## Gregg, Andrea HLTH:EX

**From:** Phillipa Stanaway <PStanaway@cnpbc.bc.ca>
**Sent:** June 14, 2019 3:55 PM
**To:** PROREGADMIN HLTH:EX
**Subject:** Cayton Report
**Attachments:** 2019-06-14 Cayton Report.pdf

Dear Sirs and Madam:

Attached please find a submission from the College of Naturopathic Physicians of British Columbia.

Yours truly,

Phillipa Stanaway
Registrar and CEO

College of Naturopathic Physicians of British Columbia
Suite 840 – 605 Robson St.
Vancouver, BC V6B 5J3

P: 604-688-8236 ext. 107
F: 604-688-8476
E: pstanaway@cnpbc.bc.ca
W: www.cnpbc.bc.ca

COLLEGE OF
NATUROPATHIC PHYSICIANS
OF BRITISH COLUMBIA

Phillipa Stanaway
Registrar
604-688-8236 Ext. 107
pstanaway@cnpbc.bc.ca

June 14, 2019

The Hon. Adrian Dix, Minister of Health
Mr. Norm Letnick, MLA
Ms. Sonia Furstenau, MLA

**BY EMAIL:** PROREGADMIN@gov.bc.ca

Dear Sirs and Madam:

**Re: Cayton Report**

We write in response to your request for written feedback on Part Two of *An Inquiry into the Performance of the College of Dental Surgeons of British Columbia and the Health Professions Act* (the "Cayton Report").

Mr. Cayton divides the recommendations in Part Two of his report into two sections: section 9, regarding short-term changes to the *Health Professions Act*, and section 10, regarding long-term structural changes to the regulatory framework. We agree with many of Mr. Cayton's recommendations in section 9. We believe they will improve the regulation of health professionals in British Columbia.

We suggest that it is too early to speculate as to whether more radical structural reform as set out in section 10 of Mr. Cayton's report is necessary. We submit that measures short of fundamental structural change, such as those identified in section 9 of Mr. Cayton's report, may well resolve concerns regarding governance, operational and financial efficiency, fairness, transparency, and the need for regulators to respond in an agile manner to modern healthcare delivery, including new technologies and team-based care. Such measures may therefore achieve the objectives set out at paragraph 10.5 of Mr. Cayton's report. We are unaware of evidence to contradict that assertion and suggest that a responsible approach to the modernization of regulation should require a preponderance of such evidence before committing to the sweeping changes set out in section 10.

**Section 9 – Reforming the *Health Professions Act***

*Mandate*

In our view, the board of the College already understands the mandate of the colleges to be the protection of patient safety, the prevention of harm, and the promotion of the health and well-being of the public, and makes decisions consistent with that understanding. However, we agree with Mr. Cayton's assertion that the mandate to "serve and protect" the public may be vulnerable to misinterpretation by the public and by registrants. A clearer, more detailed mandate to "protect the safety of patients, to prevent harm and promote the health and well-being of the public" would assist

colleges in communicating the exclusion of such considerations as labour supply from their decision-making.

*Governance*

We agree with all of Mr. Cayton's recommendations regarding governance. To his recommendation that terms of office be extended to three years and be renewable for a further three years in the interest of continuity and retention of expertise (para. 9.24), we have two additional submissions:

1. To preserve and improve continuity, terms should be staggered. This would facilitate gradual change in board composition, as opposed to a sudden, sharp change of all directors every six years; and
2. There should be robust procedures available for the removal of board members who do not meet minimum standards of conduct.

We also agree that the Ministry of Health should support voluntary mergers for inadequately-resourced colleges that cannot meet their mandates. As a well-resourced small college, we urge the Steering Committee to attend carefully to Mr. Cayton's warning that mandating mergers is not in the public interest at this time (para. 9.31). We agree with Mr. Cayton that mergers of small but adequately-resourced colleges with larger, poorly-performing colleges will create, rather than solve problems. Recent experience in BC has also made us aware that the operating costs of amalgamated colleges may far exceed the sum of the pre-amalgamation operating costs of their constituent entities. We submit that the amalgamation of several small, inadequately-resourced and/or poorly-performing entities into one large, even more inadequately-resourced and/or poorly-performing entity is unlikely to serve the public interest.

*Clarity of language and meaning*

We agree with Mr. Cayton's recommendations regarding the need for clear language and definitions of various terms in the *HPA* at paras. 9.33 – 9.37.

*Complaints and discipline*

We also agree, broadly, with the spirit of many of Mr. Cayton's recommendations regarding complaints and discipline. We particularly agree with a comment he made to the BC Health Regulators on the day of his report's publication. He observed that a presumption of the *HPA* appeared to be that all health professionals who misconduct themselves have the capacity to be rehabilitated whereas, in reality, a small number of habitual offenders typically consume a large share of regulators' resources.

