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Health Professions Council

SAFE CHOICES: A New Model for Regulating Health Professions in British Columbia

Under the *Health Professions Act*, the Health Professions Council is a six-person advisory body appointed by the Government of British Columbia to make recommendations to the Minister of Health and Minister Responsible for Seniors about the regulation of health professions.

Part I: Scope of Practice Review

This report is the result of the Health Professions Council's review of the scope of practice of 15 recognized health professions pursuant to the *Terms of Reference* from the Minister of Health and Minister Responsible for Seniors.

Mr. Epstein did not participate in the review of optometry. Another member, Brenda McBain, served on the scope panel for that review, chaired by Dr. Kazanjian.

Part II: Legislative Review

This report is the result of the Health Professions Council's legislative review of ten health professions pursuant to the Terms of Reference from the Minister of Health and Minister Responsible for Seniors. Under the *Health Professions Act* the Health Professions Council is a six-person advisory body appointed by the government of British Columbia to make recommendations to the Minister of Health and Minister Responsible for Seniors about the regulation of health professions. Irvine E. Epstein, Q.C., the Chair of the Health Professions Council, is primarily responsible for the legislative review. The report has been circulated within the Health Professions Council for review and comment.

In the legislative review the Health Professions Council examined two issues:

(1) whether designation of the professions of

- chiropractic;
- dentistry;
- emergency medical assistance;
- medicine;
- naturopathy;
- nursing, registered;
- nursing, registered psychiatric;
- optometry;
- podiatry; and
- psychology

under the Health Professions Act would be in the public interest or whether there are unique features of the health professions, or other relevant factors, that justify a continuing need for a separate statute; and

(2) what amendments, if any, are required to the current statute, rules, regulations and bylaws for each of the professions to provide adequately for the regulation of the profession in the public interest and to ensure that the current statute contains the core principles of professional regulation reflected in the *Health Professions Act* and discussed in Schedule B to the *Terms of Reference*.

Last Revised: March 08, 2002

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Health Professions Council

Scope of Practice Review Part I – Volume 1

I. EXECUTIVE SUMMARY – POLICY ISSUES

A. MANDATE

The Health Professions Council (Council) was appointed by the Minister of Health in 1991 to advise the minister with respect to applications by unregulated practitioners for designation as self-regulated health professions. In December 1994, the minister expanded the mandate of the Council. The Council was asked to review the scopes of practice of 15 regulated health professions and to review the legislation under which 10 of them were self-regulating. (See Appendix A for list of professions.)

The Council was given *Terms of Reference* (see Appendix A) which provided the criteria to be applied in the reviews of both scope and legislation. The scope review had four areas on which the Minister of Health requested recommendations: scope of practice of each profession, reserved acts, supervised acts and title restrictions.

Because of the parameters of the *Terms of Reference* the Council did not consider issues such as the cost implications of the recommendations, or the impact on education and training facilities or labour relations. These are clearly important but they did not fall within the Council's mandate. Nonetheless, these issues will likely have to be considered should the government decide to implement the new regulatory model discussed in this report.

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B. SHARED SCOPE AND RESERVED ACTS

The *Terms of Reference* set out the framework for an entirely new way of regulating health professions. Heretofore, each regulated profession had an exclusive scope of practice which prohibited others from practising within its scope of practice unless permitted to do so by statute. The new system consists of non-exclusive scope of practice statements and reserved acts.

Scope of practice statements describe in general terms what a profession does and how it does it. On the other hand, reserved acts, defined as those "tasks and services involving a significant risk of harm," need to be restricted, and may only be performed by professions to whom they are, on a non-exclusive basis, assigned, and so long as those performing them are acting within the scope of practice of their profession.

The Council developed a list of such activities, the [Reserved Acts List](#), and in its review of each profession determined which of the reserved acts it was qualified, as a profession, to perform. The list underwent revision from time to time in the course of the review process.

(See the discussion on "The Shared Scope of Practice Model Working Paper", [page 46 of written report](#) and the current list of reserved acts on "Reserved Acts", [page 4 written report](#).)

The scope of practice of each profession together with the reserved acts assigned to that profession are set out in the Executive Summary – Professions section of this Report.

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C. SUPERVISED ACTS

A third issue directed to the Council was to recommend if and how activities otherwise restricted could be performed by individuals under some form of supervision or delegation. The Council considered this issue and developed a set of protocols under which reserved acts could be performed in certain restricted circumstances by both regulated and non-regulated individuals who would otherwise not be permitted to perform these acts.

(See the discussion "Supervised Acts" commencing on [page 57 of written report](#).)

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D. RESERVED TITLES

Reserved titles are titles reserved exclusively to a health profession. Reserved titles afford a means for consumers to identify the different types of health care providers, to distinguish the qualified from the unqualified and to differentiate those practitioners who are regulated from those who are not. Titles must adequately serve the public in describing the practitioner and the services being provided and must distinguish the practitioner from others performing services outside the jurisdiction of the regulatory body. The Council considered this issue on title restrictions and made recommendations for each health profession.

(See the discussion "Reserved Titles" commencing on [page 59 of written report](#).)

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E. OBJECTIVE

From the outset, the paramount consideration was the public interest, both with respect to the scope review and the legislative review. As a corollary to that, the mandate of the Council clearly expressed the desirability of increasing public choice of health care services with the function of government being to ensure, as far as possible, that the choices available were within safe parameters.

(See the discussion "The Scope of Practice Review Process" commencing on [page 41 of written report](#).)

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F. PROCESS

The Council consulted broadly in its review process. Each individual profession was consulted with respect to its own review as well as that of all the others. Responses were sought from professional, academic and educational bodies, organizations representing employers and employees, and governmental authorities across the country as well as from public interest and consumer groups. Literature was reviewed from not only Canada but also the United States and Europe. In particular, the Council availed itself of the research and reports emanating from similar reviews in other provinces, notably Ontario and Alberta as well as Manitoba. In certain instances, to deal with specific activities which were beyond the expertise of the Council and staff, professionals were engaged to provide information and research, mainly respecting the degree of risk in certain of the reserved acts under contemplation. Finally, after a preliminary report was published with respect to each profession, public hearings were held to allow interested parties to comment on the preliminary report and make further submissions.

(See the discussion "The Process of the Scope of Practice Review" commencing on [page 42 of written report](#).)

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II. EXECUTIVE SUMMARY – ISSUES OF GENERAL APPLICATION

This section of the Executive Summary sets out the Council's recommendations in full. A general discussion of each recommendation is contained in the section of the report commencing on "Discussion oF Issues" [page 45 of written report](#).

A. RESERVED ACTS

The Health Professions Council recommends that the following reserved acts be enacted by the Minister of Health and Minister Responsible for Seniors:

1. Making a diagnosis identifying a disease, disorder or condition as the cause of signs or symptoms of the individual.
2. Performing the following physically invasive or physically manipulative acts:
 - a. procedures on tissue below the dermis, below the surface of a mucous membrane, in or below

the surface of the cornea, in or below the surfaces of the teeth, including the scaling of teeth;

- b. setting or casting a fracture of a bone or reducing a dislocation of a joint;
- c. movement of 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. administering a substance other than a drug by injection, inhalation, irrigation or instillation through enteral or parenteral means;
- e. putting an instrument, hand or finger(s)
 - i. into the external ear canal, including applying pressurized air or water;
 - ii. beyond the point in the nasal passages where they normally narrow;
 - iii. beyond the pharynx;
 - 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.

3. Managing labour or delivery of a baby.

4. Applying or ordering the application of a hazardous form of energy including ultrasound, electricity, magnetic resonance imaging, lithotripsy, laser and X-ray, or as prescribed by regulation.

- a. Prescribing, compounding, dispensing or administering by any means a drug listed in Schedule I or II of the *Pharmacists, Pharmacy Operations and Drug Scheduling Act* or as prescribed by regulation.

For the purposes of this reserved act, the following definitions shall apply:

"prescribing": the ordering of a drug.

"compounding": mixing ingredients, at least one of which is a drug.

"dispensing": preparing or filling a prescription for drugs.

- b. Designing, compounding or dispensing therapeutic diets where nutrition is administered through enteral or parenteral means.

For the purposes of this reserved act, the following definitions shall apply:

"designing": the selection of appropriate ingredients for enteral or parenteral nutrition.

"compounding": mixing ingredients, for enteral or parenteral nutrition.

"dispensing": filling a prescription for enteral or parenteral nutrition.

6. Prescribing appliances or devices for vision, hearing or dental conditions; dispensing such prescribed appliances or devices for dental conditions; fitting such appliances or devices for dental conditions; or fitting contact lenses.

For the purposes of this reserved act, the following definitions shall apply:

"prescribing": ordering the fabrication or alteration of appliances or devices for vision, hearing or dental conditions.

"dispensing": filling a prescription by fabricating or altering a dental appliance or device.

7. Allergy challenge testing or allergy desensitizing treatment involving injection, scratch tests or inhalation, and allergy challenge testing by any means with respect to a patient who has had a previous anaphylactic reaction.

(See the discussion "Reserved Acts" commencing on [page 46](#).)

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B. SUPERVISED ACTS

The Health Professions Council recommends that a provision be enacted by the Minister of Health and Minister Responsible for Seniors which sets out the duties of a health professional and his or her regulatory college when delegating a reserved act. The provision should require the following:

- The assigning health professional's governing body must provide assent to the proposed reserved act being performed by someone else;
- The reserved act to be assigned, as well as the level of supervision, must be clearly defined and circumscribed by the assigning health professional's governing body;
- Where the person to whom the act will be assigned is a regulated health professional, his or her governing body must approve of the assigning of the reserved act;
- The instruction to perform the act must be made in writing either by way of a general written protocol or through a case-specific instruction;

- The assigning health professional must be satisfied that the individual who will be performing the act has the necessary skills and training to perform the act safely;
- The assigning health professional must ensure that the person who will be performing the act accepts the assignment.

The Health Professions Council recommends that this provision apply to all professions within the new regulatory model. As a result, the Health Professions Council will not include individual recommendations for supervised acts in the summary of recommendations for each profession.

(See the discussion "Supervised Acts" commencing on [page 57](#).)

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C. MEANING OF THE TERM "ORDER"

The Health Professions Council recommends that the following definition be adopted by the Minister of Health and Minister Responsible for Seniors for the term "order":

An "order" is a prescription for a procedure, treatment or intervention. It can apply to an individual client by means of a direct order or to more than one individual by means of an indirect order:

- A "direct order" is client-specific. It is a prescription for a procedure, treatment or intervention to be administered at specific times for a specific client, written by a health professional authorized by legislation to perform the procedure, treatment or intervention.
- An "indirect order" is not client-specific. It includes protocols or clinical guidelines or medical directives and is a prescription for a procedure, treatment or intervention that may be performed for a range of clients who meet certain conditions. The indirect order identifies a specific treatment or range of treatments, the specific conditions that must be met and any specific circumstances that must exist before the indirect order can be implemented.

(See the discussion "Reserved Acts on Order" commencing on [page 52](#).)

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D. THE SOCIETY ACT

The Health Professions Council recommends to the Minister of Health and Minister Responsible for Seniors the implementation of the recommendations of the Royal Commission on Health Care and Costs (the Seaton Commission) that:

- the *Society Act* be amended so that the Health Professions Council must approve an occupational title or abbreviation [of any health care worker] before the Registrar grants protection of it;

- all health profession titles previously granted protection under the [Society Act](#) be revoked [at a date to be determined by the Minister of Health and Minister Responsible for Seniors]; and
- the [Health Professions Act](#) be amended to prohibit the use of words like "registered", "licensed" or "certified" by any health care worker unless that use has been approved by the Health Professions Council.

(See the discussion "The Society Act" commencing on [page 60](#).)

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E. REVIEW OF THE COUNCIL'S RESERVED ACTS LIST

The Health Professions Council recommends that a process be established by the Minister of Health and Minister Responsible for Seniors for the Health Professions Council to provide ongoing review and consideration of additional issues related to the new regulatory model, including the following:

- Are there other activities or new technology or techniques which ought to be added to the [Reserved Acts List](#)?
- Has a profession which previously did not qualify for a particular reserved act now acquired satisfactory competencies to have it assigned to them?
- Are there other hazardous forms of energy or hazardous substances which ought to be included on the general list of reserved acts?
- Has the [Reserved Acts List](#) hindered or impeded the delivery of health services; should some reserved acts be removed from the list?

(See the discussion "Review of the Council's [Reserved Acts List](#)" commencing on [page 62](#).)

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F. ACCESS TO LABORATORY AND DIAGNOSTIC FACILITIES

The Health Professions Council recommends that the legislation governing access to laboratory facilities be reviewed and modified by the Minister of Health and Minister Responsible for Seniors to ensure access for health professionals who are deemed by the Minister of Health and Minister Responsible for Seniors to be trained and educated to utilize test results.

(See the discussion "Access to Laboratory and Other Diagnostic Facilities" commencing on [page 63](#).)

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G. REVIEW OF RESERVED ACTS GRANTED PRIOR TO THE SCOPE OF PRACTICE REVIEW

The Health Professions Council recommends that the Minister of Health and Minister Responsible for Seniors review all reserved acts granted through regulation prior to the Scope of Practice Review to ensure that they are consistent with the current [Reserved Acts List](#).

(See the discussion "Review of Reserved Acts Granted Prior to the Scope of Practice Review" commencing on [page 63](#).)

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H. DELEGATION PROTOCOL – DELEGATION TO UNREGULATED INDIVIDUALS

The Health Professions Council recommends that the Minister of Health and Minister Responsible for Seniors review all legislation governing community, long term care and home care programs and facilities to ensure they contain the appropriate safeguards so that the delegation of reserved acts to unregulated individuals is carried out in a safe and effective manner.

(See the discussion "Delegation Protocol – Delegation to Unregulated Individuals" commencing on [page 64](#).)

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I. RISK OF HARM CLAUSE

The Health Professions Council recommends that a provision similar to the following risk of harm clause enacted in Ontario be adopted by the Minister of Health and Minister Responsible for Seniors:

No person, other than a member treating or advising within the scope of his or her profession, shall treat or advise a person with respect to his or her health in circumstances in which it is reasonably foreseeable that serious physical harm may result from the treatment or advice or from an omission from them.

(See the discussion "Risk of Harm Clause" commencing on [page 64](#).)

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J. EXEMPTIONS FROM THE RESERVED ACTS SYSTEM

The Health Professions Council recommends that the Minister of Health and Minister Responsible for Seniors include provisions for exceptions to and exemptions from the new regulatory model.

(See the discussion "Exemptions from the Reserved Acts System" commencing on [page 65](#).)

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K. RELEASE OF PRESCRIPTIONS

The Health Professions Council recommends that prescriptions for patients be delivered to patients free of cost.

(See the discussion "Release of Prescriptions" commencing on [page 65](#).)

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III. EXECUTIVE SUMMARY – PROFESSIONS

In this section, the Council lists the final recommendations regarding the four elements of the scope of practice review for each of the 15 health professions subject to the review. The complete discussion, including the preliminary report and post-hearing updates for each profession, is set out in Volume II of this report.

The Council submits to the Minister of Health and Minister Responsible for Seniors the following final recommendations with respect to its mandate of the scope of practice review of the 15 health professions.

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A. CHIROPRACTORS

(See the discussion for this profession in [Part I Volume 2](#).)

Scope of practice

The practice of chiropractic is concerned with those aspects of the restoration and maintenance of human health which relate to assessment of the spine or other joints of the human body and the associated soft tissue or nervous system, and the treatment of non-organic diseases or disorders directly related to the neuromusculoskeletal system through manipulation and adjustment by hand or devices.

Reserved acts

1. Making a diagnosis identifying as the cause of signs or symptoms of the individual, a disease, disorder or condition of the spine or other joints of the human body and their effects on associated soft tissue or the nervous system.

