with colleagues in health care. The basis of this summary was taken from a strategic planning session held March 1998 in Toronto, Ontario by the Canadian Alliance of Physiotherapy Regulatory Boards. Participants attending this planning session represented physiotherapist regulators from across Canada.

To Regulate or Not

The debate as to whether professional self-regulation provides for public protection or gives advantages to the regulated professions has existed since the first establishment of professional self-regulation. Waddington, (1994) noted this in the early history of medical regulation occurring in the 1850s in Great Britain. There are inherent costs and benefits to professional self-regulation. Governments enact regulations emphasizing the public's need for accessibility, accountability, equity, quality of care and protection from harm. However regulation can be seen to promote professional self-interests and protect "turf" through the use of restrictive scope of practice definitions and by the establishment of entry to practice and credentialing requirements. Regulated professions ensure uniform and high standards of practice, codes of ethics and ongoing monitoring of competence but they may also impose artificial barriers on interdisciplinary practice, limit safe patient choices and protect the professional's ability to earn income. O'Niel, Finnocchio, and Dower (1996) summarize the criticisms of self-regulation in their statement:

> ...although health profession regulation served the health care system and its consumers well in the past, it is out of step with current health needs and expectations.

> As a result, the regulatory system is now being criticized for increasing costs, restricting managerial and professional flexibility, limiting access to care, and for being equivocally related to quality. Perhaps most seriously, regulatory bodies are perceived as largely unaccountable to the public they serve. (p. 97)

The main issue to consider in determining the need for regulation is whether there is sufficient need to protect the public, and if so, what kind of regulation is appropriate? Determining appropriate regulation occurs in a highly political environment, with much debate on the degree of legislative control needed to adequately protect the public. Weissert (1996) points out that while traditionally there has been little overlap between the world of the health professions and the discipline of political science, the regulation of health professions is a highly political issue.

After establishing the need for regulation there are various regulatory options available for governments to use: the setting of standards, regulating input by setting of certification or licensure and external regulation by the state or self-regulation of the profession. Each regulatory option has advantages and disadvantages. In describing how different regulatory options are chosen Trebilock, Tuhoy, and Wolfson (1979) state:

> The selection of regulatory options requires the application of priorities and weights across various interests and principles... These are a matter of judgment, to be defended and debated, and ultimately to be resolved by government authorities in framing the legislation. (p. 85)

Another consideration in determining whether or not to have self-regulation for the professions is the courts' consistent determination that the professionals themselves are best qualified to pass judgment on their colleagues' professional behaviors including misconduct. The granting of self-regulatory powers to a profession recognizes that professionals are in the best position to make judgment on their colleagues' behaviors.

Health Care versus Medical Care

Health care policy continues to reflect an emerging societal value of providing health care, rather than focusing solely on medical care. The way we think about health care has changed from an illness model to wellness and overall population health, with an emphasis on

disease prevention and health promotion. There is increasing evidence that many important determinants of health lie outside the health care system (e.g. Armstrong & Armstrong, 1996; Decter, 1994; Evans, Barer & Marmor,1994; Pietroni, 1991; Rachlis & Kushner, 1994). For health regulators, the move away from a medical care model towards prevention of injury and disease affects where health professionals are employed and the type of services being provided. Traditionally, a major part of physiotherapy services was care for the consequences of illness and disability and physiotherapists were primarily employed by hospitals. The shift in society to an increased emphasis on wellness and prevention of illness and disability is resulting in expansion of the scope of practice and the competencies required by physiotherapists. For example physiotherapist are now being employed in industry where they are providing strategies for ergonomic prevention of injury.

A range of literature from different disciplinary perspectives including sociology (Friedson, 1970; Starr 1982), political science (Fulton, 1993; Savan, 1989; Toulmin, 1986; Pietroni, 1991), and economics (Evans, 1983; Jerome-Forget, White & Wiener, 1995; Rodwin, 1993), describes the medical model with reference to the hierarchy of health care professionals, with the physician at the top. Fulton (1993) describes how change in the delivery of health care is occurring and with this change the autonomy, status and power of physicians is collapsing. In reference to the new health professions legislation he states:

> The new health professions legislation in Ontario (consisting of 26 separate statutes), which impacts the province in 1993, embodies principles and mechanisms which permanently change the relationships of health care professionals. (p.235)

Peitroni (1991) and Coburn (1999) describe how the attainment of self-regulation changes the relationships among health professions, and more specifically challenges physician autonomy. The implementation in regulation of open scope of practice definitions and the expanded knowledge, skills and abilities of a wider range of health care providers are also changing the relationships between professions.

Knowledge and Technology

The continuing expansion of knowledge affects the scope of practice of health professionals and the determination of who is qualified to apply the new knowledge and advances. The continuing growth of knowledge heightens the need for regulators to address the issue of how to ensure continued competence of professionals throughout the lifespan of their careers.

Access to knowledge is more readily available with the continuing development of access to communication technologies. An example of a new communication technology affecting the regulation of health care professionals is the development of telehealth. In a telehealth system a client could receive medical advice by telephone or perhaps the internet from a practitioner anywhere in the world. A concern for regulators regarding telehealth is provision of services by a health care practitioner who is not registered in the province of the consumer who receives those services. The question of the need to regulate telehealth services gets to the heart of whether or not regulation is required for public protection. At present in both Canada and the United States, regulatory responsibility lies with the province or the state for regulatory jurisdiction over the health professional. How or if regulation will be enacted to address regulatory issues of privacy, patient safety, efficacy, ethics, quality of services, and legal and economic implications across jurisdictional areas has not yet been determined. Prompted by the issues raised by the implementation of new communication technologies a shift may occur from professional regulation to more consumer responsibility for choice of care and reliance on marketplace competition.

Changing Population and Provider Demographics

An aging population and expanded ethnic diversity is changing the demand for health care services and the type of care wanted. Additionally, it appears that consumers are increasingly asking to be involved in decisions related to their care. One approach governments use to control the costs of health care is to increase health education to

consumers and place increased responsibility on the consumer to make informed choices. It is possible that informed consumers will increasingly utilize the regulatory complaints and discipline processes to enforce the quality and effectiveness of care being delivered.

In regards to the demographics of physiotherapists there are several indicators of a potential shortage of qualified physiotherapists. The registration statistics for physiotherapists currently employed in British Columbia shows that many of those currently employed are nearing retirement. A shortage may result in pressure for regulators to lower the qualifications required to practice the profession and/or changes in the type of services the profession provides. The Alliance of Canadian Physiotherapy Regulatory Boards National Human Resource Data (1997) reported that there are 2,258 physiotherapists in British Columbia, 58.4% of whom are between the ages of 35 and 54 years, and 26.5% of whom are between the ages of 45 and 54 years. These data indicate that over the next ten years a significant number of physiotherapists may be retiring from practice. Another interesting statistic to consider when determining a possible shortage is that 81% of the practitioners are female, which may affect the availability of physiotherapists if these women are off work for family reasons.

Another change occurring for physiotherapists and other health care providers is that other care-givers are now providing services that were traditionally in the scope of practice of the physiotherapy profession. An example of this includes therapeutic exercise being prescribed by kinesiologists and exercise therapists.

Trujillo, Beggs, and Brown (1996) discuss how, for physiotherapists, there is a shift from the traditional health delivery approach to using support personnel for rehabilitation services previously provided exclusively by professionally-qualified practitioners. This is seen as cost effective and is supported by the legislative changes in regulation of health professionals. Currently, support personnel are unregulated; this is of concern in regards to public protection. For safe and effective care, the consumer needs to be able to assess the qualifications of the service provider or to rely on public protection policies such as self-

regulation. One aspect of public protection for physiotherapists and other health professionals is the development of standards for transfer of functions to another care-giver. Regulation of a profession applies only to the regulated professional, not to the person to whom a function may have been transferred. The scope of work a support person can provide is guided by the current changes in regulation defining scopes of practice, including the definition of supervised acts and reserved acts. The effectiveness for public protection of using supervised acts is not yet clear. The issues are how to appropriately delegate supervised acts appropriately and how to direct and monitor the activities of others.

Globalization

Regulatory barriers to trade are being challenged by the globalization of the world economy. Regulators are determining how to apply standards across jurisdictions. Current Canadian policies implemented in response to the effect of the global economy and increased tolerance for trade are the North American Agreement on Free Trade (NAFTA) and the provincial Agreement on Internal Trade (AIT). AIT makes specific reference to professional services. Regulation of health care professionals is a provincial responsibility, but there are overriding influences of federal government policies, particularly in the areas of qualifications to practice and maintenance of registration requirements. These inter-provincial and international trade agreements underscore the fact that regulatory policies and requirements must change to decrease or eliminate barriers to labour mobility and to allow for free movement of goods and services across provincial and international boundaries.

There are four potential barriers to the mobility of physiotherapists identified in AIT: defining scope of practice, entry-to-practice requirements, re-entry-to-practice requirements, and maintenance of registration requirements. AIT includes the principle that professional standards and criteria are to be objectively related to competence and that the level of competence used is not to be more restrictive than is necessary. As a result, professions, including physiotherapy, must establish definitions of competency, must assess competence

both at the entry level and continuing to practice level, and must document valid standards of practice.

Equity and Access

The actions of a regulatory college are guided by the Canadian Charter of Rights and Freedoms (April 1982) and by provincial legislation on freedom of information and responsibilities assigned to the Provincial Ombudmen's Office. Hamilton (1994) states that the principal reason for the dramatic increase in court decisions affecting self-regulating professions is the Canadian Charter of Rights and Freedoms (April 1982). In the Charter, criminal law principles come into the due process considerations to be used in regulating the professions. The effect of this is that regulating bodies must balance the responsibility to regulate the conduct of their members in the public interest against individual professionals' rights and freedoms accorded by the Charter. The provincial regulations on freedom of information and the powers of the Provincial Ombudsmen's office help to ensure that regulatory processes used are applied in a fair and equitable manner. An example of an equity concern for regulators is the barriers established by regulation for entry to professions or to practice a profession. The entry to practice regulations must be equitably applied to all applicants whether Canadian or foreign educated.

Health Care Governance

Throughout Canada, health care governance is moving towards regional models for policy development and the making of health care delivery decisions. The Seaton Commission (1991) acknowledged that in British Columbia there is wide support for an increased emphasis on community-based health care, designed and funded to meet the specific needs of our communities. This emphasis on community is seen in the current policies of creating regional health boards, regional funding and closer-to-home policies for service provision. The regional governance model is based on the assumption that health care delivery will improve with more input and ownership of decisions at the community level.

Associated with this shift to regional governance is a shift from institutional care to care provided within the community. The move to a regional governance model and changes in the location of service provision means there is a need for regulators to work with the regional and local governing bodies to ensure understanding and consistent application of professional standards.

Health Care Funding

Canada's publicly funded health care system was established under the policy directions for health and health care set by the Canada Health Act (1984). This act reaffirmed the program criteria for public health insurance set by the Hospital Insurance and Diagnostic Services Act (1957) of universality, accessibility, comprehensiveness, portability, and public administration. Universal health care funding covers only a portion of health care services; thus health care funding in Canada is a hybrid of private and public funding.

Currently, changes in funding are occurring as a result of policy moves toward cost containment. The conflict is between controlling costs while retaining or enhancing quality and access. Jerome-Forget, White and Wiener (1995) propose that health care reform be influenced by two concerns: the total cost of care and whether the care given is providing value for the money spent. Evans (1983) discusses how the link between different systems of regulation and funding has an impact on the effectiveness, efficiency, and quality of services. Regulators of self-regulating professions are responsible for ensuring that the ethics of the profession are maintained and that the standards of care are appropriate for public safety, quality, and effective care. There is potential conflict for professionals and funders of health care in the determination of which services can be provided within the resources available and yet still be effective and of a high quality.

Authors (Dixon, 1997; Duncan, 1990; Evans 1983) note that regulation sets restrictions on the ability of market forces to establish the scope and quality of health care delivery. In a competitive market there is more of a "buyer beware" reliance on the consumer

to make correct health care choices and this reliance means the public must be able to discern who is best qualified to provide competent and valid care. Just how the public will develop an understanding of who is best qualified to provide this care has not yet been determined. Currently, the government only regulates some professions and thus the public will need to develop an understanding of the differences between regulated and non-regulated care providers.

Both private and public funding of physiotherapy services are changing with the development of new reimbursement policies. Examples of new payment or compensation models include managed care, preferred provider contracts for services, and the use of multi-skilled and multi-disciplinary practices. There is also a shift towards a user pay approach where the consumer directly pays for the care they are receiving. These changes raise challenges of balancing the autonomy of professional judgment to provide care, the quality of care the consumer wishes to have, and the fiscal goals of the payer. The health care practitioner is faced with conflict of interest situations between the goals of regulators and funders. An example of where potential conflicts are created is in the use of incentive payments to decrease the level of services being provided or for returning a client to work within a certain time frame. When a physiotherapist's decisions have the potential of being influenced by self-interest, such as gaining more income by reducing care, there is a potential for not acting in the patient's best interests. With funding models that force practitioners to choose between honoring their responsibility to the client and honoring their funding contracts, ethical standards are becoming increasingly more difficult for practitioners to honour. In order to protect the public, regulators must answer the ethical question of whether professional judgment may be influenced by incentive payments.