Following on this observation, we particularly appreciate Mr. Cayton's interest in reducing the complexity of complaints and discipline procedures. We also agree with his recommendation that Colleges be empowered to mandate remediation and that registrants be expected to show insight as a condition of that remediation (para. 9.50). In support of that recommendation, we suggest that unwanted procedural complexity will quickly arise from new provisions intended to provide procedural simplicity if new powers or procedures are not carefully considered in light of the law of administrative action and, specifically, the principle of procedural fairness.

In response to Mr. Cayton's suggestion that the role of fines be reconsidered, we agree that fines do not improve patient safety or improve clinical practice, and that they are appropriate in cases of

financial misdemeanor or where a registrant has failed to cooperate or deliberately delayed proceedings without justification (para. 9.56). We submit that many types of misconduct may be motivated by financial interests, including practice outside of scope and failure to meet a variety of ethical obligations. Fines, and specifically the disgorgement of moneys received when the primary driver of misconduct is greed, may be an effective deterrent to such misconduct. We submit that the remedy of disgorgement would be a salutary addition to those already available under the *HPA*.

*Transparency*

We agree that regulation of health professions in BC would benefit from increased transparency and that consistency and accountability in this area is important. We agree with Mr. Cayton's recommendations regarding open meetings (para. 9.59) and the information that should be available on websites (para. 9.64), and we would embrace a standard-form annual report (para. 9.63) with enthusiasm.

We do not agree that a patient cannot give informed consent to care if they are unaware of every complaint ever upheld against their healthcare provider (para 9.62). The nebulous definition of "serious matter" and the manner in which it is linked to a public notification requirement under the *HPA* are, as Mr. Cayton observes, unhelpful and create perverse incentives (para. 9.36). We submit that the principle of "seriousness" as a condition of the requirement of publication should be preserved, but that the term should be defined more clearly and in a manner that obviates the perverse consequences that Mr. Cayton identifies.

We say this because regulators routinely receive complaints or information regarding minor matters that may have compromised a patient's confidence in the care s/he received or technically rise to the level of misconduct, but do not disclose concerns about risk to the patient or the public. In such cases, proportionate action by the regulator may benefit the public: a brief investigation may both restore the patient's confidence that s/he has received adequate care and is not in danger, and encourage the registrant to, for example, improve office procedures or remember the impact of a healthcare provider's tone and facial expressions on patients' perceptions of care.

Ideally, when a member of the public makes a complaint that is not frivolous, vexatious, or false, a registrant takes responsibility for his or her actions, however minor, to improve delivery of care and restore public confidence in the profession. An obligation to publish every such "upheld" complaint against registrants may have unintended consequences. It may discourage registrants from taking responsibility for their actions in a way that may restore patient confidence in their care, and it may also diminish the regulator's capacity to work with registrants to improve public safety and maintain public confidence. Such consequences are not in the public interest.

*Develop the role of the Health Professions Review Board ("HPRB")*

We agree with Mr. Cayton's recommendations regarding statutory time limits for investigations, and the limited utility of the HPRB in reviewing compliance with those limits (para. 9.66). We agree that colleges may benefit greatly from the publication and analysis of the HPRB's wealth of data regarding complaints and investigations (para. 9.67).

We do not agree with Mr. Cayton's recommendation to expand the role of the HPRB (para. 9.68). Colleges are typically successful in judicial reviews of HPRB decisions, often because of deference

to the colleges' expertise. We submit that the HPRB's impact upon regulatory efficacy should be evaluated before expansion of its role is considered.

**Section 10 – Replacing the *Health Professions Act***

*A framework for the future*

We agree with Mr. Cayton and with the Ministry that there is room for improvement in the areas of governance, operational and financial efficiency, fairness, transparency, and the agility of regulators in addressing themselves to developments in modern healthcare delivery, including new technologies and team-based care. We further agree that BC's regulatory framework should meet the criteria set out at paragraph 10.5 of Mr. Cayton's report. We submit, however, that measures short of radical structural change are likely sufficient to meet those objectives. We are unaware of evidence to contradict that assertion and suggest that a responsible approach to the modernization of regulation should require a preponderance of such evidence before committing to the sweeping changes set out at paragraphs 10.6 to 10.12 of Mr. Cayton's report.

We suggest that improvements to the regulatory framework in British Columbia beyond those set out at section 9 of Mr. Cayton's report should be considered in light of the principles of Right-Touch Regulation:

1. Identify the problem before the solution;
2. Quantify and qualify the risks;
3. Get as close to the problem as possible;
4. Focus on the outcome;
5. Use regulation only when necessary;
6. Keep it simple;
7. Check for unintended consequences; and
8. Review and respond to change.