2(c) Performing the physically invasive or physically manipulative act of movement of 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.

2(e)(vi) *Performing the physically invasive or physically manipulative act of putting an instrument, hand or finger(s) beyond the anal verge for the purpose of performing reserved act 2(c).*

4. *Ordering or applying a hazardous form of energy: X-ray for diagnostic purposes; ordering the application of a hazardous form of energy: MRI and CT scan.*

Reserved titles

- "Chiropractor";
- "Doctor", but only when used in conjunction with "Chiropractor" or "Chiropractic"; and
- any abbreviation of those titles.

Other recommendations

- *The Health Professions Council recommends that members of the British Columbia College of Chiropractors be allowed to order or access the results of a limited range of laboratory testing, based upon satisfying the following criteria:*
 - *Reasonable access to the laboratory testing results is not available from other sources;*
 - *the range of laboratory testing ordered is based upon the scope of practice of members of the British Columbia College of Chiropractors; and*
 - *the range of laboratory testing to be available to chiropractors shall be prescribed by regulation.*
- *The Health Professions Council recommends that a health care provider or institution be required to provide a copy of an x-ray at cost to a patient on request.*

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B. DENTAL TECHNICIANS

(See the discussion for this profession in [Part I Volume 2](#).)

Scope of practice

The practice of dental technology is the fabrication or alteration of a dental appliance or device in accordance with a prescription from a dentist, denturist or medical practitioner, and the repair of such appliance or device.

Reserved act

6. *Dispensing prescribed appliances or devices for dental conditions, provided such dispensing can be performed without intraoral procedures.*

Reserved titles

- "Dental Technician" and
- any abbreviation of this title.

Other recommendations

- *The Health Professions Council recommends that no person other than a registrant of a regulated health profession acting within their scope of practice may, for another, dispense prescribed appliances or devices for dental conditions unless such person performs such services under direct supervision in the office of a dentist or medical practitioner, and exclusively for the practice of the dentist or medical practitioner.*
- *The Health Professions Council recommends the removal of barriers to interdisciplinary practice which limit or impede dental technicians' access to dentists' prescriptions or the performance of work for denturists.*

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C. DENTISTS

(See the discussion for this profession in [Part I Volume 2](#).)

Scope of practice

The practice of dentistry is the maintenance of health through the assessment, management, treatment and prevention of any disease, disorder or condition of the orofacial complex and associated structures.

Reserved acts

1. *Making a diagnosis identifying a disease, disorder or condition of the orofacial complex as the cause of signs or symptoms of the individual.*
2. *Performing the following physically invasive or physically manipulative acts:*
 - a. *procedures on tissues of the orofacial complex that would penetrate the epidermis or the surface of a mucous membrane, and procedures in or below the surface of the teeth including the scaling of teeth; and harvesting of tissue for the purpose of surgery on the orofacial complex;*
 - b. *setting a fracture of a bone or bones of the orofacial complex or reducing a dislocation of a joint of the orofacial complex;*

- d. administering a substance, other than a drug, by injection or inhalation;
- e. putting an instrument, hand or finger(s)
 - i. into the external ear canal,
 - ii. beyond the point in the nasal passages where they normally narrow,
 - iii. beyond the pharynx,
 - iv. beyond the opening of the urethra for purposes of catheterization, or
 - vii. into an artificial opening into the body.

4. Applying or ordering the application of a hazardous form of energy, including ultrasound, electricity, magnetic resonance imaging, laser and X-ray, or as prescribed by regulation.

5(a) Prescribing, compounding, dispensing or administering by any means a drug listed in Schedule I or II of the Pharmacists, Pharmacy Operations and Drug Scheduling Act or as prescribed by regulation.

For the purposes of this reserved act, the following definitions shall apply:

"prescribing": the ordering of a drug.

"compounding": mixing ingredients, at least one of which is a drug.

"dispensing": preparing or filling a prescription for drugs.

6. Prescribing appliances or devices for dental conditions; dispensing and fitting such appliances or devices for dental conditions.

For the purposes of this reserved act, the following definitions shall apply:

"prescribing": ordering the fabrication or alteration of appliances or devices for dental conditions.

"dispensing": filling a prescription by fabricating or altering a dental appliance or device.

Reserved titles

- "Dental Surgeon",
- "Dentist",
- "Doctor",
- "Certified Dental Assistant", and
- any abbreviation of those titles.

Other recommendations

- The Health Professions Council recommends that to the extent that access to hospitals is necessary in order to carry out the scope of practice of oral and maxillofacial surgery, dentists should be granted hospital admitting privileges.

- *The Health Professions Council recommends that no person other than a registrant of a regulated health profession acting within their scope of practice may, for another, dispense prescribed appliances or devices for dental conditions unless such person performs such services under direct supervision in the office of a dentist or medical practitioner, and exclusively for the practice of the dentist or medical practitioner.*
- *The Health Professions Council recommends that the rules of the College of Dental Surgeons of B. C. must not impose restrictions on the practice of dental hygiene or any other regulated health profession which are inconsistent with the legislation or rules governing that profession.*
- *The Health Professions Council recommends the removal of barriers to interdisciplinary practice which limit or impede dental technicians' access to dentists' prescriptions or the performance of work for denturists.*

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D. EMERGENCY MEDICAL ASSISTANTS

(See the discussion for this profession in [Part I Volume 2](#).)

Scope of practice

The practice of emergency medical assistance is the performance of prehospital emergency procedures necessary for the preservation of life and health for which training and medical direction or supervision are provided.

Reserved titles

- "Emergency Medical Assistant",
- "Paramedic", and
- any abbreviation of those titles.

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E. MASSAGE THERAPISTS

(See the discussion for this profession in [Volume II, Tab 5](#).)

Scope of practice

The practice of massage therapy is the assessment of the soft tissues and joints of the body and the treatment and prevention of dysfunction, injury, pain and physical disorders of the soft tissues and joints by manual and physical methods to develop, maintain, rehabilitate or augment physical function to relieve pain and promote health.

Reserved titles

- "Massage Therapist" and
- any abbreviation of this title.

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F. NATUROPATHIC PHYSICIANS

(See the discussion for this profession in [Volume II, Tab 6](#).)

Scope of practice

The practice of naturopathy is the prevention and treatment of disease, disorder or condition of an individual through the use of education and natural therapies or therapeutics to support and stimulate inherent self-healing processes.

Reserved acts

1. *Making a diagnosis using naturopathic methods.*
2. *Performing the following physically invasive or physically manipulative acts:*

(a) procedures below the dermis but only for the following purposes:

- *venipuncture and skin pricking for the collection of blood samples;*
- *needle insertion acupuncture;*
- *removal of foreign bodies from superficial structures; and*
- *first aid treatment of minor cuts, abrasions and contusions.*

(c) moving the joints of the thoracic or lumbar spine beyond the limits the body can voluntarily achieve but within the anatomical range of motion using a high velocity, low amplitude thrust;

(d) administering a substance, other than a drug, by injection or inhalation;

(e) putting an instrument, hand or finger(s)

ii. beyond the point in the nasal passages where they normally narrow, iv.beyond the opening of the urethra, v.

beyond the labia majora, or v1 beyond the anal verge.

Reserved titles

- "Naturopath";
- "Physician", but only when used in conjunction with "Naturopathic";
- "Doctor", but only when used in conjunction with "Naturopathic" or "Naturopathy"; and
- any abbreviation of those titles.

Other recommendations

- The Health Professions Council recommends that members of the College of Naturopathic Physicians of B.C. be allowed to order or access the results of a limited range of laboratory testing, based upon satisfying the following criteria:
 - Reasonable access to the laboratory testing results is not available from other sources;
 - the range of laboratory testing ordered is based upon the scope of practice of members of the College of Naturopathic Physicians of B.C.; and
 - the range of laboratory testing to be available to naturopathic physicians shall be prescribed by regulation.
- The Health Professions Council recommends that any barriers which prevent referrals to medical specialists by members of the College of Naturopathic Physicians of B.C. be removed.

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G. NURSES, LICENSED PRACTICAL

(See the discussion for this profession in [Volume II, Tab 7](#).)

Scope of practice

The practice of nursing by licensed practical nurses is the provision of health care for the promotion, maintenance and restoration of health; and the prevention, treatment and palliation of illness and injury, including assessment of health status and implementation of interventions.

Reserved acts

2(e) For the purpose of assessing an individual or assisting an individual with activities of daily living, performing the physically invasive or physically manipulative act of putting an instrument, hand or finger(s)

- i. into the external ear canal, including applying pressurized air or water, for the purpose of cleaning patients' external ear canal, taking their tympanic temperature and using an otoscope to

examine cerumen build up;

v. beyond the labia majora, but excluding the insertion of intrauterine devices, for the purpose of performing hygiene measures and washing beyond the labia majora to the urethral and vaginal orifice;

vi. beyond the anal verge, for the purpose of performing rectal checks on patients whose assessment warrants this intervention.

Reserved acts to be performed only if the act is ordered by a health professional who is authorized by legislation to perform the act

2. Performing the following physically invasive or physically manipulative acts:

(a) procedures on tissue below the dermis or below the surface of a mucous membrane;

(d) administering a substance, other than a drug, by subcutaneous injection, inhalation, irrigation or instillation;

(e) putting an instrument, hand or finger(s)

i. into the external ear canal, but excluding cerumen management; iv. beyond the opening of the urethra; v. beyond the labia majora, but excluding the insertion of intrauterine devices; vi. beyond the anal verge; or vii. into an artificial opening into the body.

5(a) Administering orally or by subcutaneous injection a drug listed in Schedule I or II of the Pharmacists, Pharmacy Operations and Drug Scheduling Act.

Reserved titles

- "Licensed Practical Nurse",
- "Practical Nurse",
- "Nurse", and
- any abbreviation of those titles.

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H. NURSES, REGISTERED

(See the discussion for this profession in [Volume II, Tab 8.](#))

Scope of practice

The practice of nursing by registered nurses is the provision of health care for the promotion, maintenance and restoration of health; the prevention, treatment and palliation of illness and injury, primarily by assessment of health status, planning and implementation of interventions; and co-ordination of health services.

Reserved acts

1. *Performing a nursing diagnosis by making a clinical judgment of the patient's mental and physical condition that can be ameliorated or resolved by appropriate interventions of the nurse or nursing team to achieve outcomes for which the nurse is accountable.*

2(a)(i) *For the purpose of wound care, performing the following physically invasive or physically manipulative act of procedures on tissue below the dermis or below the surface of the mucous membrane:*

- *cleansing,*
- *soaking,*
- *irrigating,*
- *probing,*
- *debriding,*
- *packing,*
- *dressing.*

2(a)(ii) *For the purpose of establishing peripheral intravenous access and maintaining patency using a solution of normal saline (0.9 per cent), performing the physically invasive or physically manipulative act of venipuncture.*

2(e) *For the purpose of assessing an individual or assisting an individual with activities of daily living, performing the physically invasive or physically manipulative act of putting an instrument, hand or finger(s)*

- i. *into the external ear canal, including applying pressurized air or water;*
- ii. *beyond the point in the nasal passages where they normally narrow;*
- iii. *beyond the pharynx;*
- 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.*

5(a) *Administering or compounding a drug listed in Schedule II of the Pharmacists, Pharmacy Operations and Drug Scheduling Act.*

For the purposes of this reserved act, "compounding" means mixing ingredients, at least one of which is a drug listed in Schedule II of the Pharmacists, Pharmacy Operations and Drug Scheduling Act.

Reserved acts to be performed only if the act is ordered by a health professional who is authorized by legislation to perform the act

2(a) *For purposes other than wound care, performing the physically invasive or physically manipulative act of procedures on tissue below the dermis, below the surface of a mucous membrane, and in or below the surface of the cornea.*

2(d) Performing the physically invasive act of administering a substance, other than a drug, by injection or inhalation, except as provided in reserved act 2(a)(ii).

2(e) For the purpose of treatment, performing the physically invasive or physically manipulative act of putting an instrument, hand or finger(s)

- i. into the external ear canal, including applying pressurized air or water;
- ii. beyond the point in the nasal passages where they normally narrow;
- iii. beyond the pharynx;
- 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.

4. Applying a hazardous form of energy, including diagnostic ultrasound and X-ray.

5(a) Administering or compounding by any means a drug listed in Schedule I of the Pharmacists, Pharmacy Operations and Drug Scheduling Act.

For the purposes of this reserved act, "compounding" means mixing ingredients, at least one of which is a drug listed in Schedule I of the Pharmacists, Pharmacy Operations and Drug Scheduling Act.

5(b) Designing, compounding or dispensing therapeutic diets where nutrition is administered through enteral or parenteral means.

For the purposes of this reserved act, the following definitions shall apply:

"designing": the selection of appropriate ingredients for enteral or parenteral nutrition.

"compounding": mixing ingredients for enteral or parenteral nutrition.

"dispensing": filling a prescription for enteral or parenteral nutrition.

7. Allergy challenge testing or allergy desensitizing treatment involving injection, scratch tests or inhalation, and allergy challenge testing by any means with respect to a patient who has had a previous anaphylactic reaction.

Reserved titles

- "Registered Nurse",
- "Licensed Graduate Nurse",
- "Nurse", and
- any abbreviation of those titles.

Other recommendations

- The Health Professions Council recommends that the name of the regulatory body, the "Registered Nurses Association of British Columbia", be changed to the "College of Registered Nurses of British

Columbia".

- *The Health Professions Council supports advanced practice and primary care nursing, and recommends that legislative or regulatory mechanisms be established to enable the regulatory body for registered nursing to develop a formal regulatory system for both.*

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I. NURSES, REGISTERED PSYCHIATRIC

(See the discussion for this profession in [Volume II, Tab 9.](#))

Scope of practice

The practice of nursing by registered psychiatric nurses is the provision of health care for the promotion, maintenance, restoration and palliation, primarily of mental and emotional health and associated physical conditions by assessment of mental and physical health, planning and implementation of interventions and co-ordination of health services.

Reserved acts

1. *Performing a nursing diagnosis by making a clinical judgment of the patient's mental and physical condition that can be ameliorated or resolved by appropriate interventions of the nurse or nursing team to achieve outcomes for which the nurse is accountable.*

2(a)(i) *For the purpose of wound care, performing the following physically invasive or physically manipulative act of procedures on tissue below the dermis or below the surface of the mucous membrane:*

- *cleansing,*
- *soaking,*
- *irrigating,*
- *probing,*
- *debriding,*
- *packing,*
- *dressing.*

2(a)(ii) *For the purpose of establishing peripheral intravenous access and maintaining patency using a solution of normal saline (0.9 per cent), performing the physically invasive or physically manipulative act of venipuncture.*

2(e) *For the purpose of assessing an individual or assisting an individual with activities of daily living, performing the physically invasive or physically manipulative act of putting an instrument, hand or finger(s)*

- i. *into the external ear canal, including applying pressurized air or water;*
- ii. *beyond the point in the nasal passages where they normally narrow;*

- iii. beyond the pharynx;
- 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.

5(a) Administering or compounding a drug listed in Schedule II of the Pharmacists, Pharmacy Operations and Drug Scheduling Act.

For the purposes of this reserved act, "compounding" means mixing ingredients, at least one of which is a drug listed in Schedule II of the Pharmacists, Pharmacy Operations and Drug Scheduling Act.

Reserved acts to be performed only if the act is ordered by a health professional who is authorized by legislation to perform the act

2(a) For purposes other than wound care, performing the physically invasive or physically manipulative act of procedures on tissue below the dermis, below the surface of a mucous membrane and in or below the surface of the cornea.

2(d) Performing the physically invasive act of administering a substance, other than a drug, by injection or inhalation, except as provided in reserved act 2(a)(ii).