Competent Providers

Regulating health care professionals includes the responsibilities of establishing and ensuring qualifications for entry to practice and continuing competency requirements

throughout the career of the professional. Influences such as globalization, the Canadian Charter of Rights and Freedoms, and provincial human rights and equity legislation have made it necessary for regulators to rethink their approach to defining the qualifications which health professionals require in order to be registered. The methods of evaluating the knowledge, skills and attitudes of a health professional are evolving in many professions, including physiotherapy, to an approach based on defining competency. This is a shift from assessing performance based on credentials to competency-based evaluations. For physiotherapists this has meant the development of an inventory of entry level to practice competencies and the national competency examination. Using a competency-based approach in education, evaluation, or regulation requires understanding the terms competence, competency and competencies. Glover-Takahashi (1997), in her development of the competency examination process for the Alliance, provided the following summary:

> The concept of competence is multi-dimensional and somewhat ambiguous. (Ellis, 1988, p. 47). Although there are many definitions of competence and competencies in the literature (Parry, 1996; Curry & Wergin, 1993; Jarnison, 1993; Gilbert, 1978), there is widespread agreement that competencies are a group of interrelated elements, including the possession of knowledge, skills, and attitudes enabling an individual to perform fully and assume the role of a specified position. Other elements of competence suggested include capabilities, adaptability, aptitudes, judgments, and values. (p.5)

Physiotherapists in Canada use the following definition of competency in establishing their entry level and continuing competency requirements:

> Competency is defined as a cluster of related knowledge, skills, attitudes and judgment that affects a major part of one's job (a role or responsibility) that co-relates with performance on the job, that can be measured against well accepted standards, and that can be improved by training and development (adapted from Parry, as cited by Glover-Takahashi, 1997).

Defining competency is affected by evolving forces, including the role and functions of accreditation of health care services, regulations implementing shared scope of practices, and the changes occurring in the education of care providers. Physiotherapy education is

adapting to the forces of equity, accessibility, accountability and cost effectiveness. Maintaining quality of education with reduced resources is a challenge for educators and, indirectly, for regulators. Regulators are increasingly working with educators to define competencies and to ensure that education is relevant and incorporates new knowledge.

There is also change occurring in the education of physiotherapists. In the United States, there is a move towards a master's degree as the entry level to practice qualification. Some universities in Canada are also in the process of moving to the granting of a master's degree in physiotherapy. Graduation from an accredited university program is a regulatory requirement for licensure in Canada. Thus this change in education will impact regulatory standards for entry-level qualifications, the accreditation process used for Canadian schools, and the mobility of Canadian trained physiotherapists for employment in the United States.

Accountability

There are many aspects of accountability affecting the development of regulatory policies, including accountability to the public for both the prudent use of resources and the outcome or result of the services being provided. Bohen (1994), in describing regulatory changes occurring in Ontario, stated that:

> By the 1990s, the government's faith in the belief that regulated health professions delivered better health care was flagging. The new regulatory frameworks are resulting from governments realizing that regulators require at the least, new mechanisms for ensuring the provision of appropriate, effective and high quality care (p.1).

The move towards regulatory boards having greater accountability for their actions has resulted in the appointment of public members to regulatory boards and updating of regulatory statutes to ensure a consistent and clear process for establishing bylaws, rules and regulations.

Summary

This chapter provided a scan of the forces currently perceived to be influencing policy decisions for regulating all health professions, and in particular for the physiotherapy profession. One cannot examine the effect of health professional regulation on the regulatory objectives of public protection and enhancement of health services without considering the link between professional regulation and the range of social, economic, and political factors that affect the delivery of health care. The current regulatory changes for health care professionals are being shaped by these forces. Chapter Four will detail the process of regulatory change in British Columbia for the physiotherapy profession.

CHAPTER FOUR

REGULATION OF PHYSIOTHERAPISTS IN BRITISH COLUMBIA

Identifying the Need for Regulatory Changes

Earlier reviews of health care (Foulkes, 1973; Hastings, 1972; Seaton, 1991) show that many of the regulatory changes implemented in the Health Professions Act (1996) had been under consideration for some time. The Hastings Report, released in July 1972, recommended the development of community health centers. The report noted that changes in professional statutes were needed as the current powers established by regulation limited the use of a wider range of health providers and the expanded use of professional expertise. The Report recommended that professional self-regulation should have the sole purpose of public protection and should not advance the interest of the professions. The rationale for this recommendation included the identified conflict between professional self-interest and public protection, and the many professional and technical groups who had strongly expressed that their skills were not being used. The report criticized the self-interestedness of professions, especially the medical profession. When addressing this issue, the authors of the Hastings Report recommended that lay or public members be on regulatory boards and that scope of practice definitions be changed from rigid and exclusive to more open and allowing of a wider range of health professionals being able to provide services. This report also recommended that the legal roles, responsibilities and functions of regulation be as uniform as possible across Canada. Recommendations from the Hastings Report incorporated into the Health Professions Act (1996) include the appointment of lay or public members to regulatory boards and the development of less fixed and rigid roles in scope of practice definitions for health professionals.

Following the Hastings Report (1972), the report of Richard G. Foulkes, Health Security for British Columbians (1973), noted that professional regulation in B.C. was

fragmented, chaotic, and in some cases, obsolete. The Foulkes Report's (1973) recommendations were consistent with those of the Hastings Report in advising the removal of barriers to educational and professional advancement of personnel in the health care system. Both reports outlined the need for specific, well-defined regulation of health professionals in order to meet the overriding goal of public protection. The Foulkes Report again confirmed the sole purpose of regulation to be protection of the public and that there must be a clear separation in the roles and functions of professional and regulatory associations for this to be achieved. The Foulkes Report recommended that regulation be granted to health professions only if there is a clear danger to public safety. The report further recommended the abolishment of excessively restrictive and narrowly defined scope of practice definitions used by health professions. The 14 recommendations in the Foulkes Report were summarized in the Special Report: Consumer Participation, Regulation of the Professions, and Decentralization prepared by J.T. McLeod (1973, pp.45-47). The Foulkes Report's recommendations included that the government review all existing legislation dealing with health professions, establish a Health Disciplines Regulation Board with the power to revoke regulations made by professional colleges, and add lay or public members to regulatory Colleges. It was recommended that the Health Disciplines Regulation Board be composed of appointed members with a full-time chairman.

The recommendations of the Foulkes Report (1973) were further developed in the British Columbia Royal Commission On Health (1991) report (the Seaton Commission) which again confirmed that:

> ...the purpose of self-regulation is to protect the public from preventable harm. This privilege is granted to a profession by the provincial legislature. It is a social contract between the profession and the public. It is the property of the public the profession claims to serve. (p. D-29)

The Seaton Commission (1991) noted the lack of consistency among the 16 provincial acts in British Columbia that governed health care professions. The recommendations of the

Seaton Commission (pp. D-29 to D-37) included repealing the Health Professions Act (1994) and revise the Act to become an umbrella act regulating all of B.C.'s health care professionals. The Seaton Commission recommended establishing a Health Professions Council responsible for determining if a regulatory college should be established by a health profession. The Seaton Commission also recommended adopting the approach recently taken in Ontario and echoed the Foulkes and Hastings Reports in a recommendation to define scopes of practice in non-exclusive terms with narrowly defined reserved acts. The objective of using open scope of practice definitions is to decrease the barriers established by professional regulation in the utilization of the skills of health care providers. The Seaton Commission defined reserved acts to be those tasks or services that present a significant risk to the public. Physiotherapists participated in the public hearings held by the Seaton Commission. They informed the Commission members of the need for new legislation for physiotherapists in British Columbia.

The Regulation of Physiotherapists in British Columbia

Regulation of physiotherapists in British Columbia began with regulation under the Naturopathic Physicians Act (1936). The professional association for physiotherapists was involved with influencing the development of regulatory legislation for physiotherapists. The provincial branch of the Canadian Association of Massage and Remedial Gymnasts was formed on February 10, 1927 and the first annual meeting was held on June 7, 1927 (personal communication with H. Southard, a physiotherapy member attending these meetings and minutes). The national association had been granted a charter on March 24, 1920. It is interesting to note that the professional association and the regulatory boards that were initially formed included both massage and physiotherapy professions. This early association

later became the Canadian Physiotherapy Association (CPA). The early minutes show that physiotherapists wished to stand alone as a profession and not be regulated by another. Southard's summary indicates the first hints of legislative problems occurred in 1936 when the new Medical Insurance Act was to come before the legislature. The 1937 Canadian Physiotherapy Association Annual Report in reference to British Columbia stated:

> 1937 will go down in the history of C.P.A. as a banner year. The narrow escape from being absorbed by the Naturopathic Physicians Act amendment was all too close for comfort. Doubtless it will arouse in the members of this association an appreciation of the necessity of being strongly organized, not only to protect our own interests, but to preserve the highest standards of training and medical ethics and loyalty to each other (no pg.#).

The details on the amendment are sketchy but the annual report noted the amendments to the Naturopathic Physicians Act passed in 1936, amended in 1937 to include registration of physiotherapists and masseurs came to the provincial house in November 1937. (see appendix A). A committee of the British Columbia branch of the Canadian Physiotherapy Association held an intensive campaign of letters and interviews and involved members of the medical associations, officials of the then Workman's Compensation Board and legal assistance so as to influence the legislation to exclude physiotherapy from being controlled by the Naturopathic Physicians Act. By order-in-council on November 30th 1948, annulment of the 1937 clause in the Naturopathic Physicians Act (1938) relating to physiotherapy was attained. Legislation covering physiotherapists and massage practitioners was attained with the enacting of Physiotherapist and Massage Practitioners Act S.B.C. 1946, c.59. This act established the Association of Physical Therapists and Massage Practitioners of British Columbia. (A.P.M.P.). The establishment of A.P.M.P. created a board responsible for regulating physiotherapists and massage practitioners. For physiotherapists this established

separate regulatory and professional associations. Not all professions have this division of responsibilities within the structures of their associations.

The Physiotherapist and Massage Practitioners Amendment Act, 1954 c.32, renamed the Board of the Physiotherapists and Massage Practitioners, as the Council of Physiotherapists and Massage Practitioners (the Council) and gave it the power to make regulations respecting applications, cancellations, suspensions, and reinstatement of members. The Council was also given the authority to approve schools teaching physiotherapy and massage. Attaining authority reinforced the Council's regulatory power for establishing the qualifications required for licensure in the profession. The definitions of registered physiotherapist and masseuse were altered to give registered physiotherapists and masseurs exclusive rights to practice in their respective fields.

The Physiotherapists and Massage Practitioners Act (1946) created an unfair structure for the Council of the Association of Physiotherapists and Massage Practitioners, as it designated that the Council be composed of six physiotherapy members and three massage practitioners. This allowed members of one profession voting power over the other profession. Three membership categories were created under the act: Chartered Physiotherapists, Registered Physiotherapists and Massage Practitioners.

Chartered Physiotherapists were members of the Canadian Physiotherapy Association. The educational requirement for licensure with A.P.M. P. was a four-year baccalaureate degree in physiotherapy from the University of British Columbia, from another university in Canada, or equivalent qualifications from outside Canada. Chartered Physiotherapists were not to practice except under the prescription, supervision, or direction of a medical practitioner. Chartered Physiotherapists had three members sitting on Council and were called

Part One. The ability to work only under prescription of a physician is an example of where physiotherapists were subservient to another profession. The attaining of regulation under the Health Professions Act removed this requirement.

The Registered Physiotherapists section developed as a result of the demand for patients from the war to be treated. To resolve the personnel shortage, a shortened course of training had been established in England. The educational requirement for Registered Physiotherapists was completion of a three-year course with a specific number of hours of instruction, clinical experience, and successful completion of an examination specified by the Board of Examiners. Registered Physiotherapists were allowed to practice by direct access or without a medical practitioner referral. Registered Physiotherapists had three physiotherapy members sitting on Council and were called Part Two.

Massage Practitioners graduated from a specified school of massage therapy approved by the Council of the Association of Massage Practitioners and Physiotherapists. Until 1994 there was one private school of massage therapy in British Columbia, which offered a two-year course. Massage Therapists had three members sitting on Council and were called Part Three. Parts One, Two and Three were also called Sections.

The Act regulating physiotherapists and massage practitioners was modified in 1972 to incorporate the educational requirements and standards for the physiotherapy profession set by the professional association, the Canadian Physiotherapy Association. This established a professional association role in determining the educational standards for the profession.