*Establish a single register and adjudication body*

If, in future, Ministry receives evidence to show that additional structural change is necessary, we would support the broad direction of the recommendations at paragraphs 10.13 – 10.16. We submit, however, that a great deal of excellent public protection work occurs through peer-to-peer interactions at the inquiry stage of the complaints and discipline process. In our experience, frank discussions among peers encourage introspection and responsibility-taking in a manner that improves the efficiency of the complaints and discipline process and produces outcomes that protect the public well. We would suggest that pains be taken to avoid disruption of that aspect of the inquiry process.

In addition, we would suggest that if a single register and adjudication body is established, it should also assume the function of prosecuting unauthorized practice.

**Correcting the record**

We have submitted that before radical structural change is undertaken, the problem that such change is intended to resolve should be clearly identified. To that end, we wish to draw the Steering Committee's attention to a few important inaccuracies in Mr. Cayton's report.

Mr. Cayton's statements that "patients do not have great confidence in the colleges or in health regulation generally" (para 9.12) and that a "[l]ack of public trust in the current regulators is reflected in media headlines such as […] 'College of Naturopaths under investigation for offering treatment to 'eliminate autism'" (para. 10.4) is inaccurate in two respects.

Firstly, the quotation is inaccurate. The headline cited in the footnote below reads, "B.C. naturopaths under investigation for offering treatment to 'eliminate autism.' The article was not about the *College's* conduct; it was about the College's investigation of a *registrant's* conduct. This is a critical distinction: the misquotation suggests concerns about the trustworthiness of the College; the actual headline describes the college discharging its mandate to protect the public by investigating a registrant.

Secondly, we submit that headlines are an unreliable and, in this instance, inaccurate indicator of public opinion, as are the patient interviews referenced at paragraph 9.12 of Mr. Cayton's report. The public is significantly less concerned about regulation of healthcare professionals and less distrustful of regulators than Mr. Cayton's report suggests.

In a recent poll of British Columbians (conducted by Mustel Group, margin of error +/-3.6% at 95% level of confidence), 88 percent indicated that they had not read or heard anything in the media recently about naturopathic doctors. Over three quarters said that they were aware of how health professionals are governed and regulated in BC, and when asked whether the public would be better protected by individual regulatory bodies for each profession or one body that would regulate all of the healthcare professions, 51 percent chose the status quo, and 17 percent had no opinion. Of the 51 percent of British Columbians who chose the status quo (a regulatory body for each type of health professional), 52 percent said that it was important for each profession to have its own standards and that one general set of regulations might be too restrictive. Forty-one percent of those who chose the status quo said that it was important for each profession to maintain its own area of expertise.

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above. Due to the confidentiality provisions of the *HPA*, the College was precluded from sharing that information at the time the BC Naturopathic Association made its complaint. Indeed, the *HPA* would still prohibit sharing that information were it not for the initial complainant's decision to share details of his complaint and its resolution on his website.

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Finally, the College's submissions were not acknowledged at Appendix 1 of Mr. Cayton's report.

Respectfully submitted,

Phillipa Stanaway, B.A., M.A., J.D.
Registrar and CEO

## Gregg, Andrea HLTH:EX

**From:** Phillipa Stanaway <PStanaway@cnpbc.bc.ca>
**Sent:** January 10, 2020 3:59 PM
**To:** PROREGADMIN HLTH:EX
**Cc:** Danielle Hill
**Subject:** Feedback - Regulating Health Professionals
**Attachments:** 2020-01-10 Feedback - regulating health professionals - final.pdf

To Whom it May Concern:

Please find attached our feedback regarding the Steering Committee's consultation paper.

Yours truly,

Phillipa Stanaway (she, her)
Registrar and CEO

College of Naturopathic Physicians of British Columbia
Suite 840 – 605 Robson St.
Vancouver, BC V6B 5J3

P: 604-688-8236 ext. 107
F: 604-688-8476
E: pstanaway@cnpbc.bc.ca
W: www.cnpbc.bc.ca

*The College of Naturopathic Physicians of British Columbia's offices are located on the unceded territories of the Coast Salish peoples, represented today by the sḵwx̱wú7mesh (Squamish), seĺílwitulh (Tsleil-Waututh), and xʷməθkʷəy̓əm (Musqueam) Nations.*

January 10, 2019

The Hon. Adrian Dix, Minister of Health

Mr. Norm Letnick, MLA

Ms. Sonia Furstenau, MLA

BY EMAIL: PROREGADMIN@gov.bc.ca

Dear Sirs and Madam:

Re: Feedback – Regulating Health Professionals

The College of Naturopathic Physicians of British Columbia (the College) writes in response to your invitation to submit feedback regarding *Modernizing the provincial health profession regulatory framework: A paper for consultation*. In general terms, we agree with the Ministry of Health's stated objectives with regard to modernizing the province's health professions regulatory system – specifically increasing transparency and patient safety. In that context, the College has specific recommendations to support the achievement of the Ministry's stated objectives. We respond to each of the proposed reforms below.