2(e) For the purpose of treatment, performing the physically invasive or physically manipulative act of putting an instrument, hand or finger(s)

- i. into the external ear canal, including applying pressurized air or water;
- ii. beyond the point in the nasal passages where they normally narrow;
- iii. beyond the pharynx;
- 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.

4. Applying a hazardous form of energy, including diagnostic ultrasound and X-ray.

5(a) Administering or compounding by any means a drug listed in Schedule I of the Pharmacists, Pharmacy Operations and Drug Scheduling Act.

For the purposes of this reserved act, "compounding" means mixing ingredients, at least one of which is a drug listed in Schedule I of the Pharmacists, Pharmacy Operations and Drug Scheduling Act.

5(b) Designing, compounding or dispensing therapeutic diets where nutrition is administered through enteral or parenteral means.

For the purposes of this reserved act, the following definitions shall apply:

"designing": the selection of appropriate ingredients for enteral or parenteral nutrition.

"compounding": mixing ingredients for enteral or parenteral nutrition.

"dispensing": filling a prescription for enteral or parenteral nutrition.

Reserved titles

- "Registered Psychiatric Nurse",
- "Licensed Graduate Psychiatric Nurse",
- "Nurse", and
- any abbreviation of those titles.

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J. OPTOMETRISTS

(See the discussion for this profession in [Volume II, Tab 10.](#))

Scope of practice

The practice of optometry is the assessment of the eye and vision system through the use of diagnostic drugs and instruments and devices, such as test lenses, test cards and trial lenses; and the treatment and prevention of disorders of refraction, sensory and ocular motor disorders, and diseases and disorders of the eye and structures directly related to the vision system through the prescription and dispensing of ophthalmic devices and therapeutic pharmaceutical agents prescribed by regulation.

Reserved acts

1. *Making a diagnosis of a disorder of refraction, a sensory and ocular motor disorder, disease or dysfunction of the eye and structures directly related to the vision system as the cause of signs or symptoms of the individual.*

2(a) *Performing the physically invasive or physically manipulative act of procedures on tissue in or below the surface of the cornea for the purpose of removing superficial foreign bodies from the eye.*

5(a) *Prescribing, dispensing or administering a drug prescribed by regulation.*

For the purposes of this reserved act, the following definition shall apply:

"prescribing": the ordering of a drug.

"dispensing": preparing or filling a prescription for drugs.

The Health Professions Council recommends that the regulation through which optometrists are granted the use of therapeutic pharmaceutical agents must contain at a minimum the following elements:

- a listing of specific drug categories of therapeutic pharmaceutical agents which optometrists may use;
- a certification program including training and education requirements, and an examination; and
- a requirement to notify the treating physician any time a therapeutic pharmaceutical agent is administered, dispensed or prescribed.

6. Prescribing appliances or devices for vision conditions and fitting contact lenses.

Reserved titles

- "Optometrist";
- "Doctor", but only when used in conjunction with "Optometry" or "Optometric"; and
- any abbreviation of those titles.

Other recommendations

- The Health Professions Council recommends to the Minister of Health and Minister Responsible for Seniors that:
 - optometrists be required to deliver prescriptions for eyeglasses or contact lenses to their patients;
 - prescriptions issued by an optometrist should not indicate in any way that only an optometrist or a person qualified to issue a prescription is qualified to fill it, but may direct the patient to return to the prescriber if problems are encountered; and
 - unless a specific contra-indication is included in a prescription, it should not contain any reference or prohibition against mathematically converting it from a prescription for eyeglasses to a prescription for contact lenses.
- The Health Professions Council recommends that the name of the regulatory body, the "Board of Examiners in Optometry", be changed to the "College of Optometrists of British Columbia".

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K. PHARMACISTS

(See the discussion for this profession in [Volume II, Tab 11.](#))

Scope of practice

The practice of pharmacy is the compounding, dispensing and sale of drugs; monitoring drug therapy and advising on therapeutic values, contents and hazards of drugs and devices; and identification, assessment and recommendations to prevent or resolve drug related problems.

Reserved act

5(a) Compounding or dispensing a drug listed in Schedule I or II of the Pharmacists, Pharmacy Operations and Drug Scheduling Act or as prescribed by regulation.

For the purposes of this reserved act, the following definitions shall apply:

"compounding": mixing ingredients, at least one of which is a drug.

"dispensing": preparing or filling a prescription for drugs.

Reserved titles

- "Apothecary",
- "Druggist",
- "Pharmacist",
- "Pharmaceutical Chemist", and
- any abbreviation of those titles.

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L. PHYSICAL THERAPISTS

(See the discussion for this profession in [Volume II, Tab 12.](#))

Scope of practice

The practice of physical therapy is the assessment and treatment of neuromusculoskeletal and cardiorespiratory systems of the 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 the promotion of mobility and health.

Reserved acts

1. *Making a physical therapy diagnosis by determining the cause of subjective symptoms and objective signs relating to movement dysfunction and functional limitations.*

2. *Performing the following physically invasive or physically manipulative acts:*

(a) inserting needles below the dermis for the purpose of pain management and normalization of physiological functioning of the neuromusculoskeletal system;

(b) reducing a simple joint dislocation;

(c) movement of 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;

(e) for the purpose of bronchotracheal suctioning, putting an instrument:

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

iii. beyond the pharynx, or

vii. into an artificial opening into the body.

(e)(vi) for the purpose of performing reserved act 2(c) putting a finger(s) beyond the anal verge.

4. Applying a hazardous form of energy: laser, electricity, therapeutic ultrasound, or as prescribed by regulation.

5(a)(i) 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.

5(a)(ii) Administering on prescription, by iontophoresis or phonophoresis, a drug listed in Schedule I or II of the Pharmacists, Pharmacy Operations and Drug Scheduling Act.

Reserved titles

- "Physiotherapist",
- "Physical Therapist", and
- any abbreviation of those titles.

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M. PHYSICIANS AND SURGEONS

(See the discussion for this profession in [Volume II, Tab 13.](#))

Scope of practice

The practice of medicine is the assessment of the physical or mental condition of an individual or group of individuals at any stage of the biological life cycle; the prevention and treatment of physical and mental disease, disorder and condition; and the promotion of good health.

Reserved acts

1. Making a diagnosis identifying a disease, disorder or condition as the cause of signs or symptoms of the

individual.

2. *Performing the following physically invasive or physically manipulative acts:*

- a. *procedures on tissue below the dermis, below the surface of a mucous membrane, in or below the surface of the cornea, in or below the surfaces of the teeth, including the scaling of teeth;*
- b. *setting or casting a fracture of a bone or reducing a dislocation of a joint;*
- c. *movement of 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. *administering a substance, other than a drug, by injection, inhalation, irrigation or instillation through enteral or parenteral means;*
- e. *putting an instrument, hand or finger(s)*
 - i. *into the external ear canal, including applying pressurized air or water;*
 - ii. *beyond the point in the nasal passages where they normally narrow;*
 - iii. *beyond the pharynx;*
 - 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.*
- f. *Managing labour or delivery of a baby.*
- g. *Applying or ordering the application of a hazardous form of energy including ultrasound, electricity, magnetic resonance imaging, lithotripsy, laser and X-ray or as prescribed by regulation.*
 - a. *Prescribing, compounding, dispensing or administering by any means a drug listed in Schedule I or II of the Pharmacists, Pharmacy Operations and Drug Scheduling Act or as prescribed by regulation.*

For the purposes of this reserved act, the following definitions shall apply:

"prescribing": the ordering of a drug.

"compounding": mixing ingredients, at least one of which is a drug.

"dispensing": preparing or filling a prescription for drugs.

- b. *Designing, compounding or dispensing therapeutic diets where nutrition is administered through enteral or parenteral means.*

For the purposes of this reserved act, the following definitions shall apply:

"designing": the selection of appropriate ingredients for enteral or parenteral nutrition.

"compounding": mixing ingredients for enteral or parenteral nutrition.

"dispensing": filling a prescription for enteral or parenteral nutrition.

- i. Prescribing appliances or devices for vision, hearing or dental conditions; dispensing such prescribed appliances or devices for dental conditions; fitting such appliances or devices for dental conditions, or fitting contact lenses.

For the purposes of this reserved act, the following definitions shall apply:

"prescribing": ordering the fabrication or alteration of appliances or devices for vision, hearing or dental conditions.

"dispensing": filling a prescription by fabricating or altering a dental appliance or device.

- j. Allergy challenge testing or allergy desensitizing treatment involving injection, scratch tests or inhalation, and allergy challenge testing by any means with respect to a patient who has had a previous anaphylactic reaction.

Reserved titles

- "Doctor",
- "Surgeon",
- "Physician",
- "Osteopath" and "Osteopathic Physician", and
- any abbreviation of those titles.

Other recommendations

- The Health Professions Council recommends that barriers to complementary or alternative practices by physicians which do not present a risk of harm greater than prevailing medical treatments be removed.
- The Health Professions Council recommends that the Minister of Health and Minister Responsible for Seniors:
 - require physicians to deliver prescriptions for eyeglasses or contact lenses to their patients;
 - require that prescriptions issued by a physician should not indicate in any way that only a physician or a person qualified to issue a prescription is qualified to fill it, but may direct the patient to return to the prescriber if problems are encountered; and
 - require that, unless a specific contra-indication is included in a prescription, it should not contain any reference or prohibition against mathematically converting it from a prescription for eyeglasses to a prescription for contact lenses.

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N. PODIATRISTS

(See the discussion for this profession in [Volume II, Tab 14.](#))

Scope of practice

The practice of podiatry is the prevention, treatment and palliation of disease, disorder or dysfunction of the foot, and includes the bones, muscles, tendons, ligaments or other soft tissue of the foot and lower leg which impact on or affect the foot or foot function.

Reserved acts

1. *Making a diagnosis identifying a disease, disorder or condition of the foot or lower leg as the cause of signs or symptoms of the individual.*

2. *Performing the following physically invasive or physically manipulative acts:*

(a) procedures on tissue below the dermis of the foot and lower leg, including bony tissue and muscle, tendon, ligament or other soft tissue;

(b) setting or casting a fracture of a bone or reducing a dislocation of a joint of the foot or lower leg;

(d) administering intravenous fluids by injection and anaesthetics by inhalation;

(e)(vii) for the purpose of arthroscopic surgery of the ankle, putting an instrument, hand or finger(s) into an artificial opening of the body.

4. *Ordering the application of a hazardous form of energy: X-ray, diagnostic ultrasound, MRI, CT scanning; applying a hazardous form of energy: laser.*

5(a) *Prescribing, compounding, dispensing or administering by any means a drug listed in Schedule I or II of the Pharmacists, Pharmacy Operations and Drug Scheduling Act or as prescribed by regulation.*

For the purposes of this reserved act, the following definitions shall apply:

"prescribing": the ordering of a drug.

"compounding": mixing ingredients, at least one of which is a drug.

"dispensing": preparing or filling a prescription for drugs.

7. Allergy challenge testing involving injection, scratch tests or inhalation, and allergy challenge testing by any means with respect to a patient who has had a previous anaphylactic reaction.

Reserved titles

- "Podiatrist";
- "Doctor", "Surgeon", but only when used in conjunction with "Podiatric" or "Podiatry"; and
- any abbreviation of those titles.

Other recommendations

- The Health Professions Council recommends that any impediments to podiatrists performing reserved act 5(a), such as federal restrictions on the prescription of narcotics, be reviewed.
- The Health Professions Council recommends the following limitation to podiatry scope of practice:

The practice of podiatry does not include treatment of the foot that may affect the course or treatment of a systemic disease unless that treatment is carried out at the direction or under the supervision of a medical practitioner.
- The Health Professions Council recommends that to the extent that access to hospitals is necessary in order to carry out the scope of practice of podiatry, podiatrists should be granted hospital admitting privileges.
- The Health Professions Council recognizes that chiropodists provide valuable health care services. However, the Health Professions Council does not have sufficient information about chiropody services in British Columbia to make a specific recommendation about how it should be regulated.

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O. PSYCHOLOGISTS

(See the discussion for this profession in [Volume II, Tab 15](#).)

Scope of practice

The practice of psychology is the treatment and prevention of mental and psychological disorders, dysfunctions and conditions; and the assessment, treatment and enhancement of behavioural, emotional and interpersonal functioning by the application and use of psychometric testing, psychological assessment, psychotherapy and the treatment and management of clinical and non-clinical conditions.

Reserved act

1. Making a diagnosis, identifying a mental or psychological disorder, dysfunction or condition as the cause of signs or symptoms of the individual.

Reserved titles

- "Psychologist" and
- any abbreviation of this title.

Other recommendation

Use of the title "Psychologist" by persons who are not members of the College of Psychologists of B.C. is misleading to the public, and the Health Professions Council recommends that there be no exemptions from the title protection provisions of the recommendation on reserved titles.

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IV. THE SCOPE OF PRACTICE REVIEW PROCESS

A. INTRODUCTION

The Health Professions Council is a six-person advisory body appointed by the Government of British Columbia under the Health Professions Act (HPA), to make recommendations to the Minister of Health and Minister Responsible for Seniors about the regulation of health professions. The current members are:

- *Irvine E. Epstein, Q.C. (Chair),*
- *Arminée Kazanjian (Vice Chair),*
- *David MacAulay (Vice Chair),*
- *James Chisholm,*
- *Dianne Tingey, and*
- *Brenda McBain.*

None of these individuals is a health professional. The Council conducts its business in panels of three. This report is the result of the Council's review of the scope of practice of 15 recognized health professions pursuant to the [Terms of Reference](#) from the Minister of Health and Minister Responsible for Seniors.

1. The Nature of the Review

The primary purpose of the review was to make recommendations regarding redesign of the regulatory system for health professions in British Columbia. Under the traditional exclusive model, the various health professions were granted an exclusive right to practice within a legislatively defined scope of practice. No one, other than a member in good standing of that profession, can perform acts within the profession's scope of practice unless they are granted an exemption. The [Terms of Reference](#) contemplate a new system aimed at reducing exclusivity and increasing choices for the public. The new system is based on broad, non-exclusive scopes of practice and narrowly defined reserved acts.

The [Terms of Reference](#), which are included as Appendix A to this report, indicate that there are four main elements to the scope of practice review:

- i. scope of practice statements which describe what the profession does, the methods it uses and the purpose for which it does it;
- ii. reserved acts which are those acts that present such a significant risk of harm that they should be performed only by professionals who are qualified to perform them;
- iii. supervised acts which are reserved acts, or aspects of reserved acts, which may be performed by persons supervised by health professionals; and
- iv. reserved titles which are titles that describe a profession's services and which are reserved exclusively for the health profession.

A regulatory framework of overlapping scopes of practice and narrowly defined reserved acts creates a system which offers greater choice and accessibility to health care services and at lower costs. It also imputes a greater responsibility to individuals to inform themselves about the choices available and the implications of those choices, and reduces the paternalism of government and the professions themselves.

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2. The Process for the Scope of Practice Review

Initially, the Council met with representatives of all of the professions subject to the review. This meeting gave the professions an understanding of the Council's review process. The meeting also enabled the Council to seek the professions' views regarding their current scope of practice and discuss how it should be revised to reflect the Criteria and Guidelines (Schedule A) of the [Terms of Reference](#). After the initial meetings, the Council invited the regulatory bodies and professional associations of the health professions under review to submit written briefs outlining their positions on the four elements of the scope of practice review as they relate to their individual professions.

The Council then sent out written consultation letters to all the regulatory bodies and professional associations, as well as professional associations of unregulated health professions, national associations of health professions in Canada and the United States, organizations representing employers and employees, consumer organizations, educational institutions, and departments of health in other provinces. The consultation letters asked the professions under review and the other respondents to comment on the position of the health professions as outlined in their written briefs.

Between January 1998 and April 2000, the Council issued the preliminary reports on the scope of practice review of the 15 self-regulated health professions. The preliminary reports aimed to present the initial findings by the Council in response to the consultation process. The preliminary reports also sought to give an overview of possible issues to be raised at the public hearings which was the next step in the review process.