By 1972, the Chartered Physiotherapy section recognized that there were no regulations outlining a disciplinary process for their members. Complaints about the competence of a member could be received but the legal process and ability for disciplining

members found guilty was not specified by the legislation. By 1976, the Minister of Health had acknowledged physiotherapist requests for updating their legislation and requested input from the general membership. Although physiotherapists responded to the Minister of Health's request, only minor legislative changes were made until physiotherapists became legislated under the Health Professions Act (1996).

In 1979, the statute was renamed the Physiotherapist Act, R.S.B.C. 1979, c.327. By this time, the statute governed the professions of massage therapy, physiotherapy, and a small group of remedial gymnasts. Remedial gymnasts were an occupational group that had trained in Great Britain and by the late 1970s this training course had been discontinued. Physiotherapists were requesting that the government grant them their own statute. They wanted massage practitioners and remedial gymnasts to be covered by other legislation or to be in closed subsections within the statute regulating physiotherapists. Closed subsections would mean no further memberships would be granted; the current members could either upgrade to physiotherapy qualifications or retain their current registration but be limited in their areas of practice. By 1983, there had been several ministers of health but no legislative changes. The physiotherapy regulatory board's ability to discipline members had been tested in the legal arena and was found to be seriously wanting. Serious discipline problems had arisen which were incapable of being resolved with the existing legislation.

The Health Statutes Amendment Act, 1987, c.55, and subsequently the Health Professions Amendment Act, 1989, c.29 created a separate closed register for remedial gymnasts. This meant the limited number of remedial gymnasts practicing in British Columbia could either write the Registered Physiotherapist examination and upgrade to full physiotherapy membership or stay on a separate register until their retirement from practice.

A more significant change occurred with the Health Professions Amendment Act (1989). This change was to revise the qualifications required for registration of physiotherapists. The change enabled the Minister of Health to more readily change the educational requirements for registration. A review of the Council minutes, newsletters, and correspondence with the Ministry of Health reveals this significant change was made because of the critical shortage of physiotherapists, particularly in northern and rural areas of the province. Physiotherapists were concerned because they felt the government would have the potential to allow inadequately trained physiotherapists to work by circumventing the qualifications and examination process. To avoid the government determining who was qualified to be registered to work as a physiotherapist, the Council proposed the use of a temporary register to allow foreign-trained therapists to work while completing the required examination process. The Council emphasized that it did not want regulations changed to allow temporarily registered therapists to avoid meeting the equivalent to the Canadian educational standards.

The establishment of the temporary registration process helped alleviate the shortage of physiotherapists but also raised public protection and ethical questions. A therapist granted a temporary license did not have equivalent qualifications but was allowed to work, often in sole practice positions, with the same responsibilities and liabilities as a fully registered therapist. Temporary registration was granted while the therapists completed their educational requirements. They became full registrants once they had successfully passed the qualifying examination. Some therapists with temporary registration worked for up to two years and either did not complete their education or failed the examination. This raised the question of whether there was increased risk of harm to the public by not having enforced the full

registration requirements at the onset. For example, a physiotherapist with a temporary registration was able to practice and later deemed ineligible for registration if he or she did not successfully complete the examination process. When this situation occurred it is reasonable to conclude that the licensing board was not fulfilling its mandate of public protection.

The Chartered and Registered Physiotherapists Sections continued to ask the government for updated legislation to join the two sections and to grant disciplinary powers to the Sections. By 1988, the Ministry of Health again requested that physiotherapists develop and submit the needed changes to their legislation. In August 1988, the Chartered and Registered Physiotherapy Sections submitted to the British Columbia Department of Policy and Planning, Ministry of Health, a draft of new legislation covering the act, rules and bylaws. The draft legislation incorporated the structure and principles of having a College of Physiotherapists governed by a Board composed of provincial representation as well as lay or public representatives. The proposed legislation included inquiry and disciplinary procedures that would ensure protection of the public by defining standards of practice and defining qualifications for entry, re-entry, specialization, and continuing education.

The following list from the October 1990 minutes of the Chartered and Registered Physiotherapy legislative committee summarizes the reasons for asking for updated legislation for regulating physiotherapists.

The October 1990 minutes noted that legislation in B.C. is different from other provinces in Canada in two major aspects:

1. The Physiotherapy Act regulates the practice of two distinct professions of Physiotherapy and Massage Practitioners. The Act was labeled for one profession, the Physiotherapy Act (1946). Another profession, the Massage Practitioners, was hidden

in the Act.

2. The Act provided for the registration of two groups of physiotherapists under separate parts. The distinction between Chartered and Registered Physiotherapists had become an artificial distinction when the shortened post war course to resolve manpower needs was discontinued. There was no longer any difference in education and qualifications between Chartered and Registered Physiotherapists. The only difference between Chartered and Registered Physiotherapist was that the Physiotherapy Act (1946) allowed Registered Physiotherapists to treat patients without a physician's referral. Physiotherapists had begun to ask for this direct access to primary care for all regulated members. (no.p.#)

Amalgamation of the two parts under a common act would establish administrative efficiency, eliminate unclear divisions between the Council and the Sections and facilitate standardization of scope and standards of practice, standards for re-licensing and disciplinary procedures.

Prior to being regulated under the Health Professions Act (1996), physiotherapists were extremely frustrated with their lack of regulatory ability to discipline their members. The old legislation was inefficient, time consuming, and resulted in delays in resolving complaints. The regulatory structure of a Council and Sections meant that a complaint went through a review process at several levels. The lack of ability under the old legislation to protect the public in a timely and efficient manner was illustrated in the October 1990 brief written by the Chartered and Registered Physiotherapists Legislation Committee. "On January 29, 1990 a member pleaded guilty to three of six charges of sexual abuse and assault. This was nine years after the first investigation" (p.2).

Prior to the Health Professions Act (1994), the existing legislation did not provide mechanisms for public review. In requesting updated regulation, physiotherapists had identified the need for more open policies and procedures to regulate the profession. Physiotherapists proposed the appointment of lay representatives to the College Board and

appropriate committees, including the Discipline Committee, as an important way to increase the accountability of the actions of the Board and its committees.

Under the Physiotherapist Act (1979), consistency in registration criteria for Canadian trained and foreign trained physiotherapists was not possible. Physiotherapists had identified the need for different classes of registrants, including the ability to register foreign trained physiotherapists while they upgraded to meet the Canadian standards. In addition, consistent registration criteria were needed for foreign trained specialists, out of province sports therapists, course leaders and students. Physiotherapists also wanted the new legislation to include provisions for specifying minimum standards of competency for physiotherapists re-entering the profession or re-licensing after a lengthy absence.

Updated legislation was also required because the workplace was changing. More physiotherapists were moving from public practice to private practice. In public practice settings safeguards for public protection such as workplace policies and procedures and accreditation of facilities had already been established. Development of enforceable standards of practice including standards for equipment, facilities and business practices were required for private practices. The history of the regulation of physiotherapists in British Columbia identified the need for updated legislation and by 1989 physiotherapists were informed by the government that to attain new legislation they should consider applying to go under the new health professions legislation.

Physiotherapists and The Health Professions Act (1996)

In 1989, the Ministry of Health staff from the Policy, Planning and Legislation division advised physiotherapists that Bill 91, the Health Disciplines Act (1989), would solve their legislative needs. The Health Disciplines Act (1989) later became Bill 31 and was renamed

the Health Professions Act (1990). The latest legislation is the Health Professions Act (1996). Physiotherapists involved with developing revisions to the Physiotherapists Act (1979) were surprised with the introduction of the Health Disciplines Act (1989). Physiotherapists felt a loss of faith with the Ministry of Health for not being informed in the formative stages of developing this legislation.

As Chair of the Council of the Association of Physiotherapists and Massage Practitioners, Dediluke (1989) summarized the resistance to the new act as members feeling misled by Ministry of Health staff. The Health Disciplines Act (1989) looked like our proposed Physiotherapy Act right down to the spelling mistakes, yet we had not been informed of this pending legislation while we worked on our proposed new legislation. The new legislation included the same duties and functions for the regulatory board, the same structure for establishing the regulatory board and the same inquiry and discipline processes we had proposed. The difference was regulation under umbrella legislation, covering more than one health profession. This experience contributed to physiotherapists' resistance to moving under the new act and strengthened the opinion of physiotherapists that any new legislation such as the Health Disciplines Act (1989) and the later revised Health Professions Act (1996) must include a consultation process prior to implementation of changes. A legislated requirement to consult would increase accountability by ensuring that a political process of education and lobbying elected government representatives could occur.

Physiotherapists wished to continue with the responsibility of self-regulation but did not initially accept the use of umbrella legislation. They expressed concern that umbrella legislation would erode their self-regulating status by grouping them with other professions. They further felt the legislation would increase bureaucratic involvement in the regulation of

health professionals. Physiotherapists attempted to argue that the physiotherapy profession had specific and unique characteristics justifying separate legislation. Chritian Reuter, Chair of the Legislative Committee of the Chartered Physiotherapist Section, in his letter of September 6, 1990 to the Members of the Legislative Assembly in British Columbia (Reuter, 1990), summarized objections to the act and in the concluding paragraphs of his letter stated:

> Bill 31 is the anti-thesis of a document on which a self-regulating profession would be based. It places all power outside the health professions and degrades them to the status of unpaid civil servant who are by their choice of profession locked into this relationship without escape!

As the structure and functions of the Health Professions Act (1990) became more clearly understood by physiotherapists, the advantages of having current, defendable and enforceable regulatory laws outweighed the fears of loss of powers and status if the profession did not have a stand alone regulatory act. Physiotherapists came to accept regulation under the new umbrella legislation. The gaps and inadequacies in the old legislation for physiotherapists could be addressed by being regulated under the Health Professions Act (1990).

The Health Professions Act (1990) sets out a template of delegated regulation for all health professionals in British Columbia. Umbrella legislation is designed to cover many professions and thus provide greater consistency of regulatory frameworks and uniformity in the application of government policy. In this delegated regulatory framework, the profession itself is granted the responsibility for public protection and is responsible for the costs of regulating the profession. An advantage of a delegated regulatory structure as opposed to direct government regulation is the direct involvement of the expertise and skills of the professions in administering the regulatory responsibilities.

The two new policies of expanded regulatory responsibility for ensuring continued

competence and the review and change to defining scope of practice statements were implemented with the Health Professions Act (1990). These policies were applied to all regulated health professions whether or not they were regulated under the Health Professions Act (1994). Physiotherapists had perceived the Health Professions Council, a six person advisory body appointed by the Minister of Health under the Health Professions Act (1994), to be another level of government bureaucracy that would impede self-regulatory actions. As more information was obtained regarding the roles and responsibilities of the Health Professions Council, physiotherapists became more accepting of the need for it. The Health Professions Council was given the responsibility to consider and make recommendations to the Minister of Health on the designation of new health professions requesting regulation and to review the legislative needs and scope of practice of all currently regulated professions. Included in the legislative review for all currently regulated professions was a determination of reasons for maintenance of separate regulation of a profession or whether the profession should be regulated under the Health Professions Act (1996).

By the time both physiotherapists and massage practitioners chose to move under the Health Professions Act (1990) they were aware that other currently regulated professions could receive the same recommendation from the Ministry of Health. Physiotherapists were also aware that in Ontario, all regulated health professions were moved under legislation similar to British Columbia's. The B.C. Ministry of Health never advised the physiotherapists and massage practitioners that they must go under the new legislation. Instead, they were the first regulated professions to choose to ask the Minister of Health to be regulated under the Health Professions Act (1996).

While coming to the decision to request being regulated under the Health Professions

Act (1990), physiotherapists gave extensive feedback on the new legislation. They endorsed the need to have lay/public representatives on the regulatory board and committees but disagreed with the power of the Minister to appoint up to 50% of the members on a college board. Physiotherapists were concerned that if the number of public members was equal to or higher than professional members, the profession would no longer be self-regulating. Also of concern was the cost of the public/lay member appointments, as the issue of the remuneration of public members serving on regulatory boards remained unclear. However, physiotherapists recognized the value of the inclusion of lay members in the regulatory structure of the Health Professions Act (1990). Prior to the new legislation, physiotherapists included public appointments to the Discipline Committee and had found the lay member representation to be valuable.

The regulatory responsibility to set entry to practice requirements is important because of its effect on the availability and quality of the workforce in health care. Enforcing entry to practice requirements serves to protect the public by assessing practitioner competencies to safely perform health services. At the same time the profession may gain advantages by controlling the number of qualified practitioners able to meet the entry to practice requirements. A shortage or a restriction in the number of professionals can be used to limit access to services and to establish higher fees. This is an example of where there may be conflict between the interests of the public and the interests of the profession.