1. Improved governance

We agree that some of the proposed reforms in this section of the consultation paper will improve accountability to the public, clarify the mandate of colleges in a manner that will benefit the public and professionals, and result in more functional governance.

We agree that elections of professional members have the potential to create an actual or perceived sense of accountability to the profession, rather than to the public, on the part of board members. Broadly, we support the end of elections and the appointment of all board members, whether professional or public. We support boards of 12 members or fewer in principle, and we do not oppose a board composition including an equality of professional and public members.

*Board composition and the role of profession-specific expertise*

We observe that the proposed College of Health and Care Professionals would regulate up to 19 distinct health professions. Assuming the proposed maximum of 12 directors and an equality of professional and public members, the collective expertise of the board will not include profession-specific expert knowledge of at least 13 of those 19 professions; it is possible that all six directors with profession-specific expertise could all be members of only one profession.

If the intention of appointing members of professions to college boards is to maintain profession-related expertise on those boards, we suggest that the Steering Committee reconsider the governance structure proposed. It is not clear to us that the professional knowledge of a physiotherapist will be of much additional benefit over that of a member of the public without profession-specific expertise in decisions regarding, for example, the scope of practice for dieticians or hearing professionals. Alternatively, if the intention of professional appointments is something other than the maintenance of profession-specific expert knowledge on boards, we suggest that this be clarified in advance of structural change in order to ensure that the proposed structure is suitable to the ends Ministry wishes to achieve.

In our view, there is a minimum level of profession-related expertise that should be retained on college boards in order to protect the public, and the proposed reforms fall well short of that, particularly in the proposed College of Health and Care Professions. Although we agree with the proposal that board size be limited to 12, we do not see a way to reconcile that with the need for profession-specific expertise on boards *and* an equality of public and professional board members in the context of the proposed College of Health and Care Professionals.

A potential solution to this challenge would be to divide the proposed College of Health and Care Professionals into two or more distinct colleges. This would reduce the number of professions regulated by any one entity, while still achieving a reduction in the total number of colleges. We explore the possibility that "while 20 may be too many colleges, five may be too few" in greater detail in the subsequent section.

*Appointments, not elections: key considerations*

Given the significant impact that appointment procedures will have upon the composition and functionality of all-appointee boards, we suggest that the Steering Committee and Ministry give serious consideration to process and policy in this area. If all college board members are to be publicly appointed in future, it is critically important for the safety of the public that

a) the expected roles and responsibilities of professional board members and/or board members with profession-specific expertise be clarified, and that board composition be consistent with the fulfillment of those roles and responsibilities;
b) robust procedures be put in place to ensure that appointments of professional members do not reproduce or worsen the difficulties believed to have occurred as a consequence of elections; and
c) appointments be made in a timely manner.

Before moving toward all-appointee boards, we suggest that the Steering Committee and Ministry consider a process for appointing professionals that will not risk reproducing the worst potential results of elections. According to Mr. Cayton's report, the election of professional board members by the profession is problematic because the members either perceive themselves or are perceived by the public and professions to serve their professions' interests, and not those of the public.

We suggest that the Steering Committee and Ministry be mindful that if structural changes proceed as proposed, association and advocacy groups may be the only identifiable, surviving organs of the professions regulated by some colleges, particularly those professions regulated by the Health and Care Professions College. Unless other "expert pool" structures are put in place to cultivate a supply of regulatory-minded board members and expert committee members, colleges may be vulnerable to undue influence by association and advocacy groups, whose interests are sometimes antithetical to those of regulators and the professionals they represent. The Steering Committee's recommendation to the Minister should include provisions to mitigate this vulnerability.

We suggest that there may be a number of ways to mitigate this risk. A requirement of distance from professional associations and/or advocacy groups, as well as a "cooling off" period between service on boards of professional associations and/or advocacy groups and service on regulatory boards is one.

A more ambitious but more effective measure would be for the proposed oversight body to provide a course and examination on regulatory governance that any member of the public or the professions would

be required to take before serving on a board or committee of any college. A course that focuses on regulatory as opposed to corporate governance would assist the oversight and appointments body in identifying suitable pools of both public and professional board members, independent of direct or indirect influence by associations or advocacy organizations.