Between June 1999 and June 2000, the Council conducted the public hearings for each health profession under review, except for emergency medical assistants for which a hearing was not required. The public hearings

were designed to provide a general discussion amongst interested parties and the Council on the scopes of practice of the health professions under review.

Afterwards, the Council carefully considered the issues raised at the public hearings. This entailed a re-examination of all stages of the scope of practice review process – from the initial written briefs by the health professions to the post-public hearing submissions.

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B. HEALTH PROFESSIONS POLICY

The early impetus for the Council's scope of practice review was the Report of the British Columbia Royal Commission on Health Care and Costs (Seaton Commission). The Seaton Commission stated that the existing legislation governing the health professions creates persistent jurisdictional disputes and a distinct lack of co-operation among the health professions, despite the fact that all health professional colleges have the same mandate - to protect the public from preventable harm.

The Seaton Commission found that the primary reason for the jurisdictional disputes was the present regulatory system's reliance on exclusive scopes of practice. Under this exclusive scope of practice system, the various health professions have been granted an exclusive right to practice within a legislatively defined scope of practice. No one, other than a member in good standing of that profession, can perform acts within the profession's scope of practice unless they are granted an exemption.

The Commission concluded:

...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.

(*Closer to Home, The Report of the Royal Commission on Health Care and Costs in British Columbia, Volume 2, 1991, p. D-33*)

The Ontario system of "controlled acts" was implemented through the Regulated Health Professions Act, SO 1991, Ch. 18, and contains the same key elements - scope of practice statements, reserved acts and reserved titles - described in the Council's [Terms of Reference](#). Alberta has adopted a similar regulatory model, and Quebec has undertaken a similar process.

The Seaton Commission's recommendation echoes comments made in an earlier report, *Public Regulation of the Professions in Health Security for British Columbians, Special Report: Consumer Participation, Regulation of the Professions, and Decentralization, 1974, (Foulkes Report)*. In Chapter 3 of Volume 3, Professor J.T. McLeod dealt with public regulation of professions. Professor McLeod stated that professional interests are often in conflict with the interests of society, and cites as a growing public concern the conflict between professional regulatory bodies and the public:

[A] serious area of conflict between professional interest and the public interest appears to exist in the matter of relations between various disciplines and professions in the matter of legislative definitions of scope of practice. This is an area in which the law is at fault, but for various reasons

scope of practice legislation is often unduly narrow and restrictive, preventing the addition or substitution of various mixes of skills for the services of the professional practitioner.

...

It must be emphasized that any professional legislation which unduly restricts the scope of practice of skilled personnel may be contrary to the public interest in greater supply and accessibility of service through the development of team practice. Therefore, it is argued that: Professional legislation should not contain narrow restrictions or rigid definitions of scope of practice which are excessively exclusive; that measures should be taken ... to reduce the area of interprofessional strain and conflict; and that no prosecutions for violations of scope of practice legislation should be undertaken without the prior consent of the appropriate public authority. Insofar as may be possible with due regard for public safety, professional law should not place rigid restrictions on the scope of practice of allied health personnel, and greater flexibility should be encouraged in the allocation of roles between the health disciplines.

Thus, the trend in regulatory policy for the health professions has been towards reducing exclusivity in order to enhance interdisciplinary practice, improve accessibility for population groups to health care services and increase consumer choice, while at the same time maintaining the fundamental objective of protecting the public.

Government has the responsibility to ensure that those services which are accessible are safe and that the regulatory framework for the practice of health professions protects the public from incompetent, impaired or unethical practitioners. At the same time, the regulatory framework should not entrench a paternalistic function for professions or reserve exclusive areas of practice simply to enhance professional status and control.

These policy trends are clearly reflected in the [Terms of Reference](#) for the scope of practice review which provide the basis for a new regulatory framework for health professions in British Columbia. The new system of overlapping scopes of practice and narrow reserved acts removes barriers to interdisciplinary practice and offers greater choice and accessibility to the public. The public interest is served by professional legislation which promotes quality in the delivery of health care services within safe parameters. Indeed, the Council's primary policy objective in conducting its review is achieving the optimum balance between safe practice and consumer choice.

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C. DISCUSSION OF ISSUES

The main issues raised by this review are the following four elements: scope of practice, reserved acts, supervised acts and reserved titles.

1. Scope of Practice

The scope of practice statement describes what the profession does, the methods it uses, and the purpose for which it does it. Unlike the present legislative scheme, the statement itself does not grant an exclusive scope of practice. Nonetheless, the statement is important because: 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; and it informs the public about

the services practitioners are qualified to perform.

The Council believes that it is not necessary or useful to itemize every facet of a profession's scope of practice. Rather, a scope of practice definition should be sufficiently descriptive so that other health professions and members of the public alike can understand what the particular health professional does.

2. Reserved Acts

Reserved acts are an important element of the new scope of practice model reflected in the [Terms of Reference](#). The rationale underlying the granting of reserved acts is to protect the public by limiting provision of those particularly dangerous acts to members of specific professions who are qualified to perform them.

It is important to understand the significance of an act being reserved in the provision of health care services. Once an act is reserved in the provision of health care services, it may only be performed by members of a regulated health profession who are authorized to perform that act under their professional legislation. In contrast, if an act is not reserved, it may be performed by regulated or unregulated practitioners.

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a) The Shared Scope of Practice Model Working Paper

Early in the review process, the Council decided to clarify the concept of reserved acts. To that end, the Council undertook a consultation process in order to formulate a specific list of reserved acts to guide the Council and all participants in the process. The Council's primary concern in developing the list was whether a particular task or service presented such a significant risk of harm that it ought to be reserved to (a) particular profession(s).

The Council established some basic principles to guide it in its assessment of what is a significant risk of harm. The Council was assisted, in part, by the 1994 report of the Manitoba Law Reform Commission, Regulating Professions and Occupations. That report indicated that regulation should not be imposed unless the threat of harm to the public is serious. The report stated that three factors should be evaluated in considering the seriousness of a threatened harm:

- *the likelihood of its occurrence;*
- *the significance of its consequences on individual victims;*
- *the number of people it threatens.*

The Council recognized that it was not always easy to determine the point at which a risk of harm associated with an act becomes serious enough to justify reserving it, but these three factors serve as guides, not requirements, and were useful in the Council's deliberations.

The Council reviewed the initial scope of practice submissions, the responses to the submissions, various published materials, the regulatory model currently in place in Ontario, and the model being developed in Alberta. The list was developed from the consultation process and was based largely on the Ontario list of 13 "controlled acts." In July 1998, the Council issued the [Shared Scope of Practice Model Working Paper](#) (Working Paper) which contained the list of reserved acts. The Working Paper indicated that the list was a working list and changes may be made to the list depending on the information arising during the scope review process, or the Council's ongoing review of applications for designation. Some changes were made, and the final version of

the list is set on page 4.

The list is phrased more in terms of general descriptions, and professions can expect that, for the most part, particular professions will be granted more specific activities that fall within the general category or description. For example, it may be the case that one profession will be granted the reserved act of prescribing drugs while others may only be granted the reserved act of prescribing particular drugs. Also, some activities may fall within more than one reserved act. For example, administration of an intramuscular injection will fall within both reserved act 2(a): "performing a procedure below the dermis" and reserved act 5: "administering a drug."

Once the Working Paper was issued to participants in the process, the Council proceeded with its review of each profession, and decided which act(s) were to be granted to each profession(s). The Council's conclusions on this issue are set out in the Executive Summary - Professions section of this report. An important issue during the process was the criteria by which reserved acts were granted to individual professions. The Council's primary consideration was whether a profession was trained and educated to perform a reserved act. An important consideration was whether a profession had already been performing a reserved act pursuant to its scope of practice. The Council also reviewed curricula of educational institutions and literature regarding clinical training programs.

The Council recognized in several instances that basic training programs do not always encompass the full range of services provided by practitioners. Rather, the ability to perform reserved acts is developed through post-basic training and education programs. For example, in its review of physical therapy the Council considered the College of Physical Therapists of B.C.'s (CPTBC) request to perform acupuncture, which is not part of the general training of all physical therapists. CPTBC requires satisfactory completion of the three levels of courses offered by the Acupuncture Foundation of Canada Institute (AFCI) or the University of Alberta Programme on Medical Acupuncture. The CPTBC requires the completion of AFCI examinations or the certificate program in Medical Acupuncture of the University of Alberta. In light of this information, the Council was prepared to recommend that physical therapists be entitled to insert needles below the dermis for specific purposes set out in the recommendations on physical therapy.

The foregoing discussion also underscores the important fact that not all members of a profession are necessarily competent to perform all of the reserved acts assigned to that profession. The Council's task is to ensure that the profession generally, and not each individual member of that profession, is trained and educated to perform the reserved act in a safe and effective manner. Thus, an important part of the reserved acts system is that each profession to whom reserved acts are assigned must define the competencies required for the performance by its members of the reserved acts. This principle is reflected in section 16(2)(d) of the HPA which provides that one of the objects of a regulatory body is to establish, monitor and enforce standards of practice. Similarly, section 16(2)(c) states that another objective of a regulatory body is to establish, monitor and enforce standards of education and qualifications for registration of registrants.

The importance of the existing functions of a regulatory body was underscored in the Council's review of medical practitioners. Several respondents questioned the request of the College of Physicians and Surgeons of British Columbia (CPSBC) for a broad scope of practice including all of the reserved acts on the Council's list. The CPSBC acknowledged that not all physicians necessarily practice all services which fall within the general scope of practice but that:

[T]his general definition does not suggest that all physicians can perform all practices. Only physicians who have demonstrated competence in a particular area or speciality can practice in that speciality. In other words, while physicians are qualified and licensed generally as physicians and surgeons, the actual practice of medicine is limited by the practical and ethical restraints which require that the practice clearly be within the physician's competence.

The Council accepted the CPSBC's submissions and found in the case of medical practitioners that the practical and ethical constraints justified the granting of all the reserved acts. The Council noted that the constraints included the following:

- a well established speciality certification process, administered through the Royal College of Physicians and Surgeons of Canada, through which patients who require more sophisticated treatments are referred to certified specialists;
- the Canadian Medical Association Code of Ethics which provides that each practitioner must "Recognize your limitations and the special skills of others in the prevention and treatment of disease";
- the fact that part of the function of the College of Physicians and Surgeons is to ensure that physicians practice within their level of competency; and
- the extensive and stringent entrance requirements for registration with the College.

The Council felt that these constraints provided an assurance that medical practitioners practice within their level of competency.

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b) Investigation of Reserved Acts

As it proceeded through the review, the Council decided that it needed assistance to clarify two of the reserved acts. The relevant reserved acts were:

Reserved act 4: Applying or ordering the application of a hazardous form of energy including diagnostic ultrasound, electricity, magnetic resonance imaging, lithotripsy, laser and X-ray; and

Reserved act 5(a): Prescribing, compounding, dispensing or administering, by any means, a drug listed in Schedule I or II of the Pharmacists, Pharmacy Operations and Drug Scheduling Act.

The first issue arose with respect to hazardous energy because in its initial list, set out above, the reserved act of ordering or applying hazardous energy was not defined exhaustively. The second issue arose with respect to hazardous substances because the Council received information that the reserved act as defined may not encompass all hazardous substances.

(i) Hazardous Energy

In its Working Paper, the Council indicated that this act is not intended to encompass all forms of energy used by health professionals but only those that present a significant risk of harm. The Council also indicated that it would not be setting out a comprehensive list of hazardous energy at the outset but would leave the list non-exhaustive, and develop the list as it proceeded through the process. The Council did, however, give a preliminary indication of the types of hazardous energy that fell within the list, including diagnostic ultrasound, magnetic resonance imaging and x-ray.

(ii) Hazardous Substances

In the course of its scope review process the Council received information that indicates that there are certain substances used by some health professions, which are not listed in Schedule I or II of the Pharmacists, Pharmacy Operations and Drug Scheduling Act, but are nonetheless hazardous. For example, in its review of naturopathy, the Council received information that this reserved act, as currently worded, may not capture all potentially harmful substances. It appears that several of these potentially harmful substances are used in a variety of natural therapies and there is some overlap among the different traditions of natural medicine in their use of these hazardous substances. The Council believes that the precise identification of these is beyond its current resources and expertise.

(iii) Investigation

The Council requested the following:

1. *That the Ministry strike a task force to determine a list of hazardous forms of energy and hazardous substances requiring regulation.*
2. *That the task force provide a process for addition to, or subtraction from, the list in order to address changes in technology, developments or further studies.*
3. *That the Council provide the task force with information regarding what the professions consider to be hazardous forms of energy and/or hazardous forms of substances which they are currently using.*
4. *That the task force determine, in general terms, the level of training and qualifications necessary to access the restricted forms of energy and/or hazardous forms of substances. It will be up to the Council to determine which of the professions meet these standards.*
5. *That the task force should gather information regarding existing regulatory restrictions that pertain to hazardous forms of energy.*

Instead of convening a task force, the Minister of Health and Minister Responsible for Seniors authorized the Council to retain an expert consultant. The consultant has provided the Council with a report as to the types of energy and substances that should be reserved.

The consultant provided the Council with lists of hazardous energy and hazardous substances. However, the assessment of this scientific data merits a more intensive analysis beyond the expertise of the Council. Accordingly, the reserved acts for both hazardous forms of energy and substances are not exhaustive but are subject to the enactment of regulations.

The Council emphasizes that the lists are not complete, and therefore, for both hazardous forms of energy and substances, the phrase "or as prescribed by regulation" has been included in the Council's [Reserved Acts List](#).

Therefore, the Health Professions Council recommends that further study be undertaken on this matter and that the hazardous energy and substances lists be subject to ongoing review.

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c) Reserved Acts on Order

*Generally, when a reserved act is assigned to a specific profession, members of the profession have the authority both to make the decision that the act is required and to carry out the act. Thus the general concept of reserved acts is that once granted, the profession initiates and performs the act independently. During its review, however, the Council recognized that although a particular profession may be authorized to perform a particular reserved act, its performance may be dependent on being ordered by a member of another profession. A simple example is a pharmacist who may dispense medications, but usually only when a prescription is received from a medical practitioner. This is the concept of an order which recognizes the important distinction between competency to **perform** a reserved act and competency to **initiate** a reserved act.*

The term "order" was considered at length in the Council's review of registered nursing. There, the Council recommended that registered nurses be granted the right to perform several reserved acts on the order of another health professional who is authorized to perform the reserved act independently. There was widespread criticism of the term "order" which indicated that such a requirement would seriously impair the ability of registered nurses to assist patients in a timely and effective manner. However, the Council did not intend the term to be interpreted as requiring a patient-specific instruction in every case. Rather, the term was meant to encompass the many means by which registered nurses currently perform many services.

The Council was presented with several different definitions of the term "order." In commenting on the issue of "orders," the British Columbia Nurses' Union (BCNU) made a valuable submission regarding terminology:

[T]he BCNU would caution the HPC not to rely on terms or definitions that different parties use in different context.

...

Because there is no agreement as to what these terms [protocols, guidelines] mean or a consensus that the HPC could rely on, the BCNU would suggest that it would be very useful if the Council created its own definitions of the terms it uses. In that way, everyone reading the Council's final report will be working from the Council's understanding of these terms, rather than applying their own, perhaps mistaken, interpretations.

In this respect, it is not critical that the HPC's definitions correspond with any particular definition used in the literature, the common law or current practice. The BCNU would suggest that what is more important is that these terms be defined by the Council so that their subsequent use by the Council can be understood by all without the need for further research or debate. In doing so, it is also important that the Council make it clear what the differences are between its defined terms.

The Council agrees with this submission and will clarify what was meant by the use of the term "order."