Physiotherapists believed that educational standards for the profession should be included in the regulatory statute to protect changes from being too easily made by the government. Discussions in 1991 with Ministry of Health staff clarified that placing educational standards at the higher statute level where more legislative control is required

would in effect be a reduction of self-governance.

> The mechanism of delegated responsibility for educational standards, subject to Cabinet approval, is well-established in the legislation for nearly every health profession. To remove this well-established mechanism would certainly be regarded as an erosion of self-governance by those professions. (Strawczynski, 1991, p.2).

To relieve the physiotherapists' fear that the Ministry could too easily change educational standards, it was agreed that the Health Professions Act (1990) would be amended to require that notice of all proposed changes to regulations would be given to all regulated health professions at least three months prior to the effective date of the regulation. This change provided assurance to physiotherapists that there would be time to respond and if necessary use political lobbying to influence regulatory changes.

In moving to regulation under the Health Professions Act (1990), physiotherapists were delegated the responsibility of establishing the registration requirements for the profession. This resulted in the ability of physiotherapists to change requirements to include successful completion of a national competency examination. Physiotherapists in Canada had been actively involved in funding and developing a competency based examination for entry to practice. Assessing competency for registration through an examination set by the regulatory boards is a move away from relying solely on academic credentials for qualification. Prior to physiotherapists in British Columbia attaining their new regulatory framework, Ontario was the only province with the regulatory powers to require successful completion of the national examination for entry to practice the profession.

The decision to use the national examination initiated much debate between physiotherapists involved with regulatory duties and physiotherapists representing the professional association. The differences in opinion on the validity, cost and effectiveness of using a national examination became a primary issue affecting the choice to be regulated

under the Health Professions Act (1994). These differences in opinion were debated within physiotherapy meetings, political meetings, and included lobbying the Minister of Health. The question of who should set the entry to practice standards raises concern about the profession using regulation to control the number of registered practitioners through setting an unnecessarily high or hard to attain standard. Such a standard could affect the availability and cost of services. Physiotherapists involved with the regulatory changes had to convince the Minister of Health that the use of a national competency examination as a requirement for entry to practice as a physiotherapist was warranted for ensuring the competency of physiotherapists.

By March 1991, the Minister of Health, John Jensen, wrote a response to physiotherapists' concerns regarding the Health Professions Act (1990). Jenson (1991) clarified that although the Act was introduced to focus on new and emerging professions already regulated professions could also be designated under the act. The letter stated that the proposals for legislative changes submitted by physiotherapists were all met in the Health Professions Act (1990). Even though a profession wanting to be regulated must apply to the Health Professions Council for a review of its application, the Minister informed the Association of Physiotherapists and Massage Practitioners that there would be no need to apply through the Health Professions Council. Because physiotherapists and massage practitioners would be requesting to move under the new legislation, the Minister required only a clear statement from both the massage practitioners and the physiotherapists agreeing to separate regulation and designation under Bill 31, the Health Professions Act (1990). The Minister wanted assurance that a fair and agreed to separation was occurring between the physiotherapists and massage practitioners.

Agreeing to bypass the application through the Health Professions Council process meant there could be no request for change to the scope of practice of the professions. In 1994, the Minister of Health delegated the responsibility of reviewing the scope of practice of all regulated health professions to the Health Professions Council. It was then that review of the definitions of physiotherapy and massage scopes of practice could occur and be changed.

By January 1992, physiotherapists involved with requesting legislative changes and the members of the Council of the Association of Physiotherapists and Massage Practitioners had reconsidered the stance of wanting separate legislation and had accepted that regulatory needs could be met by moving under the Health Professions Act (1990). Physiotherapists continued to respond to the evolving changes to the Health Professions Act (1990) by giving feedback on various issues such as support that the legislation should include a mandate of yearly reporting to the Minister of Health (A.P.M.P. letter July 29, 1992, to the Minister of Health). A.P.M.P. Council accepted that the reporting process would be participatory and would provide an opportunity for the actions of the regulatory College to be monitored by the Minister of Health, thus maintaining the government's responsibility to ensure the methods chosen by Colleges for public protection were valid and warranted.

The discussion on appointees continued and physiotherapists proposed that the number of appointees should not exceed 25% of the total board membership, that the cost of appointees should be the government's responsibility, that appointments should be made with input from the regulatory board, and the appointments should not be limited, as in Ontario, to those licensed under the same umbrella legislation. The A.P.M. P. Council further recommended that the appointees should have the ability to participate in a valid manner by carrying their share of the work and responsibilities.

Changes in the Health Profession Act (1990) regarding lay appointees did occur and currently public members constitute one third of the College Boards. The government does ask for input from the regulatory boards on nominees but ultimately chooses the appointees and the Colleges are responsible for the cost of the public members' involvement. Although not set in the legislation, physiotherapists were informed that College Boards can ask for a new appointee if there is a valid reason for doing so, for example, the need to replace a non-participating appointee. The purpose of lay membership on regulatory boards is seen as a means to increase accountability of regulatory boards and to increase public protection through the active participation of public members in the work of the College Boards. The current Health Professions Act (1996) does not define a specific mechanism for lay members to report to the Minister of Health. Therefore it is reasonable to ask whether or not there is increased accountability for public protection by the appointment of lay members.

In March 1993, the individual sections of physiotherapists and massage practitioners passed motions to proceed with a request for separation with both professions to be regulated under the Health Professions Act (1990). The motion was qualified with the conditions that a) amendments be made to the present act to provide for legislative review of regulations and for lay representation of one third of the Board members, b) the Minister of Health permit the two professions to bypass the Health Professions Council application procedure, and c) the scope of practice review be delayed until all other regulated health professions were also reviewed. In 1993, there was cautious acceptance of Ministry of Health feedback that all other currently regulated professions requiring significant amendments to their legislation would also be directed to move under Health Professions Act legislation. The Chartered and Registered Physiotherapy Newsletter (April 1994) summarized the decision that the Health Professions

Act (1990) would meet the legislative goals of (a) separation of physiotherapists and massage practitioners from being regulated under one Act, (b) amalgamation of physiotherapy Parts I and II, and (c) provide updated legislation and bylaws that would allow for more efficient processing and resolution of complaints.

This decision of the A.P.M.P. Council to move under the new legislation initiated extensive debate between the professional association and the regulatory board. Prior to physiotherapists becoming regulated by the Health Professions Act (1990) and the subsequent revised Act (1996), the professional association and physiotherapy students from the University of British Columbia lobbied Members of the Legislative Assembly and the Minister of Health against the A.P.M.P. Council decision to move under the new legislation. The concerns expressed by the professional association included fear of losing independent legislation for the profession, but the strongest objection was to the regulatory college's authority to set the new entry to practice requirement of a competency examination. The debate focused on whether or not the use of a national examination process for all new registrants was a valid requirement. A criticism of implementing a national competency examination was the significant cost implication for graduating students from Canadian universities. Canadian graduates, along with the foreign applicants, would be responsible for the costs of writing the examination.

This debate included convening a special general meeting of the Registered and Chartered Physiotherapist Sections, several Ministry of Health meetings and lobbying and intense debate at the annual meetings of both the regulatory and professional associations. In 1994, the Minister of Health had become convinced of the right for the regulatory board to determine the entry to practice requirements but needed assurance that the students and

professional association members lobbying him were satisfied. The compromise attained was that when the new regulatory College was formed, it would supplement the costs of the examination for the first three graduating classes from the University of British Columbia. This provision of granting a subsidy to graduating students from the University of British Columbia convinced the then Minister of Health, the Honorable Paul Ramsey, that those lobbying against the examination process were satisfied. Thus in the end, the authority of the regulatory board to set the educational qualifications for the profession was upheld and the College of Physical Therapy of British Columbia was formed December 14th 1994 under the Health Professions Act (1993).

The debate on the use of a national competency examination for entry to practice illustrated where the interests of the profession and those of the public are not identical. It reinforced the value of the structure of the Health Professions Act (1996) that clearly sets a mandate for separating regulatory and professional groups. Such separation allows the regulatory board to focus on the mandate of public protection, and the professional associations to promote professional interests. Physiotherapists and massage practitioners already had this separation established in 1946 with their initial self-regulating legislation. Some regulated professions in British Columbia are not as clearly structured this way. This separation of roles increases public protection by reducing the potential for professional interests to take precedence over public interests.

Under the Health Professions Act (1990) and the subsequent revised Act all regulated professionals must carry liability insurance. This caused concern on the part of the Physiotherapy Association of British Columbia and the major union representing physiotherapists (The Health Sciences Association) in British Columbia. The union held that

physiotherapists employed in institutions where there was a union contract must receive insurance coverage from their employer. The College of Physical Therapists determined that hospital coverage was neither adequate for individual professional protection nor for public protection. The College compromised by accepting that physiotherapist malpractice coverage was sufficient if verified by the employer. This malpractice insurance requirement augments public protection by recognizing that accidents and negligence are possible and that there are means of retribution should these occur.

Under the Health Professions Act (1990) and subsequent revised Acts the code of ethics and standards of the profession were included in bylaws approved by an order in council of the government. The process of obtaining bylaw approval includes a review by staff of the Health Legislative Policy and Planning Division, Ministry of Health, and the requirement that the government provide notice of a bylaw prior to being brought forward to Cabinet for approval. This notice gives the opportunity for feedback to increase the accountability of both the regulatory body and the government in setting standards that are in the interests of the public. Also included is the ability of the College Board to set clinical practice guidelines and advisory statements. Clinical practice guidelines set out specifics of clinical practice and by informing the members of the profession of these guidelines there is increased regulatory enforceability to ensure these guidelines are met. Advisory statements provide interpretation of the code of ethics, standards or clinical practice guidelines and are approved by the College Board. Because the College Board has the power to set clinical practice guidelines and advisory statements, these guidelines and statements can be more readily updated as changes or new knowledge emerges.

The code of ethics and standards set by regulation provide guidance and support for

everyday decisions in the delivery of health care. They outline the responsibility of the professional to be accountable for his or her actions and to practice within his or her own level of competence. Colleges enforce the standards by responding to complaints by an inquiry and discipline process. The new health professions legislation enables a complaint to be resolved through a more enforceable, consistent and efficient process. In the new legislation, the details of the inquiry and discipline processes are clearly explained. The processes implemented include innovative approaches to encourage compliance of the practitioner by the use of consent orders as well as encouraging alternative dispute resolution. Consent orders are legally binding agreements between the regulatory board, the registrant of the profession and the complainant on the facts of the complaint and the agreed upon discipline to be enacted. The use of consent orders decreases the need for time consuming and costly inquiry and discipline hearings and results in speedier resolution of complaints. For physiotherapists, the use of the new complaint process resolved long-standing problems inherent in the old legislation. Use of consent orders reduces the costs of handling a complaint, but more importantly for public protection, it applies an administratively fair process that can be more rapidly implemented than a full inquiry and discipline process. The Health Professions Act (1996) allows the Inquiry Committee of the College to take the extraordinary action of setting limits on the practice of the registrant or by suspending the practitioner's registration during the investigation or pending the hearing of the discipline committee.

This section summarized the historical issues in physiotherapy regulation and began to describe the effects of the regulatory changes that occurred with the implementation of the Health Professions Act (1996). The two most significant changes occurring with implementation of the new act were the addition of a new regulatory responsibility for

continued competence of the regulated professional, and the way the scope of practice of the profession was defined. The next chapter will analyze the new approach to defining scopes of practice with the subsequent chapter analyzing the new regulatory responsibility of ensuring continued competency.

CHAPTER FIVE

OPEN SCOPE OF PRACTICE AND RESERVED TITLE

A scope of practice statement describes what the profession does, its purposes, and methods. Reserved titles are the exclusive labels the profession may use for defining itself. The Physical Therapy Scope of Practice Review (1998) states the importance of defining a scope of practice statement in that it:

> ...defines the area of practice for which the governing body must establish registration requirements and standards of practice; it defines the parameters of the profession for members of the profession, employers, courts and educators; it informs the public about the services the practitioners are qualified to perform. (p.9)

In B.C., the Health Professions Act (1996) changes the way scope of practice is defined by implementing open, non-exclusive scope of practice definitions and the granting of reserved titles. In B.C., the Health Professions Council has been assigned the responsibility of reviewing the scope of practice definitions and the use of reserved titles of all regulated health professions and all new professions applying for regulation. The review has four elements: scope of practice statements, reserved acts, supervised acts and reserved titles.

The terms "reserved act model" and "controlled act model" are used to describe the model that incorporates broad, non-exclusive scope of practice statements and narrowly defined reserved acts. Reserved acts are those elements of a profession's scope of practice that present significant risk of harm to the health, safety, or well being of the public. Only regulated professionals may perform or supervise the performance of reserved acts. Reserved acts are given to specific professions and may be given to several regulated professions. Supervised acts are reserved acts performed under supervision of a health professional to whom a reserved act has been granted as part of his or her scope of practice. See Appendix B for the list of currently reserved acts in B.C.