In recent years, some colleges have experienced delays in the appointment of public board members. In our view, *functus* regulatory boards may pose a risk to the public and have the potential to engender public distrust. Whatever reforms are ultimately adopted, we suggest that the Steering Committee and/or Ministry ensure that there is a process and capacity to fill vacant board positions in a timely manner.

We agree that cultural diversity among directors will help to improve cultural safety. First Nations board members should be actively sought, both as professional members and public members. Equity and inclusion are also important in healthcare regulation. In our view, incorporating lived experience and/or expertise around diverse sexual orientations, gender identities, languages, and abilities into competencies matrices for regulatory boards will also improve regulatory decision-making.

*Compensation of board members*

Regarding compensation, we agree that it is not in the public interest for board and committee members to be regarded or to regard themselves as "volunteers". Board members should be compensated in a manner that recognizes the time, effort, and expertise they contribute, and the enormous responsibility and grave consequences of error inherent in their work. Their training should also consider their previous board and governance experience.

It is in the public interest to attract the best board members possible. However, setting universal compensation will overcompensate some individuals and undercompensate others, in comparison to a typical day's earnings. If there are real concerns about an outflux of high-value expertise, the Steering Committee could recommend that Ministry establish bands of compensation roughly corresponding to "replacement income" for the respective occupations or professions of board members, or alternatively, consider "add-on" supplements or the like for otherwise high-earning individuals.

We note, however, that many board and committee members are regarded or regard themselves as "volunteers" only in the sense that the honour and privilege of serving society is seen as a part of the compensation for their regulatory work. We do not believe that the provision of "replacement income" or something close to it is required to prevent an outflux of regulatory talent. Instead, we suggest that a fair, per-meeting or per-hour amount be set for all board members.

2. <u>Reduction of the number of colleges</u>

We oppose the reduction of the number of colleges as proposed in the consultation paper.

As we stated in our previous submission to the Steering Committee, changes to the framework currently in place to protect the public should be made on the basis of evidence that the changes will likely improve that protection, or at least not diminish it. We are not aware of sufficient evidence to suggest that the changes proposed will significantly enhance public protection.

To address resource challenges where they exist, we suggest that colleges unable to meet their mandate should be permitted to amalgamate voluntarily. In many cases, the size of a college cannot necessarily be equated with its performance and efficiency.

As evidence that the proposed changes will enhance efficiency, the consultation paper cites the relatively low registration fees paid by nurses, regulated by the largest College, compared to the relatively high fees paid by podiatrists, regulated by the smallest. However, the comparison does not include fees paid by professionals of medium-sized colleges. It does not take into account the scopes of practice of the professionals whose fees it compares. It is silent on the relative effectiveness of colleges in relation to the fees paid by their registrants.

We are concerned that the consultation paper may not address those points because of a lack of evidence that larger, amalgamated regulatory structures generate better performance and greater efficiencies. As evidentiary support for the performance and effectiveness claims for the structural changes proposed, the consultation paper cites a study from a 1982 volume of the *American Journal of Nursing* for the proposition that "in clinical practice, experience and repetition of tasks improves performance," and states without additional evidentiary support that the same is true for regulation.

Regulatory practice is not the same as clinical practice, and individual performance and effectiveness are not the same as organizational performance and effectiveness. To achieve widely-supported best practices for regulation, evidence-based outcomes should be reviewed.

We are concerned that the choice to amalgamate many small and medium-sized colleges into a larger college is unlikely to generate the promised efficiencies. It stands to reason that the proposed merger of 11 colleges and four as-yet-unregulated technical professions into one regulatory body will likely have substantially higher costs than those associated with the three-college amalgamation that formed the BCCNP. These costs will be augmented further by the additional potential costs of funding the proposed oversight body. In any event, the key driver for change in healthcare regulation should be enhancement of public protection, not cost savings.

The consultation paper states that the proposed reduction in the number of colleges will support greater organizational performance and efficiency as well as promote consistency among professional standards and integrated, team-based care for patients. We agree that team-based care, good interprofessional practice, and consistency of standards among professions are not adequately supported by the current regulatory framework. In our view, however, that weakness is not an organizational, structural issue. Consistency among standards of practice, and the promotion of good interprofessional practice, may be achieved by means other than the proposed structural reform.

As just one example, the work on definitions of terms such as "order", "delegation", and "supervision" currently undertaken by the BCHR in collaboration with Ministry will assist professionals in achieving a consistent understanding of their responsibilities and relationships when working in teams.

In our view, experience in health care in BC suggests that structural change may not have a positive impact upon professionals' understanding of, and ability to, function well within the scope of their roles in care teams. Many of us know fellow British Columbians with complex healthcare needs who have experienced a lack of care coordination between their family doctors and various specialists, all of whom are regulated by the same college. Regulation by the same organization may not be the best way to ensure that professionals understand the scopes of their roles and responsibilities within a team.