Virtually all of the submissions dealing with this issue referred to such terms as "clinical practice guidelines", "clinical practice standards", "agency protocols" and "pre-printed orders." For example, the Simon Fraser Health Region, in speaking about various reserved acts, stated, "RNs develop and are guided by clinical practice

guidelines and agency protocols for the safe enactment of these competencies." The submission also indicated that these processes are generally created through a collaborative process involving administrators and health care professionals.

Simon Fraser Health Region included several examples of such guidelines and protocols with its submission. As a general comment, it stated that regulatory structures must be "flexible" and create the ability to "adapt to the increasing chaos of change." The Council supports the need for flexibility, and indeed its intention with regard to order-initiated reserved acts was intended to ensure first, public safety, and second, that health professionals and administrators would develop the processes themselves to meet the needs of the public. In other words, the Council's impression was that the present system of guidelines and protocols works well and should be facilitated by its recommendations.

The Ontario Standards of Practice for Nurses in the Extended Class contains a useful discussion of the term "medical directive" which serves to clarify further the Council's intention:

What is a "Medical Directive"?

First, it is important to understand what the terms "medical directive" and "medical protocol" mean, and how they relate to the terms "order" and "standing order."

- *A medical "order" is a prescription for treatment or an intervention. It can apply to an individual client by means of a client-specific order, or to more than one individual by means of medical directive. As such, a medical order exists in one of two forms:*
- *A "direct order" is client specific. It is a prescription of a procedure, treatment or intervention of a particular client, is written by an individual physician for a specific procedure/treatment/intervention to be administered at a specific time(s).*
- *A "medical directive" or "medical protocol" is not client specific. It is a prescription for a procedure, treatment or intervention that may be performed for a range of clients who meet certain conditions. The medical directive identifies a specific treatment or range of treatments, the specific conditions that must be met, and any specific circumstances that must exist before the directive can be implemented.*

The Ontario Standards of Practice for Nurses in the Extended Class also states that the term "standing order" is not supported by either the College of Nurses of Ontario or the College of Physicians and Surgeons of Ontario:

In the past, a "standing order" was implemented for every client, regardless of the circumstances, with no judgment expected by the person implementing the order regarding its appropriateness. It is now recognized that knowledge, skill and judgment are critical, and that no order for treatment, regardless of how routine it may seem, should be automatically implemented.

Thus, in Ontario the term order refers to both patient-specific and general orders, but not standing orders. Similarly, the Council intended that the term "order" encompass both. The Ontario Standards of Practice provide further details about orders.

When is a Medical Order Required?

The health care team needs to determine whether a procedure can safely be ordered by means of a medical directive, or whether direct assessment of the client by the physician is required before the procedure is implemented. Procedures that require direct assessment of the client by the physician require a client-specific order.

What Information Does a Medical Directive Need to Include?

There are a number of specific components required in a medical directive. These are:

- *A description of the procedure(s) being ordered;*
- *Specific client conditions which must be met before the procedure(s) can be implemented;*
- *any circumstances which must exist before the procedure(s) can be implemented; and*
- *any contraindications for implementing the procedure(s).*

The degree to which client conditions and situational circumstance are specified will depend on the client population, the nature of the orders involved, and the expertise of the health professionals implementing the directive. The following are also required:

- *the name and signature of the physician authorizing the medical directive; and*
- *the date and signature of the administrative authority approving the medical directive (for example, the Intensive Care Unit Advisory Committee).*

Who Should be Involved in the Development of a Medical Directive?

A medical directive is an order for one or a series of procedures. Although it is by definition a medical document, the collaborative involvement of health care professionals affected directly or indirectly by the medical directive is strongly encouraged.

The Council's intention was that an order could apply generally or to a specific patient. The professions involved in the process should develop orders of a general nature which would authorize nurses to proceed to perform the reserved acts assigned to them for certain classification of patients in situations which met the criteria and parameters set forth in the general orders. Specific orders would continue to be used as they are now in those situations where, for example, medical practitioners order specific reserved acts to be performed on specific patients. A number of submissions acknowledge that this does not represent a marked departure from the current practice and that such protocols or orders are in fact generally in place.

The Council expects the professions themselves, together with others involved in the process such as hospital administrators, to work together to determine the best way to implement the initiation of reserved acts where the interest of the patients require the acts to be done by registered nurses who have the competence to perform them.

Therefore, the Health Professions Council recommends that the following definition be adopted by the Minister of Health and Minister Responsible for Seniors for the term "order":

An "order" is a prescription for a procedure, treatment or intervention. It can apply to an individual client by means of a direct order or to more than one individual by means of an indirect order:

- A "direct order" is client specific. It is a prescription for a procedure, treatment or intervention to be administered at specific times for a specific client, written by a health professional authorized by legislation to perform the procedure, treatment or intervention.
- An "indirect order" is not client specific. It includes protocols or clinical guidelines or medical directives and is a prescription for a procedure, treatment or intervention that may be performed for a range of clients who meet certain conditions. The indirect order identifies a specific treatment or range of treatments, the specific conditions that must be met, and any specific circumstances that must exist before the indirect order can be implemented.

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3. Supervised Acts

The Criteria and Guidelines which are attached to the [Terms of Reference](#) state that although reserved acts may only be performed by certain professions, it may be appropriate for other persons to perform them, or aspects of them, under the supervision of members of those professions. The Criteria and Guidelines also indicate that where the Council is satisfied that a reserved act may be performed under supervision, it may recommend training and qualification requirements, limitations regarding where the act may be performed and the degree of supervision which should be exercised.

The Council believes that some clarification of terms would be useful as the [Terms of Reference](#) do not define "supervision." In reviewing the responses to the scope of practice submissions, most professions have used the terms "delegation" and "supervision" interchangeably. However, technically, there appears to be a distinction between the terms.

In his book *A Complete Guide to the Regulated Health Professions Act* (Canada Law Book, 1995), Richard Steinecke discusses the meaning of these terms. "Delegation" is where the delegating professional makes a determination that an individual is competent to perform a task and that individual then carries out the task without the delegating professional being present. "Supervision," on the other hand, implies a more intense control over the act than does "delegation" and will usually require the supervisor's physical presence.

In the Council's view, although this Term of Reference refers to "supervised" acts, it is intended to encompass any situation where someone other than the person to whom the reserved act has been granted performs that act. In other words, this Term of Reference refers to both delegation and supervision.

It implies that the Council will, for each reserved act granted to each profession, determine the circumstances in which the act may be performed by someone other than a member of that profession. Arguments were presented that legislation is a blunt instrument. Other submissions stated that the issue of delegation and supervision is a question of individual competence and the circumstances of each case, and that supervision of certain acts can be addressed only after a careful review of all the circumstances surrounding a particular act and by imposing, where necessary, clear guidelines, restrictions or conditions on such supervision.

The College of Physicians and Surgeons of British Columbia (CPSBC) submits that compiling a list of acts which may be delegated or performed under supervision would not adequately address the complexities of medical situations which present to physicians, nor would it protect the public. CPSBC notes that there will be situations where, because of the individuals involved, the site or location, or the specific nature of the presenting problem, it may not be appropriate to delegate an act which might otherwise be capable of delegation.

The Council accepts much of these submissions and believes that it would be better to take a general approach to the issue of supervision. The general thrust of the approach is that the decision as to whether an act can be performed under supervision should be left up to the health professions, and that a set of principles embodying the duties of the delegating professional and his or her regulatory college be established and enacted into legislation when the shared scope of practice model takes effect. The principles are derived largely from the Canadian Medical Association's Guidelines for Delegation of a medical act.

Therefore, instead of dealing with supervised acts individually for each profession, the Health Professions Council makes the following general recommendation:

The Health Professions Council recommends that a provision be enacted by the Minister of Health and Minister Responsible for seniors which sets out the duties of a health professional and his or her regulatory college when delegating a reserved act. The provision should require the following:

- **The assigning health professional's governing body must provide assent to the proposed reserved act being performed by someone else;**
- **The reserved act to be assigned as well as the level of supervision must be clearly defined and circumscribed by the assigning health professional's governing body;**
- **Where the person to whom the act will be assigned is a regulated health professional, his or her governing body must approve of the assigning of the reserved act;**
- **The instruction to perform the act must be made in writing either by way of a general written protocol or through a case-specific instruction;**
- **The assigning health professional must be satisfied that the individual who will be performing the act has the necessary skills and training to perform the act safely;**
- **The assigning health professional must ensure that the person who will be performing the act accepts the assignment.**

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There are ethical and legal issues involved in assigning reserved acts which will have to be addressed by all parties.

The Council wishes to emphasize that its proposal is not intended to apply on a case-by-case basis. The requirement for approval of the governing body is meant to apply generally and not to individual cases, and would be satisfied by, for example, a general protocol in respect of delegation of reserved acts.

The Council believes this general approach to supervised acts more accurately reflects the reality that procedures to be delegated vary from profession to profession and may include subsets and variations of reserved acts and, further, may be performed under a myriad of circumstances and conditions.

Finally, the Council emphasizes that the issue of supervised or delegated acts arises only with respect to reserved acts. Thus, the general provision regarding supervision will not apply in respect of acts which are not reserved.

4. Reserved Titles

Reserved titles are titles reserved exclusively to a health profession. Reserved titles afford a means for consumers to identify the different types of health care providers, to distinguish the qualified from the unqualified, and to differentiate those practitioners who are regulated from those who are not. Titles must adequately serve the public in describing the practitioner and the services being provided and must distinguish the practitioner from others performing services outside the jurisdiction of the college. The Seaton Commission explained that while it may not be in the public interest to maintain exclusive scopes of practice, it may be appropriate to grant an exclusive (reserved) title to a health profession so the public will know that the professional with whom they are dealing is regulated by a college and is therefore qualified and subject to disciplinary processes for incompetent, impaired or unethical practice.

a. The Society Act

In the course of its review, the Council determined that currently any body that applies for registration under the Society Act, RSBC 1996, c. 433, including several health profession associations, can reserve titles under s.9(1) of the [Society Act](#). The Council believes that the title protection system under the [Society Act](#) could be confusing or misleading to members of the public who may conclude, on the basis of the exclusive use of title conferred under the [Society Act](#), that a member of a registered society or association is subject to regulation which does not, in fact, exist. Unlike the Council's review of an application for designation under the HPA, the Registrar under the [Society Act](#) does not conduct a detailed public interest analysis of the society, its membership or the services it provides with a view to regulation of the members of the applicant society.

In addition, there is no general restriction on a health care worker using a title which includes the words "registered," "licensed" or "certified" even though he or she has not been granted a title under either the [Society Act](#) or the HPA. During the scope of practice review, a number of professions suggested the inclusion of the term "registered" in their title, but the practice of the Council has been to avoid use of the term "registered" and to reserve the descriptive term alone, such as "dietitian," for exclusive use of members of the college. The use of the term "registered" is unnecessary; however, there are exceptions, which have been discussed in specific instances, for example, "registered nurse."

Generally, the title protection regime under the Society Act can be misleading to the public. In the Council's view, such unregulated use of these terms is not in the public interest as it may imply government sanction.

In its 1991 Report: Closer to Home, the Royal Commission on Health Care and Costs recommended that:

7. a. the [Society Act](#) be amended so that the Health Professions Council must approve an occupational title or abbreviation before the Registrar grants protection of it;
- b. all health profession titles previously granted protection under the [Society Act](#) that have not been approved by the Health Professions Council be revoked two years after the passing of the revised [Health Professions Act](#); and
- c. the [Health Professions Act](#) be amended to prohibit the use of words like "registered," "licensed" or "certified" by any health care worker unless that use has been approved by the Health Professions Council.

The Council adopts and supports these conclusions and recommends their implementation.

Therefore, the Health Professions Council recommends to the Minister of Health and Minister Responsible for Seniors the implementation of the recommendations of the Royal Commission on Health Care and Costs (the Seaton Commission) that:

- the **Society Act** be amended so that the Health Professions Council must approve an occupational title or abbreviation [of any health care worker] before the Registrar grants protection of it;
- all health profession titles previously granted protection under the **Society Act** be revoked [at a date to be determined by the Minister of Health and Minister Responsible for Seniors]; and
- **the Health Professions Act be amended to prohibit the use of words like "registered," "licensed" or "certified" by any health care worker unless that use has been approved by the Health Professions Council.**

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b) Christian Science Nursing

Although the title "Christian Science Nurse" appears in the current Nurses (Registered) Act, the Council received no comments or submissions on this title from Christian s

Science nursing groups, nor did the three nursing groups reviewed by the Council request this title. Therefore, the Council did not recommend that it be reserved.

5. Additional Issues

In the course of its investigations, research and consultations, certain issues not explicitly included in the [Terms of Reference](#) were considered by the Council, including the following:

a) Review of the Council's Reserved Acts List

The Council received many submissions requesting that a system be established to deal with revisions to the [Reserved Acts List](#). Through such a system, the [Reserved Acts List](#) could be modified to include new technologies and treatment modalities. Further, the system could address requests for an expanded scope of practice when, by reason of advanced training, professions develop competencies and qualifications to perform reserved acts which were not previously assigned to them. It is important that the regulatory system be flexible enough to recognize changes in technology and treatment methods, and to provide for the expansion of a profession's scope of practice, if necessary.

The Health Professions Council recommends that a process be established by the Minister of Health and Minister Responsible for Seniors for the Health Professions Council to provide ongoing review and consideration of additional issues related to the new regulatory model including the following:

- Are there other activities or new technology or techniques which ought to be added to the [Reserved Acts List](#)?
- Has a profession which previously did not qualify for a particular reserved act now acquired satisfactory competencies to have it assigned to them?
- Are there other hazardous forms of energy or hazardous substances which ought to be included on the general list of reserved acts?
- Has the [Reserved Acts List](#) hindered or impeded the delivery of health services; should some reserved acts be removed from the list?

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b) Access to Laboratory and Other Diagnostic Facilities

The [Terms of Reference](#) indicate that barriers to practice should be eliminated wherever it is possible to do so without increasing the risk of harm to the public. So long as a person is practising within the assigned scope of practice they ought to have access to whatever additional services, as may be reasonably necessary or helpful, are available, and legislative barriers as well as barriers erected by other professions should be prohibited. A recurring issue in the scope of practice review was access to diagnostic facilities such as laboratories and imaging and scanning facilities. In the Council's review it concluded that several health professionals, such as chiropractors and naturopathic physicians, ought to have access to certain diagnostic tests. However, the Council was advised that the College of Physicians and Surgeons of British Columbia (CPSBC) controls access to such facilities through the Medical Practitioners Act and Rules (the MPA). CPSBC has determined that anyone ordering a test is practising medicine, thereby excluding many health professionals from access to

laboratories. The barrier created by the MPA effectively prevents chiropractors and naturopathic physicians from practising within their scope.

Therefore, the Health Professions Council recommends that the legislation governing access to laboratory facilities be reviewed and modified by the Minister of Health and Minister Responsible for Seniors to ensure access for health professionals who are deemed by the Minister of Health and Minister Responsible for Seniors to be trained and educated to utilize test results.

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c) Review of Reserved Acts Granted Prior to the Scope of Practice Review

The Council's [Reserved Acts List](#) was developed from 1998 onwards in conjunction with the scope of practice review. A number of health professions were designated as health professions through regulation, and assigned reserved acts prior to the development of the [Reserved Acts List](#).

Therefore, the Health Professions Council recommends that the Minister of Health and Minister Responsible for Seniors review all reserved acts granted prior to the Scope of Practice Review in order to ensure that they are consistent with the current [Reserved Acts List](#).