Defining the Reserved Act Model

The Health Professions Council's Shared Scope of Practice Model Working Paper (1998) clarified the intent of the move towards the use of a reserved act model for defining scope of practice. The terms of reference recognized that:

> ...certain tasks or services performed by a health profession may carry such significant harm to the health, safety and well being of the public that they should be reserved to a particular profession, or shared amongst qualified professions. The only restrictive element of a profession's scope of practice will be any reserved acts within that scope. (p.1)

The Health Professions Council, in determining how to assess which acts are of significant harm, was assisted in part by the 1994 Manitoba Law Reform Commission Regulating Professions and Occupations. The Health Professions Council accepted three principles to use in determining the seriousness or significance of potential harm to the public. The three criteria used are:

- the likelihood of its occurrence;
- the significance of its consequences on individual victims;
- the number of people it threatens (p. 2).

During the early consultation process with the Health Professions Council the College of Physical Therapists, along with the B.C. Dietitians and Nutritionists Association expressed concern about the criterion of the number of people threatened. The professions argued that an act should be reserved if even a small number of people are affected. The Health Professions Council agreed with this concern and determined that not all three factors were needed in order to reserve an act.

The Move to Open Scope of Practice Definitions

Implementing a reserved act model for defining scope of practice reduces regulatory restrictions on providing health care services by reducing the ability of any one regulatory College to enforce exclusive license to practice an area of work. However, there are differing social, economic, and political perspectives on the extent to which a regulated scope of practice definition establishes dominance and control over the delivery of health care

services. Coburn, Torrance and Kaufert (1983) examine the historical development of how medicine attained the status of being a dominant profession with restrictive control over the activities of other professions and claims to exclusive competence to practice medicine. Friedson (1970), in defining medical dominance used the following criteria:

1. self-regulation over the content of work;
2. regulation over the terms and conditions of work;
3. control over other occupations in the division of labor;
4. and control of clients. (p. 407)

Using Freidson's definition of medical dominance it can be concluded that self-regulation of the medical profession in B.C. enables physician dominance in the provision of care. The powers established by self-regulation enabling the medical profession to place restrictions on the division of labor and the content of who can do what work. This dominance is a major factor in the current government decision to change the way scope of practice is defined by regulation and is supported by conclusions of earlier reviews of health care in B.C.

Health care reviews in B.C. have recommended the change to non-exclusive scope of practice definitions. The Hastings Report (1972) recommended the development of interdisciplinary teams where roles and scopes of practice were not narrowly defined. This report concluded that narrow scopes of practice definitions restricted the professional's application of skills and is contrary to the public interest in that such definitions limit the supply of health care providers and consumer accessibility to services. Similarly, McLeod (1973) concluded that regulation that unduly restricts a profession's scope of practice is contrary to the public interest of wanting greater supply and accessibility to skilled personnel, and the ability to have greater flexibility in the utilization of different health disciplines. The Seaton Commission (1991) concluded that existing legislation governing health professions creates ongoing jurisdictional disputes and lack of cooperation between health professions. In summarizing their findings, the Commission stated:

> According to a number of professional associations and unions, scopes of practice - who is allowed to do what to whom and under what circumstances - are a source of conflict. Your submissions also state that, contrary to their purpose, present legislation

> and regulations governing the care of health professions tend to protect the profession at the expense of the public (p.19).

The Seaton Commission recommended a move to open scopes of practice statements and concluded that:

> ...exclusive scopes of practice should be narrowed to focus on preventing harm, as has been initiated recently in Ontario. We believe that more appropriate, cost effective and timely health care could be provided to more patients if B.C. were to follow the Ontario initiative. (D-33)

It is too early to determine if the move to using open scope of practice definitions will result in appropriate, cost effective and timely health care. There is continued tension in balancing the use of regulation to ensure competent health care providers and the effect of regulation on the supply and cost of care.

The Effect of Implementing Open Scope of Practice Definitions

It has been explained that implementing a reserved act model reduces regulatory restrictions on the provision of health services but that professions which are granted reserved or controlled acts do have the potential to use the reserved act to set restrictions on the availability of manpower, services and costs of services.

The use of an open scope of practice definition recognizes that more than one professional group has the skills and knowledge to provide health care services and reduces claims by any single profession of having exclusive competence to perform health services. This approach should result in a more flexible and efficient use of health workers, and potentially in increased cost effectiveness. Expanding the ability of a range of health care practitioners to provide health services and enabling overlapping competencies does not solve turf protection and inter-professional competition. Regulatory ability to protect turf is reduced but the health delivery market will still face inter-disciplinary competition issues and there will be ongoing questioning of who is competent to provide the services.

Implementation of the reserved act model for defining scope of practice allows a greater range of health professionals to fully use their training, expertise, and skills. This

expanded ability is influencing changes in the education of health care professionals. One example is in the development of physiotherapy and rehabilitation assistant programs. Another is in the move for a Masters level degree as the entry to practice requirement for physiotherapy.

The difficulty for the public is how to determine which profession is best qualified to provide a specific health service. An example of how using an open scope of practice definition can cause confusion in understanding the choice of services and competencies of the health care providers is seen with the Health Professions Council's recommended scopes of practice for massage therapists and physical therapists. The scope of practice definitions proposed for the two professions are very similar with the exception of which reserved acts are given to a profession. It was recommended that massage therapists not be granted any reserved acts as none of the acts performed by massage therapists meet the criteria of significant risk of harm to the public. The reserved acts proposed for physical therapists are those actions that meet the criteria of risk of harm (Appendix C). At the time of this writing, these statements have not yet been finalized and will undergo further review prior to being incorporated into the legislation.

The Massage Therapy Scope of Practice Review preliminary report released in 1998 defines the practice of massage therapy as:

> the assessment of the soft tissues and joints of the body and the treatment of dysfunction, injury, pain and physical disorders of the soft tissues and joints primarily by manipulation to develop, maintain, rehabilitate or augment physical function, to relieve pain and promote health. (p. 3)

The Physical Therapists Scope of Practice Review (B.C.1998) preliminary report defines the practice of physical therapy as:

> the assessment and treatment of the neuro-muscular and cardiorespiratory systems of the human body by physical or mechanical means for the purpose of maintenance or restoration of function that has been impaired by injury or disease, for pain management and for promotion of mobility and health. (p.3)

In reading these two definitions it is difficult to discern the difference between a

massage practitioner and a physiotherapist. Because the statements are open and generic in nature it is important when making decisions on choice of care to discern who can best perform the services, the qualifications needed to provide the services, and the standards of practice of the profession. It is also important for the public to know which professions are regulated, thus being assured that the professions are enforcing acceptable standards of education and practices. How the public will know which professions are regulated is yet to be determined.

The reserved act which physical therapists argue needs to be included along with the proposed reserved acts is the ability to conclude an assessment with a physical therapy diagnosis. Other professions including nursing are arguing that reserved act of diagnosis must be granted to professions other than medicine. Nurses and physiotherapists argue that concluding an assessment with a diagnosis determined within the competencies of the profession occurs in everyday good practices as a necessary step in determining the most effective treatments to provide. Being unable to do so impairs this process and continues physicians' dominance in the delivery of health care. This limitation is contrary to the given reasons for implementing in regulation the use of open scope of practice definitions. As the Health Professions Council has not yet concluded the review of scope of practice, this issue is undetermined.

Through the implementation of the reserved act model, the investigation of complaints against a practitioner shifts in emphasis from looking at whether or not the practitioner was working within his or her scope of practice to focusing on the harm that occurred and the competence required for the practitioner to perform the action. There will still be regulatory control over the reserved acts and complaints may come forward regarding practitioners performing reserved acts that are not granted to their profession. The shift to the focus on harm is due to the wide scope of acts that are not reserved and the ability of these acts to be done by both regulated and non-regulated care-givers. What arises with this change is a

heightened need for the regulatory structure to establish defensible and enforceable standards of practice. To this end the Health Professions Act (1996) incorporates current principles of administrative law for establishing regulations to set and enforce the standards of practice of the professional.

The ability of regulated professions to enforce standards of practice was recently upheld in a court decision between the College of Physical Therapists of British Columbia and College member C. Eng. (British Columbia Supreme Courts (2000) Carolyn Eng. v. College of Physical Therapists.) In this judgment the petitioner argued that the College had no jurisdiction to discipline the petitioner and could not enforce the professional standards as they were not approved by the Lieutenant Governor-in-Council. This argument failed based on the Health Professions Act (1996) ss.33 through ss.39, which states that the College, on its own motion, may investigate a practitioner in regards to professional misconduct. There is no requirement to legislate conduct by way of the act or by way of the bylaws in order for the College to have jurisdiction over the conduct of the physiotherapist. This judgment referred to a long standing state of the law occurring as far back as the turn of the century quoting:

> Chrichton (1906) 13 O.L.R. 271, (DC) at 284, the court held: Implicit in the concept of a profession is the existence of standards which are benchmarks for the practice of the profession. The standards may be written or unwritten. They may or may not be prescribed by the governing statute or regulations (Eng vs. College of Physical Therapists, 2000, p.6).

The ability to enforce standards of practice is reinforced by this court decision. The Health Professions Act (1996) updates the process of inquiry and discipline to enable the use of current principles and policy directions of administrative law.

Establishing standards of practice by regulation is linked to defining the competencies of practice for professionals. The defining of competencies and standards of practice has heightened the need for regulators to use evidence-based standards of practice in determining whether or not there was harm or incompetence on the part of the practitioner. The heightened need to use evidence-based decisions in regulation and throughout the whole health care

system was supported by the 1997 National Forum on Health, Creating a Culture of Evidence-Based Decision Making in Health. The Forum recommended "Canada must move quickly towards an evidence-based system and to put into place the necessary resources to build a more effective and efficient health system" (p.35). In regards to evidence-based practice, the National Forum on Health recommended "licensing bodies incorporate the use and development of evidence-based clinical practice guidelines into standards of care required of members" (p. 33). To be valid evidence-based clinical practice guidelines need to incorporate the best evidence to date and be established with ongoing processes for review and updating.

In 1996, the Canadian Physiotherapy Association developed a discussion paper on clinical practice guidelines (CPA, 1996). The introduction to this paper noted that a variety of factors and environmental forces influence the development of clinical practice guidelines and the evaluation of the effectiveness of using such guidelines. The development and use of evidence-based clinical practice standards for regulatory purposes is affected by the gaps in and limitations of current research on standards of care and the lack of knowledge as to whether or not clinical practice guidelines are the most effective means for ensuring practitioners provide the best care. Although there is a shift in regulation towards defining professional competencies and the use of evidence-based practice guidelines, regulation does not determine the effectiveness of a treatment. Another consideration in the use of clinical guidelines is the ability of the guidelines to be relevant for differing professional knowledge and approaches to the provision of care. Professions will incorporate evidence into their practices in differing ways.

Despite the possibilities of attaining public protection through professional regulation, there are limits to public protection inherent in the structure of professional self-regulation. The self-regulatory powers to ensure professional competence are only applicable to the registrants of the Colleges. Thus, if the person performing the service is not a regulated professional, other legal means must be available for the public to use if harm occurs. Other

public protection strategies include the qualifications required to obtain a business license and the setting and enforcement of standards of care by those funding the care. The public can also be protected by the use of the legal system to determine injury or harm. Utilizing these other means of liability and risk management strategies raises the question of who should be responsible for enforcing professional standards, the professions through self-regulation or these other means. Setting and enforcing standards of care allows the profession to have power and control within the health care system. The extent to which professions should have this control is part of the ongoing debate on the purpose and value of professional self-regulation. The implementation of the reserved act model for defining scope of practice reduces regulatory control in one area, but power and control is retained through the regulatory ability to set and enforce standards of care.

The reserved act model for defining scopes of practice increases reliance on the ability of consumers to make informed decisions about their care. However, complete reliance on the ability of consumers to determine the best practitioner for their needs is not desirable. There is a wide range of capabilities among the people who utilize health services. In addition, consumers are being asked to make decisions when ill health places them in a vulnerable position. Consumers have the challenge of dealing with a large volume of knowledge and interpreting the validity of that knowledge. For these reasons, governments have accepted that the need for self-regulation is necessary to protect the public.

Reserved Titles

Under the Health Professions Act (1996), the Health Professions Council may recommend to the Minister of Health that in regulating professions under the Act, one or more titles should be used exclusively by the registrants of the regulated profession. Giving title protection is one way of informing the public of a professional grouping, but it is questionable as to how the public knows which titles are protected.