Even if it were, we observe that in the proposed new five-college structure, medical doctors, nurses, and pharmacists – the three professions that members of the public would most likely identify as "team"

healthcare providers who work together regularly – will remain siloed. On the other hand, such disparate professions as opticians, speech pathologists, chiropractors, and medical laboratory technologists, who do not typically work together as teams, will be governed by one board. This appears inconsistent with the stated objective of promoting consistency and role clarity among team-based care providers through structural change.

Again, if there is good evidence to suggest that the changes proposed will promote consistent standards and team-based care, we suggest that this be provided to colleges and the public so that we may move forward in full support of the proposed measures.

If, on the other hand, there is little or no evidence that, for example, physiotherapists, dieticians, and practitioners of Traditional Chinese Medicine will be better regulated by the same organization, it may be that while 23 colleges may have been too many, five may be too few. We suggest that there may be more natural alignments among sub-groupings among the professions currently proposed for regulation by the College of Health and Care professions according to various criteria, including but not limited to:

1. Risks of practice;
2. Reserved titles – for example, “doctor,” “therapist,” “technician,” and “other”;
3. Similarity of scope of practice;
4. Publicly or privately provided care; and
5. So-called “conventional” or “alternative” care.

The consultation paper suggests that a reduction in the number of colleges will make it easier for patients and families to determine their point of contact in the event of questions, concerns and complaints about health professionals. We agree that patients and their families should not be required to knock on up to 19 doors before they may make a complaint, express a concern, or ask a question. It should be simple and easy for members of the public to bring public safety concerns to regulators.

Again, we suggest that measures short of the proposed level of structural reform may provide a more elegant solution to this problem. For example, in addition to maintaining a central register, the proposed new oversight body could assume functions such as the maintenance of a “hotline”, website, and email address for routine and general queries, the triage and redirection of complaints and queries to colleges when necessary, and the prosecution of unlicensed practice.

Finally, regarding the role of profession-specific expertise in the proposed framework, we are concerned about the marginalization of such expertise to the level of subcommittees. Further to our comments in the above section on governance, clarification of the role of professional board members, if not for profession-specific expertise, would be welcome. Although the stated objective of reducing the number of colleges is to reduce the number of regulators, rather than the number of professions, we are concerned that the combination of the proposed changes to governance and the proposed reduction of colleges may have the unintended effect of eroding or eliminating some professions over time.

*The College of Health and Care Professions: challenges*

The Steering Committee proposes the amalgamation of colleges with overlapping but distinct scopes of practice, and distinct, sometimes incommensurable theories of health and illness into a single College of Health and Care Professions. We anticipate that conflicts among those theories, which function within

ideological frameworks that are unique to some professions, may stymie fair, transparent, and effective regulatory decision-making if changes to both governance and structure are made as proposed.

For example, naturopathic doctors and dieticians have differing viewpoints regarding the evidence for some dietary recommendations. Each viewpoint is equally correct within its respective theoretical framework. In the event that policies, standards, or questions of clinical expertise around naturopathic dietary recommendations were ultimately referred by a profession-specific-expert committee to a board whose professional members were all dieticians, it seems likely that the naturopathic approach to dietary recommendations would erode over time.

If an objective of the proposed reforms is a push toward mainstream, publicly provided care, we suggest that the Steering Committee make that objective explicit so that colleges and the public may comment.

*Naturopathic doctors should be regulated by a prescriber, dispenser and/or primary care provider regulator*

Finally, we suggest that as prescribers and primary care providers, naturopathic doctors should be regulated by a college that regulates other prescribers, dispensers, and/or primary care providers. To that end, the College is open to the possibility of working with another regulator and we are engaged in exploratory conversation at this time.

In our view, it is particularly important for the safety of the public that naturopathic doctors be regulated by a regulator of prescribers and/or dispensers. Specifically, naturopathic doctors should be regulated by an organization that participates in the nascent BC Prescription Monitoring Program ("PMP"), with procedures and programs in place to support and act upon the detection of unauthorized and/or inappropriate prescriptions, as well as prescribing patterns among individuals, within regions, and among professions in a manner consistent with best practices.

There is a common misconception that naturopathic physicians do not prescribe conventional, pharmaceutical drugs. Naturopathic physicians do employ a range of non-drug interventions, such as lifestyle modification, diet and exercise, that are lower risk, engage patients proactively and are cost effective. However, patients often see naturopathic doctors for presentations of more advanced illness, such as high blood pressure, diabetes, hormonal issues, autoimmune illnesses, inflammatory bowel disease and digestive issues. In these situations, naturopathic doctors use prescription medications to help manage or alleviate symptoms, while other longer term, proactive approaches may be employed to eventually reduce or even remove the need for those medications.