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d) Delegation Protocol – Delegation to Unregulated Individuals

During its review of the nursing professions, the Council heard many submissions about the practice of delegation of reserved acts to unregulated individuals. The Health Employers Association of British Columbia (HEABC) indicated that in many workplaces, such as residential and long term care facilities, health care workers perform tasks and services normally performed by members of regulated health professions. One example is dispensing of medications. The HEABC was concerned that the new regulatory system would prevent the practice of delegating tasks to unregulated individuals whom they regarded as highly trained and educated but unregulated. HEABC submitted that, with resource shortages, this process must continue for these facilities to meet the growing demand for these services. Currently, section 14 of the HPA provides that it is not a violation of the HPA to practice a profession, discipline or other occupation in accordance with another act. This would appear to allow the practice of delegation to unregulated health care workers as long as it is done through the process provided by the relevant legislation. Nonetheless, after reviewing that legislation, the Council is concerned that the legislation referred to above does not contain the necessary safeguards, such as supervision and training, which ought to be in place.

Therefore, the Health Professions Council recommends that the Minister of Health and Minister Responsible for Seniors review all legislation governing community, long term care and home care programs and facilities to ensure they contain the appropriate safeguards so that the delegation of reserved acts to unregulated individuals is carried out in a safe and effective manner.

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e) Other Elements of the Reserved Acts System

The [Terms of Reference](#) set out the main elements of a reserved acts model. As described in the Criteria and Guidelines, the model is based on the controlled acts model of regulation in Ontario. There are other elements of a reserved acts system which are essential to the proper functioning of the new regulatory model. These include:

(ii) Risk of Harm Clause

Inasmuch as the reserved acts system permits unregulated provision of health services other than reserved acts, it is essential that a general risk of harm clause be enacted to ensure accountability for the performance of health services by unregulated providers. This was considered essential by many of the parties responding. The Ontario model was frequently cited as an approved precedent. In Ontario, the harm clause prohibits any unregulated person from treating or advising a person with respect to his or her health in circumstances where it is reasonably foreseeable that serious physical harm may result from the treatment or advice. As Linda Bohnen states in her book, *Regulated Health Professions Act, A Critical Guide*, the "essence of the harm clause is that the practitioner should not have ventured on the treatment at all."

Therefore, the Health Professions Council recommends that a provision similar to the following risk of harm clause enacted in Ontario be adopted by the Minister of Health and Minister Responsible for Seniors:

No person, other than a member treating or advising within the scope of his or her profession, shall treat or advise a person with respect to his or her health in circumstances in which it is reasonably foreseeable that serious physical harm may result from the treatment or advice or from an omission from them.

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(ii) Exemptions from the Reserved Acts System

In a reserved act system, only persons specifically authorized by legislation may perform reserved acts. All others are prohibited from doing so. Similar regulatory models recognize the need for exceptions to the general prohibition. Under the HPA, for example, section 14(b) provides an exception for "providing or giving first aid or temporary assistance to another person in case of emergency" Similarly, the Ontario exceptions include providing emergency assistance, students acting under the supervision of a health professional, treating a person by prayer or spiritual means, treating a member of one's own household and assisting a person with "routine activities of living." The Ontario system also exempts certain services which might otherwise constitute reserved acts, such as ear piercing and ritual circumcision of boys.

Therefore, the Health Professions Council recommends that the Minister of Health and Minister Responsible for Seniors include provisions for exceptions to and exemptions from the new regulatory model.

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f) Release of Prescriptions

The Council has considered the issue of issuing prescriptions to patients for dispensing by another health professional. Examples are prescriptions for eyeglasses and contact lenses and prescriptions for dental appliances. To the extent restrictions on issuing or releasing such prescriptions represent a barrier to interdisciplinary practice, the Council recommends that they be prohibited.

Therefore, the Health Professions Council recommends that prescriptions for patients be delivered to patients free of cost.

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D. A FINAL WORD

Despite the countless hours that have been devoted to the production of this report, both by the members and staff of the Council and the dedicated members of the various health professions, not only in British Columbia but also in other parts of Canada and the United States, it is but the first step in what promises to be an exciting development of the regulatory system. Ontario is already seen throughout the continent as the innovator of a new and effective system that can serve as a model for others. The Council has liberally borrowed from Ontario, and during its review the comparable body in that province, the Health Professions Regulatory Advisory Council, has frequently called upon the Council's experience in this field. We see this interaction as a much needed development, particularly with implications arising from requirements for portability and uniformity in the regulatory process. The Council trusts that those who now take up the task will be able to build upon the framework the Council has established. Of one thing the Council can assure them: the professions themselves are by and large governed by dedicated and objective members who take seriously their primary function of ensuring their professions are governed in the public interest.

The Council has attempted to balance the objectives of this review process: to enhance the choices available to the public in determining its health care needs while ensuring that the choices are within safe parameters. It is in addressing the different points of view as to how these competing interests can best be satisfied that the challenge arises. The foundation is here, the structure now awaits fulfillment.

Last Revised: March 08, 2002

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Health Professions Council

SAFE CHOICES: A New Model for Regulating Health Professions in British Columbia

Part I: Scope of Practice Review

Irvine E. Epstein, Q.C., Chair
Arminée Kazanjian, Vice-Chair
David MacAulay, Vice-Chair

March 2001

FOREWORD

Under the *Health Professions Act*, the Health Professions Council is a six-person advisory body appointed by the Government of British Columbia to make recommendations to the Minister of Health and Minister Responsible for Seniors about the regulation of health professions.

This report is the result of the Health Professions Council's review of the scope of practice of 15 recognized health professions pursuant to the *Terms of Reference* from the Minister of Health and Minister Responsible for Seniors.

Mr. Epstein did not participate in the review of optometry. Another member, Brenda McBain, served on the scope panel for that review, chaired by Dr. Kazanjian.

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Health Professions Council

SAFE CHOICES: A New Model for Regulating Health Professions in British Columbia

Part II: Legislative Review

Irvine E. Epstein, Q.C., Chair

March 2001

Forward

This report is the result of the Health Professions Council's legislative review of ten health professions pursuant to the Terms of Reference from the Minister of Health and Minister Responsible for Seniors. Under the *Health Professions Act* the Health Professions Council is a six-person advisory body appointed by the government of British Columbia to make recommendations to the Minister of Health and Minister Responsible for Seniors about the regulation of health professions. Irvine E. Epstein, Q.C., the Chair of the Health Professions Council, is primarily responsible for the legislative review. The report has been circulated within the Health Professions Council for review and comment.

In the legislative review the Health Professions Council examined two issues:

1. whether designation of the professions of

- chiropractic;
- dentistry;
- emergency medical assistance;
- medicine;
- naturopathy;
- nursing, registered;
- nursing, registered psychiatric;
- optometry;
- podiatry; and

- psychology

under the *Health Professions Act* would be in the public interest or whether there are unique features of the health professions, or other relevant factors, that justify a continuing need for a separate statute; and

2. what amendments, if any, are required to the current statute, rules, regulations and bylaws for each of the professions to provide adequately for the regulation of the profession in the public interest and to ensure that the current statute contains the core principles of professional regulation reflected in the *Health Professions Act* and discussed in Schedule B to the Terms of Reference.

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I. EXECUTIVE SUMMARY

In accordance with the Terms of Reference, the Council undertook a review of specific statutes governing ten health professions.

Each of the professional statutes was compared to the HPA and the core principles of regulation set out in the Terms of Reference, with a recommendation made regarding designation of the profession under the HPA.

During a consultation process involving not only the specific profession under review but also other health professions and interested parties, the Council expanded its original review to include two additional matters, one requested by the Minister of Health and Minister Responsible for Seniors (Minister) and one which

originated from the consultation process.

First, the Minister directed the Council to consider the issue of mandatory membership in professional associations. Second, the Council reviewed the HPA in light of submissions made by participants in the review process and established a series of suggested revisions to the HPA to improve its effectiveness.

Also, during the review three professions-registered psychiatric nursing, naturopathic medicine and psychology-requested designation under the HPA, thus negating the need for further review by the Council.

This report recommends as follows:

RECOMMENDATIONS ON DESIGNATION

- The Health Professions Council recommends that the Optometrists Act and the Podiatrists Act be repealed and those professions designated under the *Health Professions Act*.
- The Health Professions Council recommends that the Chiropractors Act, the Dentists Act, the Medical Practitioners Act, and the Nurses (Registered) Act be repealed and those professions designated under the *Health Professions Act* as soon as revisions are made to the *Health Professions Act* to reflect the unique features of those professions.
- The Health Professions Council recommends that the *Health Emergency Act* not be repealed, and the profession of emergency medical assistance not be designated under the *Health Professions Act*.

RECOMMENDATIONS ON REVISIONS TO THE HEALTH PROFESSIONS ACT

- The Health Professions Council recommends that section 20 of the *Health Professions Act* be modified to provide for a more flexible registration process, which would allow the registration committee to delegate approval of applications to the Registrar.
- The Health Professions Council recommends that the *Health Professions Act* be amended to remove the right of the complainant to appear as a party.
- The Health Professions Council recommends that section 40 of the *Health Professions Act* be amended to restrict the right of appeal to the parties in a disciplinary hearing.
- The Health Professions Council recommends that section 19 of the *Health Professions Act* be revised to create a category of matters for which cabinet approval is not necessary.
- The Health Professions Council recommends that the Ministry of Health and Minister Responsible for Seniors take steps necessary to address the issue of delay in the bylaw approval process.
- The Health Professions Council recommends that disciplinary provisions of the *Health Professions Act* be clarified to ensure that they encompass both "professional misconduct" and "conduct unbecoming."
- The Health Professions Council recommends that the *Health Professions Act* be revised to include provision for a summary review process for complaints and a related provision for an internal appeal from a dismissal of a complaint through the summary review process.

- The Health Professions Council recommends that the *Health Professions Act* be amended to include a requirement that discipline committees issue written reasons for decisions made during disciplinary hearings.
- The Health Professions Council recommends that the *Health Professions Act* be amended to adopt a provision similar to section 42 of Ontario's Health Professions Procedural Code which provides that:
 1. Evidence against a member is not admissible at a hearing of allegations against the member unless the member is given, at least ten days before the hearing,
 - a. in the case of written or documentary evidence, an opportunity to examine the evidence;
 - b. in the case of evidence of an expert, the identity of the expert and a copy of the expert's written report or, if there is no written report, a written summary of the evidence; or
 - c. in the case of evidence of a witness, the identity of the witness.
- The Health Professions Council recommends that the *Health Professions Act* be revised to include specific provisions for fostering use of alternative resolution, including mediation.
- The Health Professions Council recommends that the Attorney General be given the authority to enforce the provisions prohibiting persons from performing services which should only be done by registered health professionals.
- The Health Professions Council recommends that the *Health Professions Act* be revised to adopt a provision similar to section 26(5)(b) of the Dentists Act which provides:

If, after giving the applicant an opportunity to be heard, the council determines that at the time of the application an investigation, review or proceeding is taking place in this or any other jurisdiction which could result in the suspension or cancellation of the applicant's authorization to practise dentistry in that jurisdiction, the council may refuse to grant registration or grant registration for a period or subject to other terms and conditions.

- The Health Professions Council recommends that the *Health Professions Act* be revised to adopt a provision similar to article 5.05(e) of the Dentists Act Rules which provides:

Reporting actions of registrants. Members must advise the registrar without delay if they have reasonable grounds to believe that a current or former registrant:

- i. *has contravened the act or a rule made under it;*
- ii. *has failed to comply with a limitation, term or condition imposed under the act or the rules;*
- iii. *has been convicted in Canada or elsewhere of any offence that, if committed by a registrant, would constitute conduct unbecoming a registrant or unprofessional conduct;*

- iv. *has incompetently practised dentistry or carried out the duties and procedures delegated to him as a registrant;*
- v. *has engaged in conduct unbecoming a registrant;*
- vi. *has engaged in unprofessional conduct;*
- vii. *has failed to comply with an agreement that is binding on him under section 4.1(3) of the act; or*
- viii. *is suffering from a physical ailment, emotional disturbance or an addiction to alcohol or drugs that impairs his ability to practise dentistry or carry out the duties and procedures delegated to him.*

- The Health Professions Council recommends the adoption of a peer assessment program similar to that described in section 51 of the Medical Practitioners Act, but only if restrictions on use of information during such a process, such as those set out in section 83(1) to 83(4) of Ontario's Health Professions Procedural Code, are included.
- The Health Professions Council recommends that the *Health Professions Act* be revised to provide a provision similar to section 71(4) of the Medical Practitioners Act which provides:

The executive committee may, on the terms it sees fit, stay the operation of any punishment or penalty imposed on a person appealing under this section until the outcome of the appeal, and may require the giving of reasonable security for its costs of the appeal and payment of a fine already imposed as a condition of granting the stay.

- The Health Professions Council recommends that the *Health Professions Act* be revised to include a provision similar to section 21 of the Medical Practitioners Act which provides:

Special deputy registrar

21 (1) The council must designate a person appointed under section 20 (3) as the special deputy registrar.

(2) The special deputy registrar must

(a) receive and investigate complaints of sexual misconduct made to the college;

(b) on completion of an investigation of a complaint of sexual misconduct, review the findings of the investigation and recommend the action the sexual misconduct review committee should take under section 28 (2) (d); and

(c) perform other duties as directed by the sexual misconduct review committee or the registrar.

(3) *With the prior approval of the sexual misconduct review committee, the special deputy registrar may authorize an inspector to complete an investigation under this section under the supervision of the special deputy registrar.*

(4) *The special deputy registrar may attempt to resolve a complaint of sexual misconduct informally if the complainant consents and*

(a) the circumstances warrant informal resolution of the complaint in the opinion of the special deputy registrar, or

(b) a direction has been made under section 28 (2) (d) (iii) to make the attempt.

- The Health Professions Council recommends that the *Health Professions Act* be revised to include a provision similar to section 67(2) of the Medical Practitioners Act which provides:

On an inquiry or hearing, the council, executive committee or inquiry committee may employ, at the college's expense, the legal or other assistance it thinks necessary or proper.

- The Health Professions Council recommends that section 35 of the *Health Professions Act* be amended to add a duty to notify a registrant as well as provide an opportunity to respond to the allegations prior to action being taken under the section, with an exception for cases involving substantial risk to the public, in which case action may be taken without prior notice to the registrant.
- The Health Professions Council recommends that the *Health Professions Act* be revised to include a provision similar to section 62 of the Medical Practitioners Act which provides:

Reinstatement of entry in register

62 (1) If the council directs the erasure from the register of a person's name or of another entry, that person's name or entry must not be again entered on the register except by direction of the council or by order of the Supreme Court or of the Court of Appeal on an appeal.

(2) If the council thinks fit, the council may direct the registrar to restore to the register a name or entry erased from it, with or without payment of a registration fee, and the registrar must restore it.

- The Health Professions Council recommends that the *Health Professions Act* be revised to include a provision similar to section 50 of the Medical Practitioners Act which provides:

(1) A person who has been convicted of an indictable offence by a court in British Columbia or elsewhere is not entitled to be registered and the council may erase the person's name from the register.

...

(3) The registration of a person must not be refused and the name of a person not be erased for a conviction for a political offence or for an offence that ought not, in the council's opinion, either from the nature of the offence or from the circumstances under which it was committed, to disqualify the person from practising under the Act.

- The Health Professions Council recommends that all regulatory bodies be called "colleges." This will require changes to the legislation governing registered nursing, optometry and podiatry.
- The Health Professions Council recommends that section 22 of the *Health Professions Act* be amended to provide discretion not to disclose a member's address or phone number where there are reasonable grounds to believe that disclosure may jeopardize the member's safety.

RECOMMENDATIONS ON CHANGES TO THE HEALTH EMERGENCY ACT

- The Health Professions Council recommends that the *Health Emergency Act* be amended to include sections 16(2)(d), 16(2)(f) and bylaw 18 of the *Health Professions Act* which provide:

16(2) A college has the following objects:

(d) to establish, monitor and enforce standards of practice to enhance the quality of practice and reduce incompetent, impaired or unethical practice amongst registrants;

(f) to establish, for a college designated under section 12 (2) (h), a patient relations program to seek to prevent professional misconduct of a sexual nature.