The current use of titles does not tell the public which professions are regulated, what

services they can expect or whether or not the person is qualified to provide that service. The consistent and valid use of titles and labels to designate a profession or the competence of a professional is important for public protection so the public knows the type and quality of services to be received and can have confidence that they are receiving care from the profession of their choice. The Seaton Commission (1991, D-34) recognized the confusion for the public in the use of the terms "registered" " licensed" or "certified" and recommended that the use of these terms be prohibited by any health professional unless that use has been approved by the Health Professions Council. In the review of scopes of practice and the designation of titles, the Health Professions Council to date has not made consistent recommendations for the use of the registered, licensed or certified titles. The government also allows the use of titles without a registration process. An example of this is social workers, where, currently registration is on a voluntary basis.

The use of reserved titles can be confusing for the public when a professional designation is also used as a descriptor for the service being provided. There are many examples where other professions and caregivers use the term physical therapy: "I am doing my physical therapy", instead of, " I am doing my exercises prescribed by my physiotherapist." In the submissions to the Health Professions Council, naturopaths and chiropractors indicated their members are trained in providing physiotherapy. While their members may use common procedures such as electrotherapy, exercise and manipulation, physical therapists contend that members of these Colleges do not practice physical therapy. To reduce this confusion, physical therapists have strongly urged a policy change to protect professional titles and professional designations. This has not yet occurred. Other professions, including respiratory therapists and occupational therapists, faced with similar confusion on the use of terms, have tried to address this by using federal legislation and applying to trademark or patent laws to regulate the use of terms labeling the profession or describing the services provided by the profession. To date, these applications are still being considered by

the federal government. What continues to be important for public protection is resolving the use of titles and terminology in order to establish a clear and consistent nomenclature that is understood by the public.

Summary

Implementation of the reserved act model for defining scope of practice has the potential to remove unjustified regulatory restraints on the ability of professionals to use their knowledge and abilities to provide health care and reduces but does not absolutely resolve the extent to which the scope of practice definition establishes regulatory control on the delivery of health care. The Health Professions Act (1996) diminishes the medical dominance of physicians but does not eliminate this dominance.

The implementation of open scope of practice definitions for the regulated health professions allows the public more choice but places an increased reliance on them to be informed. The change in defining what a professional is able to do from restrictive and exclusive terms enhances the need for regulation to define and enforce the competencies of the professional. This means that attaining public protection requires a supporting legislative framework with the power to establish and enforce valid standards of registration and practices. To this end, the Health Professions Act (1996) establishes a framework of current enforceable regulatory law including a new regulatory responsibility of ensuring continued competency of the regulated health professional.

Although the Health Professions Act (1996) enables the granting of reserved titles for regulated professions, there remains a lack of clear and consistent use of titles and labels to describe health professional services. This lack of clarity in use of title and labels and the difficulty in knowing the competencies of different professions makes it difficult for the public to know who is best qualified to perform specific health services.

CHAPTER SIX

ASSURING CONTINUING PRACTITIONER COMPETENCE

One of the newer regulatory responsibilities assigned in 1993 for all self-regulated professions in B.C., including physiotherapists, is the responsibility to ensure a professional's competence throughout his or her career. Regulatory responsibility for continued competence resulted from ongoing recognition by government and the public that competence of the professional needs to be monitored on an ongoing basis to ensure quality, safety and public protection.

A review of the policies and practices for physiotherapy and other professions shows that the continuing competency requirement is not unique to B.C. as it is being added to regulatory acts in other provinces and countries. In Canada, Ontario was the first province to put this regulatory responsibility in its legislation. In the United States, the report of the Pew Health Care Commission-Task Force on Health Care Regulation (September 1995) recommended each state should "require the development, implementation, and evaluation of continuing competence requirements" (p.5). In response to this recommendation, the Federation of State Boards for Physical Therapy appointed a task force on continuing competency in 1998. The task force report, Continuing competency, A discussion paper, released in April 1998, discusses the need, and possible means, to develop a national consensus on how regulators can work towards ensuring continued competency.

In Canada, an implication of the provincial trade agreements is the need to determine equitable, transferable, and defensible entry to practice and continuing competence requirements for professional regulation. Nationally, the Alliance's 1998 strategic plan includes the mandate to build a national consensus and strategy to meet this continuing competency responsibility of the provincial regulatory colleges. The College of Physical Therapists of B.C. is supportive of the need for a national approach for ensuring continuing

competency.

The Health Professions Act (1996) delegates under the duty and objects of a College the responsibility "to establish and maintain a continuing competency program to promote high practice standards amongst registrants" (Section 15.1.2 (e)). There is also the duty to establish, monitor and enforce standards of education and qualifications for registration and to establish, monitor and enforce standards of practice that enhance the quality of practice and reduce incompetent, impaired or unethical practice amongst registrants. Thus, the competence of the practitioner is approached within the statute from three directions: a continuing competence program, registration standards, and standards of practice.

Attaining Continued Competence

There are many unanswered questions about the most effective means to attain continued competence. Recently, Braham and Williams (1999) prepared a survey report, Licensure, certification and continuing competence practices among Canadian regulated professions. In this survey, 155 professions responded from the 343 professions who were asked to participate. Ninety-five percent of respondents indicated that the reason for implementing a continuing competency program was public protection. Of the 12 assessment methods surveyed, the most common approaches taken included continuing education and self-assessment. The authors stated:

> Interestingly, these two approaches were ranked the lowest for satisfaction, indicating a growing realization that while easy to implement, these two approaches have not been very effective in meeting their designed purpose of protecting the public. In contrast, assessment centers and computerized examinations were the least common approaches to current assessment, but were the two methodologies that received the highest ranking of satisfaction (p.2).

The process of developing a viable continuing competency program provides an opportunity for self-regulated professions to research factors that influence a professional's competent performance over the length of his or her career and to use knowledge to maximize the probability of public protection and provision of quality health care. There is the need to

determine professional competencies, ways of measuring competence, and the effectiveness of continuing competence activities on increasing the quality of health service.

The move to establish a program to ensure continued competency does not replace the traditional regulatory responsibility to handle complaints by an inquiry and discipline approach for protecting the public from incompetent practitioners. A regulatory College has the duty "to superintend the practice of the profession" and "to establish, monitor and enforce standards of practice to enhance the quality of practice and reduce incompetent, impaired or unethical practice amongst registrants" (H.P.A. Section 15.1(2)). The addition of ensuring continued competence recognizes that attaining quality of practice only by searching for those professionals whose practice is not competent ("the bad apples") does not affect the majority of the members of the profession. This conclusion is illustrated by reviewing the complaints dealt with by physiotherapists in B.C. In 1998, the total number of physiotherapists registered in B.C. was 2255, including 72 student registrants. In 1998, the regulatory board for physiotherapists dealt with 54 complaints. Of these 54 complaints, 33 were outstanding complaints from previous years and 21 were complaints received in 1998. In 1997 there were 20 new complaints. The number of complaints carried forward was a result of the inadequacies in physiotherapy regulatory legislation prior to going under the Health Professions Act (1996). The move to the new legislation has enabled the CPTBC to resolve these complaints. Thus, the number of complaints received relates to only about one percent of the registrants.

<u>Continuing Competency is not an Isolated Responsibility</u>

The Health Professions Act (1996) sets the expectation that the profession's regulatory and professional roles are to be distinct and separate, yet in the area of competency there are both separate and overlapping roles for the individual professional, the regulatory college, the professional associations, the academic educators, and the employers or funders of care. The regulator is responsible under the Act for ensuring entry to practice and continuing

competency; the professional association complements this by its responsibility for enhancing competency, and the educators are responsible for the provision and development of education. The professionals themselves have a responsibility to be competent, while the employer/funder is responsible for ensuring those they employ or fund are keeping up to date and competent in the services they provide.

Entry to practice competencies and continuing competencies are strongly linked to the extent and quality of the professional's education. For public protection, it is necessary to ensure that the standards of education result in competent professionals. There is a range of approaches to ensuring quality of educational programs, including regulation by government and mandatory or voluntary accreditation programs. For physiotherapists, the use of a national entry to practice competency examination has a feedback loop to the university programs. In addition, university physical therapy programs also participate in an accreditation process.

It is a responsibility of the Health Professions Council to investigate and "to ascertain what education programs exist in the province or elsewhere for the proper education and training of persons with respect to the practice of the health profession and evaluate the content of those programs" (H. P.A. 9, (2), (1)). Defining what is proper education and training is a complex task that depends on many factors, including the validity of the knowledge being taught, the scope of the knowledge obtained, and the methods of assessing whether what is taught is learned. It is important to note this is a potentially strong power that has been granted to the Health Professions Council and perhaps is an example of where the impact of delegating a regulatory responsibility has not been fully thought out. It is not clear how the Council will assess educational programs, and discussion has not occurred regarding whether or not it is appropriate for the Council to have this regulatory responsibility.

With regard to the proposed scope of practice proposal of massage therapists in B.C., physiotherapists expressed concern about the regulation of private post secondary schools in B.C. and the potential conflicts in the accreditation processes currently in use. Detailed

discussion of validity of education programs, the mix of privately and publicly funded education programs, and marketplace competition in the delivery of education is beyond the scope of this thesis. It is important to note, however, the link between regulation and education and the responsibility of the self-regulated profession to assess entry level and continued competency.

Because funders of health care (including the government) want to fund competent and quality care, they are naturally interested in the competence of heath care providers. In determining the standard or quality of care, there is potential conflict between regulators and funders because regulators are responsible for setting standards for entry to practice, continued competency and services. Those funding health care may hold the view that regulators establish standards that are not affordable on an ongoing basis. Funders may wish to modify these standards because they want to enhance profits or stay within budget. This conflict enhances the need for regulators to defend and validate the reasons behind the standards.

The Approach Taken by the College of Physical Therapists of British Columbia

The Quality Assurance Committee (QA) of the CPTBC has been assigned the responsibility of developing a program to assure continuing competency. The QA committee is composed of college board members, a representative of the provincial professional association, and members from the academic community.

The QA Committee has approached the matter of ensuring competence throughout a career by reviewing the many different approaches that exist and developing basic guiding principles. The issues around delivering continuing competency programs are complex and there are no clear methods to ensure competence. The approaches considered were professional portfolios, self-assessment instruments, professional certification, continuing education (mandatory and voluntary), re-administration of entry level examinations, administration of mid-career examinations, peer review, practice reviews, use of standardized

patients and cases, and computer-based client simulations.

The QA Committee reviewed the range of approaches to continuing professional competency summarized by Barnhill (1997) as a continuum from the "angel's-trust-me" model to the "insect's-show-me" model. The "angel's- trust-me" model is based on self-evaluation, where the role of the regulatory college is to encourage competence. The "insects-show-me" model is based on re-certification examinations and prescriptive continuing education requirements. The "insect-show-me" model assumes that some professionals will not be appropriately motivated to maintain competence, therefore the shared responsibility of the regulatory college and professional. The "angels-trust-me" model is based on the assumption that all professionals are motivated and will do what is necessary to maintain competence.

Sheets and Winn (1996) proposed using a system of markers and indicators that licensing boards could use to identify practitioners whose performances were below accepted standards. The methods of determining which practitioners are at higher risk of working below acceptable standards is an area where the QA Committee sees the need for further research. The QA Committee felt that the currently available complaint statistics are inconclusive in determining indicators of professional practice below acceptable standards. Having a system of markers as to which practitioners are at higher risk for performance below standards would be helpful for determining which practitioners would require greater follow up by the regulatory board.

Physiotherapists did not choose mandatory continuing education as a method for ensuring continued competence. The effectiveness of voluntary and/or mandatory continuing education for continued competence and increasing quality of care is debatable. The rationale used to defend voluntary continuing education is that a professional's choice whether to take courses should be respected and that mandatory continuing education is contrary to adult learning principles. An advantage of mandatory continuing education is the ability of the

regulatory board to measure attendance and to potentially judge which educational activities are to be of benefit to the professional.

More research into the relationship between continuing education and competence is necessary because of the current legal duty of regulatory boards to ensure continued competence. Current means of evaluating the outcome of continuing education ranges from documenting attendance, to having participants give opinions on the educational activity to attempting to measure changes in practitioner competencies such as attitudes, skills and knowledge. The highest level of evaluation is assessing the impact that continuing education has on practitioner behavior and the provisions of quality health care. Changes in professional behaviors are difficult to demonstrate empirically, although performance measures such as patient satisfaction surveys and functional assessment techniques of treatment outcomes are evolving. To this end, measuring effectiveness of treatment using outcome measures continues to be a professional development focus in current physiotherapy publications and in workshops sponsored by the physiotherapy professional associations.

Other approaches used to promote learning or to identify the need for learning include feedback, peer reviews, mentoring, administrative guidelines and rules, financial incentives, performance assessments, audit procedures such as chart audits, and office record reviews. Each of these approaches has strengths and limitations for motivating the professional to change or improve his or her practice competence.