Ensuring that naturopathic doctors prescribe safely and appropriately is a priority for the College. As an example, in recognition that antibiotic resistance is one of the great healthcare challenges of our time, the College's Standards of Practice Committee is currently finalizing draft standards and guidelines on antimicrobial stewardship.

The PMP is a joint initiative of the Ministry of Health, regulators of prescribing and/or dispensing professions, and others to promote safe prescribing, dispensing and improved outcomes for patients. Currently, the Registrar of the College sits on the PMP Advisory Committee along with senior leaders from the following organizations:

- BC Ministry of Health;
- BC Ministry of Mental Health and Addictions;
- BC Coroners Service;
- College of Physicians and Surgeons of BC (CPSBC);
- British Columbia College of Nursing Professionals (BCCNP);
- College of Dental Surgeons of BC (CDSBC);
- College of Midwives of British Columbia (CMBC); and
- College of Pharmacists of British Columbia (CPBC).

The PMP aligns with the Government of BC's overall strategy to improve the safety and appropriate prescribing and use of prescription medications and reduce associated patient harms, and with the mandate of the BC Ministry of Health to lead, innovate and manage the PharmaCare program to improve patient health outcomes in BC.

The PMP will analyse data from BC's PharmaNet database to assist regulators of prescribers in detecting unauthorized and/or inappropriate prescriptions of drugs that have the potential to cause harm, as well as patterns of prescribing among individuals, within regions, and among professions as a whole that may inform future regulatory best practices. Its proposed deliverables will likely include:

1. Drug Atlases include geographical and historical trends for specific drugs over specific time periods;
2. Summary of monitored drugs/practices for each college;
3. Identification of issues that may result in potential harm to patients or the public;
4. Specific reports as requested by the regulatory colleges, Government and key stakeholders; and
5. Prescriber "snapshots," which will compare prescribing practices of each individual prescriber with mean prescribing practices of their peers.

Crucially, it is our understanding that regulators' participation in the PMP is also expected to bring about access to PharmaNet for those prescribing professionals who do not yet have access to the database, including naturopathic doctors. This will mean access to individual patients' prescribing histories so that naturopathic doctors may make the most informed and appropriate prescribing decisions possible.

The proposed College of Health and Care Professions will likely be consumed with merging the business units and programs of up to 18 healthcare professions, in addition to naturopathic medicine, for some time after its creation. In that context, the proposed College may not be best-positioned to participate in the PMP, establish programs that will use its data to protect the public, and establish the necessary rules and supports to ensure that naturopathic doctors—just one of 19 professions – access and use PharmaNet data safely and appropriately to inform their prescribing. Rather, we suggest that it would be beneficial for naturopathic doctors to be regulated by a college that will already have similar programs, rules and supports in place.

*Committees requiring profession-specific expertise*

In our view, while committees that address registration and patient relations do not require profession-specific expertise, committees that address complaints, examinations, quality assurance programs, standards of practice, and examinations all require significant profession-specific expertise.

3. Strengthening the oversight of regulatory colleges

Broadly, we do not oppose the creation of the oversight body, although we do query whether the robustness of oversight proposed will be necessary if the number of colleges is reduced to five. Should that reduction take place, we suggest that the Steering Committee consider whether the public may be adequately safeguarded by more modest oversight.

We are particularly in favour of the establishment and public reporting of standardized performance metrics, as well as standardized annual report forms. We feel that these will improve both consistency and public perception of consistency among colleges. Further, we would embrace the establishment of model bylaws, and a simplified process for the adoption of bylaws consistent with the model bylaws.

We also support the proposed oversight body's proposed role in the board member and discipline panel member appointment process, qualified by our comments regarding appointments in the section regarding governance above. We suggest that the Steering Committee consider expanding the oversight body's mandate to working with colleges to establish and maintain "profession-specific expert pools" – perhaps in conjunction with a selective training course and/or examination on regulation – that would cultivate a ready supply of regulation-minded board members and expert committee members independent of influence by association and advocacy group interests.

We also agreed with Mr. Cayton's recommendation that the wealth of regulatory data could be analysed and published by the oversight body to great public and regulatory benefit. We applaud the Steering Committee's proposal that the oversight body "[publish] guidance on regulatory policy and practice" based on such data.

Finally, we reiterate our suggestion that the oversight body assume responsibility for the prosecution of unlicensed practice. The practice of health professions by unlicensed individuals poses a serious risk of harm to the public, undermines the legitimacy of the regulatory system, and inspires distrust of that system among the public and health professionals alike. Unlicensed practice often falls into the jurisdiction of several colleges from a theoretical perspective, in that an unlicensed practitioner may engage in practices or use reserved titles common to several different professions. In practice, however, responsibility for investigating and prosecuting unlicensed practice is distributed irrationally, in that it is typically undertaken by the regulator that learns of it first, rather than on the basis of principle. A central body, funded collectively by all health profession regulators, would be better positioned than any one regulator to efficiently and effectively investigate and prosecute unlicensed practice.