Patient relations committee

18. (1) The patient relations committee is established consisting of [6] persons appointed by the board.

(2) The patient relations committee must include at least [2] public representatives, at least 1 of whom must be an appointed board member.

(3) The patient relations committee must

- (a) establish and maintain procedures by which the college deals with complaints of professional misconduct of a sexual nature,
- (b) monitor and periodically evaluate the operation of procedures established under paragraph (a),
- (c) develop and coordinate, for the college, educational programs on professional misconduct of a sexual nature for members and the public as required,
- (d) establish a patient relations program to prevent professional misconduct, including professional misconduct of a sexual nature,
- (e) develop guidelines for the conduct of registrants with their patients, and
- (f) provide information to the public regarding the college's complaint and disciplinary process.

(4) For the purposes of this section, "professional misconduct of a sexual nature" means

- (a) sexual intercourse or other forms of physical sexual relations between the registrant and the patient,
- (b) touching, of a sexual nature, of the patient by the registrant, or
- (c) behaviour or remarks of a sexual nature by the registrant towards the patient;

but does not include touching, behaviour and remarks by the registrant towards the patient that are of a clinical nature appropriate to the service being provided.

Prior to the enactment of this provision, both the Emergency Health Services Commission and the Emergency Medical Assistants Licensing Board should be consulted about which body is best able to fulfill the duties required by these programs.

- The Health Professions Council recommends that the provisions in the *Health Emergency Act* dealing with the complaints and discipline process be amended to ensure that the investigative and adjudicative functions are entirely separate, and that complainants are afforded a right of internal appeal regarding dismissed complaints.
- The Health Professions Council recommends that the *Health Emergency Act* be amended to provide for a general rule that disciplinary hearings are open to the public, subject to the list of exceptions set out in bylaw 12(5)(a) to (d) of the *Health Professions Act* Bylaws.
- The Health Professions Council recommends that the following *Health Professions Act* provisions be added to the *Health Emergency Act*.
 1. section 33(4) which deals with the inquiry committee's power to take any action it considers appropriate to resolve a complaint, including mediation;

2. section 36 which provides that the inquiry committee may resolve complaints by way of registrants' undertakings or consents;
3. section 37 which describes the contents of a citation;
4. section 38 which sets out the procedure for a discipline committee hearing; and
5. section 40 which provides for an appeal by a person aggrieved or adversely affected by a decision of the discipline committee.

RECOMMENDATION ON MANDATORY MEMBERSHIP

- The Health Professions Council recommends the repeal of any provision in any professional statute, rule or regulation that requires members of a regulated health profession to belong, or to pay dues, to a professional association.

RECOMMENDATION ON OVERSIGHT OF REGULATORY COLLEGES

- The Health Professions Council recommends a process be established by the Minister of Health and Minister Responsible for Seniors for the Health Professions Council to provide ongoing review and oversight of the regulatory colleges.

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Health Professions Council

TERMS OF REFERENCE

Scope of Practice / Legislative Review of Recognized Health Professions

In accordance with the authority established in section 24 of the [Health Professions Act](#), the Health Professions Council is hereby directed to review the scope of practice and the legislative framework for all recognized health professions and to consider the following matters in accordance with the [Criteria and Guidelines \(Schedule A\)](#).

1. How should the existing scope of practice for the health profession be legislatively defined in order to reflect fairly and accurately the current state of practice in that field of health care and reflect the public interest in the practice of the profession?
2. Should any of the tasks or services performed by the health profession be considered "reserved acts" exclusive to that health profession (or jointly with other related professions) because of the risk of harm involved to the health, safety or well-being of the public?
 - 2.1 Which of the reserved acts, or aspects of the reserved acts, may be performed by persons supervised by practitioners, and under what terms and conditions?
3. Do the titles reserved exclusively for the health profession adequately serve the public?
4. Would designation of the health profession under the [Health Professions Act](#) be in the public interest or are there unique features of the health profession, or other relevant factors, that justify a continuing need for a separate Act?
5. What amendments, if any, are required to the current Act, rules, regulations and bylaws for each profession to adequately provide for the regulation of the profession in the public interest and to ensure they contain the core principles of professional regulation reflected in the [Health Professions Act](#) and discussed in [Schedule B](#)?

The statutes to be examined are listed in [Schedule C](#) together with specific directions about priority reviews.

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SCHEDULE A - CRITERIA AND GUIDELINES

1. How should the existing scope of practice for the health profession be legislatively defined in order to reflect fairly and accurately the current state of practice in that field of health care and reflect the public interest in the practice of the profession?

- The current definition may require expansion and updating to reflect academic/scientific advancements in the practice of the profession and in related professions.
- A concise legislative definition of the tasks and services appropriately delivered by registrants is required. This should include any limits on the scope of practice that may be necessary for public protection and may involve limits on a class or classes of registrants who have different skills and abilities than other registrants.
- An aspect of scope of practice may be shared between two or more discrete health professions.

2. Should any of the tasks or services performed by the health profession be considered "reserved acts" exclusive to that health profession (or jointly with other related professions), because of the risk of harm involved to the health, safety or well-being of the public?

- Where a reserved act is presently conferred on a health profession, the Council will determine if it is necessary to continue that exclusivity for reasons of public protection, in view of the desirability of maximizing consumer choice and limiting cost of health care services.
- Only those tasks and services involving a significant risk of harm should be reserved exclusively for members of that health profession.
- A reserved act may be conferred on more than one profession where the Health Professions Council is satisfied that it is an appropriate aspect of the scope of practice of each profession.

2.1 Which of the reserved acts, or aspects of the reserved acts, may be performed by persons supervised by practitioners, and under what terms and conditions.

- Although reserved acts may only be performed by certain professions, it may be appropriate for other persons to perform them, or aspects of them, under the supervision of members of those professions.
- Where the Council is satisfied that a reserved act, or an aspect of it, may be performed by another person under the supervision of a practitioner, it will recommend the terms and conditions under which it may be performed, including but not limited to,
 - whether it should only be performed by a person having certain training or qualifications,
 - whether its performance should be limited to specific locations such as a hospital, or

- the degree of direct or indirect supervision which should be exercised.

3. Do the titles reserved exclusively for the health profession adequately serve the public?

- The reserved title must adequately serve the public in describing the practitioner and the services which are being provided.
- The title must adequately distinguish professional members from others performing similar services outside the jurisdiction of the college.

4. Would designation of the health profession under the [*Health Professions Act*](#) be in the public interest or are there unique features of the health profession, or other relevant factors, that justify a continuing need for a separate Act?

- Where the profession favours designation, and designation would be in the public interest, the Council may -- following its review of scope of practice -- forego the legislative review and recommend the form of a regulation for designation of the profession under the [*Health Professions Act*](#).
- Where a profession expresses a preference for retention of a statute, the Council should consider these factors:
 - Does the degree of complexity in operating the existing college make it difficult to convert to the regulatory scheme established under the [*Health Professions Act*](#)?
 - Is more than one health profession regulated by the same college? If so, would separation of the regulatory responsibilities be desirable because of the difficulties experienced with the existing scheme?
 - Is the current Act so flawed that it needs to be repealed and replaced or are only minor amendments required?
 - Is it likely that a new Act for the health profession would closely resemble the [*Health Professions Act*](#)?
 - A high degree of consistency between statutes is essential to reflect the minimum regulatory requirements that apply equally to all health professions.
 - It would be desirable to minimize the number of statutes that apply to the governance of health professions in order to facilitate statutory amendments as required from time to time.

5. What amendments, if any, are required to the current Act, rules, regulations, and bylaws to adequately provide for the regulation of the profession in the public interest and ensure they contain the core principles of professional regulation reflected in the [*Health Professions Act*](#) and discussed in [*Schedule B*](#)?

- The [*Health Professions Act*](#) embodies those core principles of professional regulation which the Ministry considers are desirable or essential, for a profession to be effectively regulated in the public interest.

- The [*Health Professions Act*](#) should be considered the standard or template of professional legislation -- it sets out the relevant matters which should be included in a professions statute and provides appropriate bylaw-making authority for those which should be contained in ancillary legislation. Where membership in a professional association is compulsory, the bylaws of that association should also be considered.
- Each health profession's legislation should be compared with the [*Health Professions Act*](#), with a view to identifying those provisions which are inadequate, incomplete or missing -- as well as those which do not serve the public interest.
- Regulation of Emergency Medical Assistants under the [*Health Emergency Act*](#) should be reviewed with particular regard to the role of the Emergency Health Services Commission and to the terms of the collective agreement.
- The review will require close scrutiny of the five essential core principles of effective professional regulation set out in [*Schedule B*](#).

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Review Process

- It is anticipated that the scope of practice / legislative review will include a consultation process with affected stakeholders.
- The Terms of Reference and information regarding the progress of the review will be circulated in the Health Professions Bulletin of the Legislation and Professional Regulation Division of the Ministry.
- The Council has been requested to deal with the following three statutes first for the reasons noted:
 - [*Optometrists Act*](#) -- the profession has been asking for an expansion of its scope of practice for some time.
 - [*Naturopaths Act*](#) -- the profession has been seeking approval of a pharmacopoeia for some time and the Act requires updating.
 - [*Dentists Act*](#) -- there is a need to examine issues respecting the appropriate governance structure for the College of Dental Surgeons.

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SCHEDULE B - CORE PRINCIPLES

Mandate of the regulatory body

- The mandate for health professions has been defined in section 15.1 of the *Health Professions Act* (and has been replicated in each of the other profession statutes).
- Legislative provisions -- including provisions found in regulations, rules and bylaws -- which are outside of those enumerated duties and objects should serve the public interest.
- Barriers to inter-disciplinary practice are not generally in the public interest. The public interest is best served when all related health professions work together collaboratively to maximize the quality and choice of services for the consumer in any field of health care.
- Activities of a regulatory body to promote the economic, political, and professional interests of its members must not compromise the ability of the regulatory body to regulate the profession in the public interest.

Registration requirements for entry into the profession

- Principles of administrative law, including natural justice and fairness, must be reflected in the admissions criteria and application process for both new graduates of accredited educational programs and foreign-trained practitioners.
- There must be objective requirements for registration and for accreditation of education programs.
- Applicants should have appropriate rights of appeal of decisions affecting their ability to register.

Quality assurance measures

- There should be effective mechanisms for monitoring the continuing competency of practitioners, including the ability to set mandatory continuing education requirements.
- A committee of the board should be responsible for reviewing the standards of practice and code of ethics and circulating new practice guidelines and bulletins to members.

Complaint and disciplinary processes

- The principles of administrative law, including natural justice and fairness, should be respected within the regulatory scheme for the handling and disposition of complaints.
- Penalties should be adequate to protect the public.
- Rights of appeal -- whether internal or to the courts -- of decisions following a hearing and decisions not to proceed to a hearing must be available to the complainant and the practitioner.

Accountability mechanisms

There should be a requirement for Government approval of rules or bylaws.

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SCHEDULE C - HEALTH PROFESSIONS STATUTES

PRIORITY ACTS

[Optometrists Act](#)
[Naturopaths Act](#)
[Dentists Act](#)

OTHER ACTS

[Chiropractors Act](#)
[Health Emergency Act](#)
[Medical Practitioners Act](#)
*Nurses Act **
[Nurses \(Registered\) Act](#)
[Nurses \(Registered Psychiatric\) Act](#)
[Pharmacists, Pharmacy Operations and Drug Scheduling Act *](#)
[Podiatrists Act](#)
*Physiotherapists Act **
[Psychologists Act](#)

* Scope of practice review only. *The Pharmacists, Pharmacy Operations and Drug Scheduling Act* was only recently enacted (1993) and reflects the unique features of the practice of pharmacy. The Physiotherapists Act has been repealed in favour of the designations of physical therapy and massage therapy under the [Health Professions Act](#). The *Nurses (Licensed Practical) Act* is also to be repealed in favour of the designation of licensed practical nursing under the [Health Professions Act](#).

The *Dental Technicians and Denturists Act* and the [Hearing Aid Act](#) are not included because of applications submitted to the Health Professions Council by practitioners regulated under these Acts.

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Health Professions Council

Reserved Acts List

EXPLANATIONS

The Council's Reserved Acts List has undergone a number of changes since its inclusion in the Council's Discussion Paper in April 1997. The Discussion Paper was sent out to stakeholders and regulatory and membership bodies of health professions, to obtain their views on the Council's scope of practice review process.

In July 1998, the Council issued the Shared Scope of Practice Model Working Paper (Working Paper). The Working Paper complements the Discussion Paper and is the result of the consultation process on the Discussion Paper.

The following Reserved Acts List is the Council's current version, dated August 2000, and contains endnotes that explain the changes since the version contained in the [Working Paper](#).

RESERVED ACTS LIST

1. Making a diagnosis identifying a disease, disorder or condition as the cause of signs or symptoms of the individual.
2. Performing the following physically invasive or physically manipulative acts:
 - a. procedures on tissue below the dermis, below the surface of a mucous membrane, in or below the surface of the cornea, in or below the surfaces of the teeth, including the scaling of teeth;
 - b. setting or casting a fracture of a bone or reducing a dislocation of a joint;
 - c. movement of 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. administering a substance, **other than a drug¹**, by injection, inhalation, **irrigation²**, or **instillation through enteral or parenteral means³**;
 - e. putting an instrument, hand or finger(s),

- i. into⁴ the external ear canal, including applying pressurized air or water⁵ ,
 - ii. beyond the point in the nasal passages, where they normally narrow,
 - iii. beyond the pharynx,
 - 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.
 3. Managing labour or delivery of a baby.
 4. Applying or ordering the application of a hazardous form of energy including diagnostic ultrasound, electricity, magnetic resonance imaging, lithotripsy, laser and X-ray.
 - a. Prescribing, compounding, dispensing or administering by any means a drug listed in Schedule I or II of the Pharmacists, Pharmacy Operations and Drug Scheduling Act.
- For the purposes of this reserved act, the following definitions shall apply:
- "prescribing": the ordering of a drug.
- "compounding": mixing ingredients, at least one of which is a drug.
- "dispensing": preparing or filling a prescription for drugs.
- b. Designing, compounding or dispensing therapeutic diets where nutrition is administered through enteral or parenteral means.
- For the purposes of this reserved act, the following definitions shall apply:
- "designing": the selection of appropriate ingredients for enteral or parenteral nutrition.
- "compounding": mixing ingredients, for enteral or parenteral nutrition
- "dispensing": filling a prescription for enteral or parenteral nutrition.⁶
6. Prescribing appliances or devices for vision, hearing or dental conditions; dispensing such prescribed appliances or devices for dental conditions; fitting such appliances or devices for dental conditions, or fitting contact lenses.

For the purposes of this reserved act, the following definitions shall apply:

"prescribing": ordering the fabrication or alteration of appliances or devices for vision, hearing, or dental conditions.

"dispensing": filling a prescription by fabricating or altering a dental appliance or device.⁷

7. Allergy challenge testing or allergy desensitizing treatment involving injection, scratch tests or inhalation, and allergy challenge testing by any means with respect to a patient who has had a previous anaphylactic reaction.⁸

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Footnotes:

1. The phrase "other than a drug" was inserted as a result of the Council's review of the scope of practice of registered nursing, dated August 11, 2000.
2. The term "irrigation" was inserted as a result of the Council's Registered Nurses Scope of Practice (Preliminary Report) issued in March 2000. The new wording of the reserved act was first reflected in the Council's Reserved Acts List, March 2000.
3. The phrase "or instillation through enteral or parenteral means" was inserted as a result of the Council's Recommendations on the Designation of Dietetics, issued in October 1999.
4. The word "into" replaced the original term "beyond" and is a result of the Council's Recommendations on the Designation of Speech-Language Pathology and Audiology which is currently being finalized.
5. The phrase "including applying pressurized air or water" was inserted as a result of the Council's Recommendations on the Designation of Speech-Language Pathology and Audiology which is currently being finalized.
6. This is an entirely new reserved act and is the result of the Council's Recommendations on the Designation of Dietetics, issued in October 1999.
7. The definitions of the terms, prescribing and dispensing was added to the Council's Reserved Acts List, November 1999 as a result of the Council's Dental Technicians Scope of Practice (Preliminary Report) issued in June 1999.
8. The original wording of this reserved act is as follows:

Allergy challenge testing in which a positive result of the test is a significant allergic response; or allergy desensitizing treatment in which there is a risk of significant allergic response.