Upon reviewing the above methods, the CPTBC concluded that a quality assurance professional portfolio model should be used to ensure continuing competency. The proposed quality assurance program is similar to programs being developed for other regulated professions. It establishes a proactive and supportive approach to foster growth and development of professional practice and enables adequate separation from the disciplinary complaints-driven system. The portfolio approach is designed to guide the self-assessment of professional practice. The intent is to provide tools whereby the regulated professional will be

able to reflect on his or her professional practices, identify learning needs, develop learning goals, select an approach to learning, complete the learning activity, and evaluate the impact of the learning on his or her identified goals and learning needs. The content of the portfolio consists of past and present experience, current career status, professional strengths and weaknesses, and short and long term career goals.

There is a fundamental debate about the effectiveness for ensuring competency with a voluntary or mandatory program. Physiotherapists have determined that an element of compulsion is required and thus a link to the inquiry and discipline process is necessary. It is proposed that this link would be used when a practitioner does not complete his or her portfolio to a satisfactory level, or if there is an identified risk to the public. If either scenario occurred, the inquiry and discipline process would be used to suspend or limit the practitioner's registration. The objective of the continuing competency program in using a quality assurance approach is not to correct the behaviors of incompetent practitioners by punitive means, but to provide the tools for fostering the continued competence of all practitioners.

The QA Committee suggested the professional portfolio incorporate a section where the physiotherapist is asked to look at his or her practice status and to take stock of the environment in which he or she lives and works. This is because one's work environment and personal circumstances may affect competence. It is arguable that the public is not adequately protected by professional regulation as there are environmental factors that potentially impair the ability of the professional to perform services within the standards set by the professional regulations. Kushner (1992) proposes that the causes of poor quality of care can be identified by looking at the efficiencies of how care is provided and the effect of the regulatory standards of the individual professionals providing the care.

Evaluating the work environment raises the question of how extensive the regulatory College's role should be in assessing and influencing work environments. This is again a

balance of power question and relates to how or if a College should have involvement in negotiating and/or mandating work-setting influences on the standard of care. The College's regulatory responsibilities are directed at the professional, not at the employer or funder of care, but if the professional cannot meet his or her College standards because of the work setting, it is plausible that Colleges will be persuaded to have greater involvement in this area.

The choice of using self-assessment in the professional portfolio acknowledges that it is the responsibility of the individual practitioner to ensure his or her own competence. This individual responsibility is one of the factors used to define a professional. Critics of this approach challenge the ability of the professional to engage in critical reflection and have insight into his or her behavior enough to determine his or her learning needs. An advantage of this model is how it incorporates a range of ways to keep knowledge and skills up to date, thus respecting individual learning needs and overcoming the problem of access to continuing education opportunities. This approach is remedial and proactive rather than punitive and its implementation appears to be affordable.

Although the College has accepted the use of a professional portfolio to ensure continued competence there remains many unanswered questions about the standards and measurement tools used. The College realizes that ongoing research is required to determine what compromises a satisfactory portfolio and how to deal with unsatisfactory portfolios. There needs to be continued research into the effectiveness of using a professional portfolio approach to ensuring continued competence.

It is too early to determine if this new regulatory responsibility will be effective in enhancing the quality of health care and protection of the public. G. Debling (personal communication, 1998) has assisted other industries in developing self-assessment continuing competency tools. He reports that an early result of the follow-up analysis of professional portfolios or diaries indicates increased knowledge of the standards and policies of the profession and increased application of the policies results in improved service provision.

In summary, the new regulatory responsibility for ensuring continuing competency has introduced to regulators the ability to develop a proactive, preventative approach to ensuring competency throughout the career of all regulated professionals. The desired outcome of this new regulatory responsibility is improved quality of care. The implementation of the continuing competency requirement could also result in collaboration between professional associations, regulators, educators and funders with a result of improved quality of care.

The punitive complaints and discipline approach affects only a few incompetent practitioners whereas the impact of an effective continuing competency program will affect all regulated members of the profession. As stated by Steinecke (1996),

> ...the development of effective continuing competency programs may be much more effective than the whole of the complaints, discipline and fitness to practice activities of the College, and it will likely be more cost effective as well because it does not involve hearings. (p.9-1)

The development, implementation and eventual outcome measurement of the effectiveness of continuing competency programs has become a current focus of research driven by the change in regulatory policy. There are researchable questions on competency, learning and retention of knowledge, skills and abilities, and on the effect of practice environments on professional competence. The effect on public protection of implementing the regulatory responsibility to ensure competency throughout the lifespan of the professional's career has yet to be researched.

CHAPTER SEVEN

CONCLUSIONS

Self-regulation of the health professions affects the supply side of health care services and is only one of many factors that interplay to affect the quality of health care. It is a significant factor because many aspects of the delivery of health care are dependent on the qualifications and availability of care providers. Governments establish the regulation of professionals with the overall objectives of public protection and direction of the quality of health care. Regulation establishes mechanisms for the enforcement of standards of practice for professional behaviors. The need for professional self-regulation is based on the imbalance between professional and public knowledge and the service relationship between the health care provider and the consumer of service. Although self-regulation of the professions is for public protection, the granting of regulation to the professions does give power and status to the professions. These powers may be used in the best interest of the professions and not in the best interest of the public. In the development of regulatory legislation it is this tension between professional control and interests and public interests that directs policy decisions on how to regulate the professions.

The historical summary shows that policy changes can take a substantial amount of time to implement and thus highlight the significance of the current changes. Several decades of health reviews (Foulkes Report, 1973; Hall Commission, 1964; Hastings Report, 1972; Pew Commission, 1997; Seaton Commission, 1991) had identified the need for regulatory reforms. All reviews identified the need for regulatory reform because regulation has an impact on professional control of the availability, cost and quality of health providers.

Changes in regulatory policy are also being driven by an increase in expectations by the public for accountability and responsiveness of professionals and the health care system. Professional knowledge establishes a power relationship between the consumer and the

professional. Illich et al (1977) discusses professional power as being different from other occupations and defines three types of professional authority:

> ...the sapient authority to advise, instruct and direct; the moral authority that makes its acceptance not just useful but obligatory; and charismatic authority that allows the professional to appeal to some supreme interest of his client that not only outranks conscience but sometime even the *raison d'etat.* (p.17-18)

The regulation of health care professionals reinforces the characteristic of a professional to use autonomous judgments and to control his or her work. How a professional gains exclusive rights to manage his or her work is documented by Friedson (1970). Using Friedson's (1970) definition of medical dominance it can be concluded that the establishment of self-regulatory powers has an effect on the division of labor and the content of who can do what work. The current regulatory change to using open scope of practice definitions and the resulting ability for more consumer choice is changing the dynamics of professional authority. It is still too early in the implementation of these changes to determine where the balance between professional power and the effect on the consumer will evolve, but it can be concluded there is a shift to more consumer choice which is resulting in a questioning of professional authority.

The Health Professions Act, R.S.B.C. 1996, c.183 implements substantive changes in the regulation of health professionals in B.C. The new act was first introduced in 1990 and evolved with changes into the current 1996 legislation. This legislation establishes a new structure of umbrella legislation that includes a policy shift from restrictive or exclusive scope of practice definitions to defining scope of practice by the use of an open reserved act model and a new regulatory responsibility to ensure continued competency. The traditional regulatory functions of setting standards of qualifications to practice the profession and enforcement of minimum standards of practice using a complaints and discipline process are

standardized and retained in the new legislation.

The case study of the regulatory history of the physiotherapy profession in British Columbia documents the evolution of regulation for a health profession and shows the need for and effects of the current regulatory reform. Physiotherapists in B.C. became regulated under the Health Professions Act in December 1994 as one of the first previously self-regulated health professions to go under the new legislation. The new legislation provided physiotherapists with a much needed current regulatory framework to enforce the standards of practice of the profession. It removed the subservient role requirement to only work under medical prescription and enabled separating the joint regulation of massage therapy and physiotherapy under one regulatory act.

The findings of this study show that incorporated within the self-regulatory umbrella legislation are methods of increasing consumer focus, accountability, administrative efficiency and appropriate division of power between professional boards, regulatory boards, and the government. The government has chosen to use delegated umbrella legislation to establish a self-regulating structure where the professions themselves administer the regulatory law. Administrative efficiency is attained by the move toward uniform regulatory language and the use of template/ umbrella legislation in which all self-regulated professions have similar legislative duties and functions.

Accountability to the public has been attained through the appointment of lay or public members to the regulatory boards. Accountability is also increased by the legislation incorporating the principle that all regulatory board members, both professional and public, have the responsibility to regulate in the public interest rather than in the interest of the profession. In regards to the appointment of lay members the physiotherapy profession chose

to set in their bylaws a limitation on the length of the term of appointments of lay members. The rationale for this decision was that turnover of lay members would facilitate greater input of public concerns. The Health Professions Act (1996) does not set the length of terms for appointment of lay members but leaves this to each profession to establish in their bylaws.

Other accountability mechanisms included in the new act are annual reporting to the Minister of Health and mandated malpractice insurance to be carried by all health professionals. The annual reporting provides a method of informing the Minister of regulatory actions and can be used to alert him or her to changes in regulation that may be required in response to changes in the delivery of health care. The Act, however, does not specify the information to be reported to the Minister nor whether there will be checks to see if the regulatory boards are performing their functions.

Granting professional self-regulation reinforces the concept that attaining regulation is a natural step in the development of a profession and establishes status and powers for the regulated profession. To balance this concern, the new Act retains a consumer focus by establishing a defined method for professions to apply for regulatory status. Self-regulation is granted only when the public interest is served by doing so, and when the advantages clearly outweigh the disadvantages. Establishing this process reduces the potential of using political influences to attain regulatory status and thus increases the accountability of the regulatory structure. The responsibility for determining if a health profession should be recommended for regulatory status is given to the appointed Health Professions Council established under the new legislation. It is important to note that the need for public protection criterion used by the Council does not include determining the effectiveness of the health care services nor which profession is better qualified to perform the services. In determining which professions

are to be granted reserved acts, the Council does need to determine if the profession is qualified to perform the reserved act. In selecting one profession to be qualified to perform reserved acts over other professions means the Council is determining which professions are better qualified. The determination of the qualifications by the Health Professionals Council does place the responsibility with an appointed board with expertise instead of decisions being made by politicians.

In granting self-regulation to a health profession, the government has specified the appropriateness of division of jurisdictions and functions between the professional and regulatory groups within a profession. The regulatory College's sole responsibility is administration of the regulatory regime in the interest of the public. There can no longer be joint professional and regulatory boards where there is potential conflict between the interests of the profession and the interests of the public. For both physiotherapists and massage practitioners, separation of the regulatory and professional association boards was already established.

The move to utilizing a reserved act model for defining the scope of practice of health professions removes unjustified barriers to health care services and thus changes the relationships between health professions. The study reveals that the move to the reserved act model enables more health professionals to fully use their knowledge and skills to provide care and reduces, but does not eliminate, the ability of any one profession to control an area of health services. It is important to note that in B.C. it has not been mandated that all professions be regulated under the Health Professions Act (1996), but all professions are undergoing a review of their scope of practice. It is anticipated that the recommended definitions of scope of practice, once determined by the Health Professions Council, will be

given to the Minister of Health for regulatory changes in all licensing acts whether or not the profession is regulated under the Health Professions Act (1996). A similar standardization occurred when implementing the regulatory responsibility of continued competency as this requirement was placed as an amendment in all health professions' regulatory acts. The use of the reserved act model to define scope of practice reduces regulatory barriers to the utilization of professionals but, dependent on which reserved acts are granted to a profession, the granted reserved acts still allows a profession to retain control over services.

Although physiotherapists have been designated to have some reserved acts that are determined to have significant risk of harm, a large part of physiotherapy practices are shared competencies with other health care providers. The reserved act model for defining scope of practice appears to do little to decrease physician monopoly over services. The medical profession appears to be granted all the controlled or reserved acts, which will continue to reinforce the traditional hierarchy of physician control. Rappolt (1999), in analyzing the reserved act model for defining scope of practices, states:

> However, by circumscribing medicine's formally all encompassing and exclusive scope of practice, it has been possible for other professions to encroach on medicine's traditional domain. (p. 121)

Not granting diagnosis as a reserved act to professions such as nursing and physiotherapy limits these professions' ability to have shared competencies in the delivery of health care and places a barrier to the full utilization of professional competencies to provide care. Physiotherapists and other professions including nursing are arguing that the reserved act of diagnosis must be granted to professions other than medicine. It can be argued that concluding an assessment with a diagnosis determined within the competencies of the profession occurs in everyday good practices as a necessary step in determining the most

effective treatments to provide. Without this ability limits are being set on the services that can be provided. As well, the inability to conclude an assessment with a diagnosis continues physicians' dominance in the delivery of health care. This limitation is contrary to the given reasons for implementing in regulation the use of open scope of practice definitions. As the Health Professions Council has not yet concluded the review of scope of practice, the resolution of this issue is yet to be detemined.