*Concerns*

We observe that there may be tensions among the proposed functions of the oversight body. Some of its proposed functions require independence and impartiality, including, for example, appointments to boards and disciplinary panels, and review of colleges' investigative decisions. Others are intrinsically evaluative and partial, such as systemic reviews and investigations of colleges' performance. In addition,

we suggest that the public and health professionals alike will find it challenging to believe that an organization funded by the colleges will oversee them impartially. In our view, the oversight body should be truly independent, and therefore funded by the public of British Columbia.

4. Complaints and adjudication

We are in broad agreement with many of the Steering Committee's proposals regarding complaints and adjudication.

*Independent discipline process*

We agree with most of the Steering Committee's proposals regarding a new discipline process. In our view, its language concerning the need for "at least one health professional with clinical competence in the same health profession as the registrant" on each discipline panel may be overbroad. "Clinical competence" may be in the eye of the beholder. As set out above, some professions have overlapping scopes of practice, and there may be professionals who have "clinical competence" in the performance of many aspects of other health professions, but hold distinct theories and ideologies of health and illness. Such individuals may be ill-qualified to adjudicate whether, for example, a registrant of a different health profession met the standard of care in his or her treatment of a patient.

In our view, there is value in specific professional expertise. We would suggest that the Steering Committee recommend that discipline panels include at least one health professional who is a registrant or former registrant of the same health profession as the registrant, and no more than one other person who is a registrant of any other health profession. We suggest that these proportions be maintained in cases where a larger panel is necessary.

*Investigations*

We support the Steering Committee's proposals regarding the continued role of colleges in the investigation of complaints, greater scope for colleges to make limited public comment if a complaint becomes known to the public as permitted to the Law Society of BC, wider discretion of Inquiry Committees to dispose of complaints, and the requirement to consider past conduct in determining sanction.

*Publication requirement*

We strongly oppose the requirement that all *actions* taken to resolve a complaint be published. We would support a more moderate approach, also proposed in the Steering Committee's consultation paper, that all *sanctions* imposed in relation to complaints be made accessible to the public. In our view, careful definition of the term "sanction" would enable new legislation to strike the right balance between the right of the public to know if their healthcare provider has a history of conduct or competence that should pose concerns, and the right of healthcare professionals to privacy should they readily admit to minor matters and agree to take appropriate remedial action.

We are concerned that a requirement to publish actions taken in relation to the most minor upheld complaints will discourage efficient resolution of complaints in a manner that protects the public. With a guaranteed outcome of publication in even the most minor cases, there will be little incentive to healthcare professionals to admit responsibility and commit to necessary change. Rather, it is likely that colleges will be required to prove the facts of a large proportion of complaints before a discipline panel.

It is our understanding that many colleges currently resolve most complaints by way of admissions, undertakings, and agreements. Discipline hearings are expensive and time-consuming. They are not an efficient resolution to matters that might otherwise be resolved by admissions, undertakings, and agreements. The proposed oversight body, which will presumably compensate members of the discipline panel, and the colleges, which we assume will continue to be responsible for prosecuting disciplinary matters, will likely face significantly increased operating costs in the event that publication of even minor upheld complaints is required. In this context, high costs and human resource constraints may also prevent the timely hearing of complaints. Significant delays in proceedings are not in the public interest. They undermine public trust and allow evidence to become stale over time, potentially jeopardizing regulators' ability to achieve results that best protect the public.

5. Information sharing

We agree that regulators should be able to share information with other regulatory agencies when it is necessary to do so in order to investigate information regarding a potential risk to the public. This should include other health profession colleges, health authorities, Health Canada, and the police.

We suggest that the Steering Committee consider recommending measures that strike the correct balance between the privacy interests of patients and complainants, and broader public protection interests. Wide discretion to disclose information to other agencies may place both regulators and complainants in a difficult position in cases where there is a clear public interest in disclosure, but, for example, a complainant wishes for some or all information that they have provided to be kept confidential to the regulator to whom they have complained and the party or parties under investigation. A narrower obligation to disclose in certain circumstances will clarify expectations among all parties and improve confidence in the integrity of the regulatory framework.

We thank the Steering Committee for this opportunity to comment upon its proposals and we look forward to the opportunity of working together with the Ministry of Health and other regulators to shape reform in the interests of British Columbians.

Respectfully submitted,

Phillipa Stanaway

Registrar and CEO