Although the new legislation makes significant changes for regulation of health professionals it is still very difficult for a member of the public to know how to evaluate the quality of the health services they receive. The legislation is silent on how to increase efficiencies in the delivery of care and how to determine the most cost effective mix of health care provider to be used. The new regulatory regime does shift increased responsibility to the consumers and funders of health care to make informed decisions in choosing health care services. This study identified that there are barriers to effective public understanding and ability to make these decisions. There is an imbalance of knowledge between health professionals and consumers and there are vulnerable consumers who may not be able to make sufficiently informed decisions. In health care, consumers have a direct service relationship with professionals and usually need services at a time when reliance on the professional's knowledge and skill is paramount to their well-being.

The utilization of open scope of practice definitions establishes the potential for an increased range of services to be provided by a wider range of both regulated and unregulated care providers. There are only a few reserved acts held exclusive to designated professions. Allowing unregulated caregivers to provide health care services further places the responsibility of assessing quality of care wholly onto the consumer and/or on the funder of

the care. The new framework has not been implemented long enough to evaluate whether this shift to increased consumer responsibility for decisions will result in harm to the public or if there is enough consumer awareness and knowledge to make informed decisions.

The result of having only a few reserved acts is a shift towards determining incompetent practices of a regulated professional by having enforceable standards of practice within the regulatory structure. The ability to enforce standards of practice is enhanced by the new legislation incorporating current principles of administrative laws. For physiotherapists, this was extremely important because of the outdated nature of their old legislation.

The value to consumers, employers and funders of health care services of using regulated professionals is enforcement of entry to practice, continuing competency qualifications and standards of practice under which the professional works. The answer to the question of how the consumer will know who is or is not regulated is still unclear. The new act incorporates a process of designating professional title(s) but this alone does not provide enough information to the consumer to know whether a given professional is regulated and what that means in terms of services that the consumer can expect.

The updated regulatory structure incorporates the necessary tools to carry out regulatory responsibilities and is set to ensure that the activities of regulatory boards are effective and coordinated in the interest of the public. The Act establishes the ability for the College Board to set and enforce standards of practice at several levels. The process of dealing with complaints and discipline is updated with current due process laws that will increase efficiency and provide a process where complaints are investigated and resolved in a manner that is satisfactory and credible to the public. The traditional regulatory functions of establishing and enforcing entry to practice competencies and the approach for dealing with

incompetent practices by using a complaints and discipline system remains incorporated into the new regulatory framework.

The new legislation clearly sets that it is the responsibility of the College to establish, monitor and enforce standards of education and qualifications for registration. The means to enforce qualifications for registration are by setting entry to practice standards, including examination and approval of educational programs. This responsibility to set entry to practice standards provides for the consumer an assurance of competency of the care provider. Through regulation under the Health Professions Act (1996), physiotherapists in British Columbia moved to using a national competency examination for entry to practice. Currently, changes are occurring in establishing, monitoring and enforcing standards of education. Potential issues that require further study include the validity of current accreditation programs, how quality and standards are enforced for private and/or for profit educational programs, and how much control the profession, the Health Professions Council or the government should have on setting the educational requirements.

A significant change with the new act is the regulatory responsibility to ensure continued competency throughout the career of the regulated professional. There are many unanswered questions on the development, implementation and eventual measurement of the effectiveness of continuing competence programs. The effectiveness of the regulatory changes implemented with the Health Professions Act (1996) will be determined over time by measuring whether the public is protected from harm and whether there is enhanced quality of health care. Measures of effectiveness could include measures of health status, measures of quality of care and outcomes, analysis of cost effectiveness and efficiencies in the use of health care manpower, and accountability measures such as the number of complaints

received by Colleges.

The government policy implemented with the Health Professions Act (1996) is for individual professional regulation under an umbrella framework statute. The new legislation sets a template for all professions but retains for each profession a separate College. The government also established a set of model or template bylaws to be used by all regulated health professions. The use of consistent or similar bylaws raises the question of whether or not public protection is best achieved with profession-specific standards or if it is feasible and more effective to have generic standards for all professions. Support of the use of common standards reflects an acceptance of the premise that all professions will base their code of ethics and standards of practice on agreed upon evidence of valid practices, and on the values of society in which the professional is practicing. A move to generic standards presumes that there are no differing views among the professions. Such a move could become a way of one profession dominating the standards of care and imposing one professional view of client and health care situations onto other professions. There are multiple factors to consider in how evidence relates to actual practice, a most dominant factor being defining differences in professional philosophies and treatment approaches.

Governments have historically kept the regulation of health care plans, delivery sites and health care professionals separate. It is increasingly important to ask if the lack of integration amongst these systems of regulation contributes to a lack of coordination and inefficiencies, thus affecting the quality of health care. The implementation of ensuring continuing competency requirements has increased health policy debate around the influence of professional regulation in the structure of the work environment. Professional self-regulation is established in recognition that the profession has the expertise to determine

standards of care, but the impact on the work environment of enforcing these standards acutely raises the question of whether the standards are there to protect the public or to promote professional control of the work place.

Trade agreements such as the Agreement on Internal Trade (AIT) are creating moves towards standardization of regulatory functions and this may encourage a move towards joint professional regulation where several professions are regulated under one regulatory board and/or a move to a national regulatory framework. Some of the strengths of arguments for a national framework include increased uniformity of standards and enforcement, elimination of multi-jurisdictional regulatory expenses and increased mobility between jurisdictions. Some possible weaknesses of a national regulatory framework include the potential of greater costs for administration and enforcement and decreased responsiveness for consumer protection because of the size and scope of the responsibilities. Any change to a national regulatory framework would need to address the jurisdictional issue of the Provinces' responsibility to regulate health care.

It is also warranted to consider a policy option of consolidating professions under one regulatory board instead of discrete individual Colleges. Prior to going under the Health Professions Act (1996) massage therapists and physiotherapists were regulated under one board. Under the new legislation separation was attained. A loss with the separation is the fact that massage therapists and physiotherapists no longer meet routinely at the same regulatory table where there is the potential to address issues of inter-professional rivalry. Both professions have lesser resources to fund regulatory duties. With the current move to defining open scopes of practice and similar overlapping competencies between the two professions it is arguable that joint regulation could enable greater consistency in the development and

enforcement of common standards of practice.

Issues for further study include a continued need to examine the outcome of professional regulation on public protection, quality of health services and costs in delivery of health care. It is an ongoing question as to whether or not professional regulation is the most effective way for governments to protect the public and to direct the provision of quality health care. Tied closely to this question is the evolving determination in society of what constitutes acceptable, affordable and effective health care. The granting of self-regulation to a profession does not mean there has been a determination of which services are necessary, nor whether the services are effective. Of the many facets to be examined in determining effective regulatory policies an important facet is the characteristics of professional dominance and the nature of professionalism. The balance between self-regulation enabling professionals powers to dominate or control areas of work and the need for public protection remains an ongoing issue. The basic question remains: Who benefits the most from professional self-regulation- the public or the profession?

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APPENDIX A

The Act Respecting Naturopathic Physicians was passed 1936, amended 1937 for the registration and admission of Physiotherapists and Masseurs. Regulations passed in 1938.

Abridged

Part II of the Regulations covered Restrictions for Physiotherapists and Masseurs as follows:

19.(1). No physiotherapist or masseur shall undertake the treatment of any ailment, disease, defect of disability of the human body except under the prescription of a physician legally qualified in the Province of British Columbia to diagnose and prescribe treatment for such ailment, disease, defect or disability.

(2) No physiotherapist or masseur shall make or attempt to make any adjustment of any bony structure of the human body.

(3) No physiotherapist or masseur shall use any form of medicated bath except by prescription or under the direction of a registered physician.

Appointment of Physiotherapist for Examinations.

(20) The Board of Naturopathic Physicians, for the purpose of such examinations of applicants for registration under this Part of the Act as a physiotherapist or masseur, may appoint from time to time a registered physiotherapist to assist the Board of Examiners in the examination for such applicants.

Penalties.

(23) Any person registered under this Part of the Act who commits any breach thereof or who willfully or falsely pretends to be a physician, doctor, or assumes any title, addition, or description other than 'registered physiotherapist' or 'registered masseur' as the case may be, shall be liable, on summary conviction to pay a penalty not exceeding one hundred dollars nor less than twenty-five dollars and may be suspended or removed from the register by the Board.

The regulations further defined a physiotherapist as:

24. 'Physiotherapist' for the purpose of this Act, shall mean any person who practices therapy by means of manipulations, mechanistic, hydro, thermo, helio, or electrical methods for the treatment of any ailment, disease, defect, or disability of the human body, but who does not diagnose nor prescribe.

Qualifications were defined as:

26. Any person, being twenty-one years of age, on satisfying the Board of Naturopathic Physicians as to moral character, may register under this Part of the Act as a 'physiotherapist' provided such applicant has passed the Junior Matriculation in British Columbia or its equivalent, and has taken a four-year course in training in a college approved by the Board of Supervision, consisting of:

(a) Three years' training in such fundamental studies as elementary physics and chemistry (preferably taken in the high-school course for matriculation), anatomy, physiology, personal and community hygiene, elementary nursing principles, elementary nursing methods, bandaging and first aid, rudiments of elementary psychology, ethics of nursing, foundational principles of preventative medicine (susceptibility, immunity, protection, elementary general bacteriology, (infection and inflammation), elementary pathology, diseases amenable to treatment by massage (passive, active, controlled movements, gymnastic exercises), technique of massage, usage of assisting methods (baths, heat, light, electricity, instruments, and mechanical appliances), special massage (medical, surgical, orthopaedic, pediatric).

(b) One years' training in the special branches of massage, and gymnastics at a school of training for that purposes approved by the Board of Supervision, and passes such examinations as may be prescribed by the Board of Examiners.

Physiotherapists and Masseurs will also by regulation 30 denied the right to vote at any

meeting of the Association of Naturopathic Physicians and by regulation 31 form advertising that they treat any specific disease.

APPENDIX B

PROPOSED RESERVED ACTS IN BRITISH COLUMBIA

1. Communicating to the individual or his or her personal representative a diagnosis identifying a disease or disorder as the cause of systems of the individual in circumstances in which it is reasonably foreseeable that the individual or his or her personal representative will rely on the diagnosis.

2. Performing a procedure on tissue below the dermis, below the surface of a mucous membrane, in or below the surface of the cornea, or in or below the surfaces of the teeth, including the scaling of teeth.

3.Setting or casting a fracture of a bone or a dislocation of a joint.

4. Moving the joints of the spine beyond the individual's usual physiological range of motion using a fast, low amplitude thrust.

5. Administering a substance by injection or inhalation.

6. Putting an instrument, hand or finger

i beyond the external ear canal

ii. beyond the point in the nasal passages where they normally narrow

iii. beyond the larnyx,

iv. beyond the opening of the urethra,

v. beyond the labia majora,

vi. beyond the anal verge, or

vii. into an artificial opening into the body.

7. Applying or ordering the application of a form of energy prescribed by the regulations under this act.

8. Prescribing, dispensing, selling or compounding a drug as defined in clause 113(1) of the Drug and Pharmacies Regulation Act or supervising the part of a pharmacy where such drugs are kept.

9. Prescribing or dispensing, for vision or eye problems, subnormal vision devices, contact lenses or eye glasses other than simple magnifiers.

10. Prescribing a hearing aid for a hearing impaired person.

11. Fitting or dispensing a dental prosthesis, orthodontic or periodontal appliance or a device used inside the mouth to protect teeth from abnormal functioning.

12. Managing labour or conducting the delivery of a baby.

13. Allergy challenge testing of a kind in which a positive result of the test is a significant allergic reaction.

APPENDIX C

PROPOSED RESERVED ACTS GIVEN BY THE HEALTH PROFESSIONS COUNCIL FOR MEMBERS OF THE COLLEGE OF PHYSICAL THERAPISTS OF BRITISH COLUMBIA

a. Performing procedures below the dermis for purposes of acupuncture for the management of pain and or/normalization of physiological functioning of the cardiorespiratory and neuromuscular systems to be granted to members of the College of Physical Therapists of B.C.
b. Moving the joints of the spine beyond the limits the body can voluntarily achieve but within the anatomical range of motion using a high velocity low amplitude thrust:
c. Putting a finger(s) beyond the anal verge for the purposes of moving the joints of the spine beyond the limits the body can voluntarily achieve but within the anatomical range of motion using a high velocity low amplitude thrust;
d. Putting an instrument beyond the point of the nasal passages where they normally narrow, beyond the pharynx, or into an artificial opening into the body for the purposes of brachotracheal suctioning; and
e. Administering on prescription, by inhalation or instillation, a mucolytic agent, bronchodilator, or analgesic solution listed in Schedule I or II of the Pharmacists, Pharmacy Operations and Drug Scheduling Act. P. 3-4