The wording was changed for the Council's Reserved Acts List, November 1999 during the Council's review of Naturopathic Medicine.

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Health Professions Council

Shared Scope of Practice Model Working Paper

At the direction of the Minister of Health, the Health Professions Council is reviewing the scopes of practice and legislative framework for all recognized health professions in British Columbia. The [Terms of Reference](#) given to the Council set out the framework of a new model for regulating the health professions.

At the time of the reference from the Minister, the scopes of practice of the regulated health professions in the province were framed in exclusive and restrictive terms. The right to provide health services falling within the scope of practice of a particular profession was restricted to persons who were members of the regulatory body of that profession or to those who were specifically exempted from the restrictions.

Under the new regulatory framework set out in the [Terms of Reference](#), scope of practice statements for health professions will no longer be exclusive. Henceforth, a scope of practice statement will define an individual profession's activities in broad, non-exclusive terms. Defined in these terms, aspects of the scope of practice of each health profession may overlap, or be shared, with those of other health professions.

Within this framework of shared scopes of practice, the [Terms of Reference](#) recognize that certain tasks or services performed by a health profession may carry such a significant risk of harm to the health, safety or 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.

Thus, unlike the present system in which each profession is granted exclusivity within its entire defined scope of practice (subject to specified exceptions), only those acts which present a significant risk of harm will be reserved. In short, the government has assigned the Council the task of creating a regulatory model based on broad, non-exclusive scope of practice statements and narrowly defined reserved acts.

The four elements of the scope of practice review are scope of practice statements, reserved acts, supervised acts and reserved titles. The Council has previously provided direction regarding the issues of scope of practice statements and reserved titles but believes that some clarification of reserved acts and supervised acts is necessary in order to provide focus for the scope of practice review process.

An earlier version of this paper was sent out for consultation to all health professional associations and regulatory bodies, representatives of alternative health care groups and other interested parties. The Council met to discuss the responses to consultation, and this version of the paper incorporates many of the comments made.

The Council intends to use this paper, in conjunction with the [Terms of Reference](#), as it proceeds with the scope of practice review.

1. RESERVED ACTS

Reserved acts are an important element of the new scope of practice model reflected in the [Terms of Reference](#). Reserving only those acts which present a significant risk of harm ensures that the focus of professional regulation remains public protection and not the enhancement of professional status or control. The new model also allows for greater consumer choice in the delivery of health care services. Indeed, the Council's fundamental objective in conducting the scope of practice review is to attain the optimum balance between consumer choice and public safety.

The Council felt it important to establish some basic principles to guide it in its assessment of what is a significant risk of harm. In this regard, the Council was assisted, in part, by the 1994 report of the Manitoba Law Reform Commission, Regulating Professions and Occupations. That report indicated that regulation should not be imposed unless the threat of harm to the public is serious. The report stated that three factors should be evaluated in considering the seriousness of a threatened harm:

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

In the Council's view, it is not always easy to determine the point at which a threat of harm associated with an act becomes serious enough to justify reserving it. The three factors listed above will guide us in that decision.

Several respondents to the consultation, including the College of Physical Therapists, the BC Dieticians' and Nutritionists' Association and the BC Nurses' Union, questioned the third factor. Their basic point was that if an act is dangerous it should be reserved regardless of the number of people it threatens. The Council agrees. The Council emphasizes that the list of factors are not criteria that must all be met; they are intended only as a guide to the factors that must be balanced in determining whether an act should be reserved. An act need not satisfy all three factors to be reserved. A procedure determined to have significant consequences (factor two) will be reserved regardless of the number of people it threatens. In short, factor three indicates that the Council will consider the risk in proportion to the number of people threatened, but it does not mean that a very dangerous act which threatens only a small group of people will not be reserved.

With this policy background in mind, the Council reviewed the scope of practice submissions, the responses to the submissions, various published materials, the regulatory model currently in place in Ontario, and the model being developed in Alberta. The Council considered the list of controlled acts used in Ontario, and with modifications, decided to use it as a guide as it proceeds through the profession-specific reviews.

The list is phrased more in terms of general descriptions, and professions can expect that, for the most part, particular professions will be granted more specific activities that fall within the general category or description. For example, it may be the case that one profession will be granted the reserved act of prescribing drugs while others may only be granted the reserved act of prescribing particular drugs. Also note that some activities may fall within more than one reserved act. For example, administration of an

intramuscular injection will fall within both Reserved Act 2(a): "performing a procedure below the dermis" and Reserved Act 5: "administering a drug".

Finally, note that the list is the Council's working list and changes may be made to the list depending on the information arising during the scope review process, or the Council's ongoing review of applications for designation.

In the following discussion, the reserved acts appear in bold with accompanying comments in regular typeface.

Footnote:

[The reserved acts are listed in their August 2000 modified form at this link.](#)

1. Making a diagnosis identifying a disease, disorder or condition as the cause of signs or symptoms of the individual.

The Council believes it important to distinguish between diagnosis and assessment. Essentially, diagnosis is the identification of the cause of signs or symptoms. Assessment is a process of observation and evaluation of the physical status or progress of a patient, which may involve observation of symptoms, but does not include naming or identifying a disease, disorder, or condition as the cause of these symptoms.

In the Council's view, all health care practitioners assess a client's progress and response to services rendered. Practitioners who offer assessments have provided information to the Council on this issue, either in recent applications for designation or in submissions in the scope of practice review. Such practitioners include: counsellors, rehabilitation practitioners, prosthetists and orthotists, athletic trainers and recreation therapists.

In the Council's view, it is the identification of a disease, disorder or condition as the cause of signs or symptoms of the individual which should be a reserved act, and the process of assessment should continue to be in the public domain. Both regulated and unregulated practitioners would be free to perform assessments during the course of providing health care services, subject always to the proposed general risk of harm clause.

The College of Massage Therapists submits that communication should be added to this reserved act. However, the Council believes that the fundamental harm associated with the act of diagnosis resides in the act of diagnosis, not communicating a diagnosis.

The BC Nurses' Union submits that assessing a patient or client in order to make a diagnosis identifying a disease, disorder or condition as the cause of signs or symptoms determined during the assessment should be included as a reserved act. Thus, the Nurses' Union does not appear to dispute the Council's exclusion of assessment from the reserved acts list but suggests that a modified form of assessment, a nursing diagnosis, should be reserved to registered nurses.

In the Council's view, the reserved act proposed by the Nurses' Union would fall within the general reserved act of diagnosis as defined above. However at this stage in the process the Council is not determining which acts or aspects of the acts will be reserved for specific professions. That is an issue which will be considered in the profession specific reviews. Therefore, the Council defers consideration

of the Nurses' Union proposal.

2. Performing the following physically invasive or physically manipulative acts:

In considering the preamble, the College of Chiropractors submits that "physical manipulation" is in the public domain and including it in the preamble to this reserved act creates confusion. The Council disagrees. The wording of this act is clear; it is not intended to reserve all physically manipulative or physically invasive acts, and the Council does not believe any confusion would arise.

(a) procedures on tissue below the dermis, below the surface of a mucous membrane, in or below the surface of the cornea, in or below the surfaces of the teeth, including the scaling of teeth;

The College of Physical Therapists submits that the term "procedures on tissue below the dermis" requires further clarification, noting that there are modalities which affect tissues below the dermis but which do not require the penetration of the dermis. In the Council's view "procedures on tissue below the dermis" clearly includes only acts requiring a puncturing of the skin, and the type of acts described by the College of Physical Therapists would not fall within this reserved act.

(b) setting or casting a fracture of a bone or reducing a dislocation of a joint;

In reviewing information about the Alberta and Ontario models, the Council was persuaded of the general risk involved in setting or casting a fracture or reducing a dislocation of a joint. Clearly, professional expertise and training are required.

(c) movement of 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;

The Council received considerable information from the B.C. College of Chiropractors, the College of Physical Therapists of B.C. and various other respondents on the issue of chiropractic adjustment, spinal manipulation, mobilization and manual therapy. The above description of the reserved act represents what the Council believes, after a thorough review of the information provided by the professions as well as a review of relevant literature, to represent the most concise definition of the specific procedure which presents a significant risk of harm in this category.

(d) administering a substance by injection or inhalation;

The Council has determined that there are serious risks involved in the act of administering substances which do not qualify as drugs under Reserved Act 5, below, and that these activities should be restricted. The substances of concern include intravenous fluids, oxygen and gases which, if improperly administered, can cause extremely serious or life threatening complications.

The Pacific Coast Association of Aromatherapy submits that the use of essential oils should be included on the list of reserved acts. However, the Council has not been presented with information which sufficiently outlines the risk of harm associated with this practice, and does not believe it should be reserved.

The BC Nurses' Union submits that other forms of administration such as "irrigation, instillation, and via catheters or other instruments" should be included within this reserved act. In the Council's view, however, the risks associated with such procedures would fall within other reserved acts such as (e), below.

(e) putting an instrument, hand or finger(s),

- beyond the external ear canal,
- beyond the point in the nasal passages, where they normally narrow,
- beyond the pharynx,
- beyond the opening of the urethra,
- beyond the labia majora,
- beyond the anal verge, or
- into an artificial opening into the body.

The College of Physical Therapists, the College of Massage Therapists and the BC Nurses' Union all supported adding "hand or finger(s)" to this reserved act. The Nurses' Union provided specific examples of the harm that can arise from the use of hands or fingers in various circumstances, and the Council was persuaded that "hand or finger(s)" should be added to this reserved act.

3. Managing labour or delivery of a baby.

The management of labour or delivery is a distinct act which carries an independent risk of harm. In the Council's view, while the reserved acts of diagnosis and using instruments may be encompassed within this reserved act, the professional judgment and expertise involved in the management of labour or delivery carries an independent risk.

4. Applying or ordering the application of a hazardous form of energy including diagnostic ultrasound, electricity, magnetic resonance imaging, lithotripsy, laser and X-ray.

The Council decided that this act should be made non-exhaustive for the present time but should clearly indicate the types of energy that would fall within it. As the process proceeds, the list will be developed further. The Council recognizes that there may be other regulatory controls in place which affect this area. However, the Council's mandate is in respect of the health professions, and determining what tasks or services present such a significant risk of harm that they should be reserved to qualified health professionals. Therefore, in including this act on the list the Council has not taken into account the other regulatory controls which may affect delivery of these services.

The Council received several submissions requesting clarification of this reserved act, for example, from the College of Massage Therapists and the College of Physical Therapists. The Council's

intention is that this reserved act remain non-exhaustive for the present time, and that at the end of the profession specific review process a comprehensive list of hazardous energy will be established.

However, the Council believes that some clarification at this stage in the process would be useful. First, regarding ultrasound, the Council does not believe that therapeutic as opposed to diagnostic ultrasound should be reserved as it has not been provided with evidence of harm associated with the use of ultrasound other than evidence of risk to the fetus. The Council notes that its conclusion on this point is consistent with the positions developed in the provinces of Alberta and Ontario. Second, the term "electricity" is not intended to cover all electrical energy but only more hazardous forms of electrical therapy such as electroconvulsive therapy, cardiac pacemaker therapy, cardioversion, defibrillation, fulguration and electrocoagulation. The comprehensive list of hazardous forms of energy will likely include such therapies, and it will be unnecessary to include the term electricity in the final version of this act.

5. Prescribing, compounding, dispensing or administering by any means a drug listed in Schedule I or II of the Pharmacists, Pharmacy Operations and Drug Scheduling Act.

For the purposes of this reserved act, the following definitions shall apply:

"prescribing": the ordering of a drug.

"compounding": mixing ingredients, at least one of which is a drug.

"dispensing": preparing or filling a prescription for drugs

The original version of this act included only the term "drug". The BC Dieticians' and Nutritionists' Association submits that the act should state "Prescribing, compounding or dispensing a drug, **food or nutrient** restricted under provincial or federal legislation. The Council accepts that there may be a risk of harm associated with such other substances but at the present time believes that the present federal and provincial regulatory system are sufficient to address the risks associated with such substances.

At this time this reserved act includes only substances which require a prescription (Schedule I to the provincial Pharmacists Act and substances which are sold "behind the counter" (non-prescription but must be sold from restricted area of pharmacy). This is essentially the way Ontario and Alberta defined this act.

6. Prescribing appliances or devices for vision, hearing or dental conditions; dispensing such prescribed appliance or device for dental conditions; fitting such prescribed appliances or devices for dental conditions, or fitting contact lenses.

The special training and skill involved in prescribing the devices described above is well documented in the submissions received to date. The risks associated with fitting contact lenses and dental appliances relate to the close contact with the skin, oral structures, mucous membranes or corneal surfaces involved in such fitting. The filling of a prescription for an appliance for dental problems requires special knowledge and skill regarding materials suitable for sustained use within the oral cavity including knowledge about contraindications, allergic responses and hazardous substances. All of these activities present significant risks of harm in the delivery of health care to individuals.

Several respondents, including the College of Opticians, the Vision Council of Canada, the Dispensing Opticians Association of BC, and the [Opticians Association of Canada](#), submit that dispensing eyeglasses should be a reserved act. The Council is not satisfied that there is a sufficient risk of harm in the dispensing of eyeglasses to justify including it on the list of reserved acts.

Finally, the Council notes that the issue of dispensing hearing aids is under consideration by the application panel.

7. Allergy challenge testing in which a positive result of the test is a significant allergic response; or allergy desensitizing treatment in which there is a risk of significant allergic response.

The risk of harm in this reserved act is serious and can be life threatening. It should be carried out in a controlled setting by a health professional who is competent to perform such testing, and treat an allergic response.

2. SUPERVISED ACTS

The [Criteria and Guidelines](#) which are attached to the [Terms of Reference](#) state that although reserved acts may only be performed by certain professions, it may be appropriate for other persons to perform them, or aspects of them, under the supervision of members of those professions. The [Terms of Reference](#) also indicate that where the Council is satisfied that a reserved act may be performed under supervision, it may recommend training and qualification requirements, limitations regarding where the act may be performed and the degree of supervision which should be exercised.

The Council believes that some clarification of terms would be useful as the [Terms of Reference](#) do not define "supervision". In reviewing the responses to the scope of practice submissions, most professions have used the terms delegation and supervision interchangeably. However, technically, there appears to be a distinction between the terms.

In his book "A Complete Guide to the Regulated Health Professions Act" (Canada Law Book, 1995), Richard Steinecke discusses the meaning of these terms. Delegation occurs when the delegating professional makes a determination that an individual is competent to perform a task and that individual then carries out the task without the delegating professional being present. Supervision, on the other hand, implies a more intense control over the act than does delegation and will usually require the supervisor's physical presence.

In the Council's view, although this term of reference refers to "supervised" acts, it is intended to encompass any situation where someone other than the person to whom the reserved act has been granted performs that act. In other words, this term of reference refers to both delegation and supervision.

This term of reference implies that the Council will, for each reserved act granted to each profession, determine the circumstances in which the act may be performed by someone other than a member of that profession. Several respondents to the scope of practice consultation stated that the issue of delegation and supervision is a question of individual competence and the circumstances of each case, and that supervision of certain acts can be addressed only after a careful review of all the circumstances surrounding a particular act and by imposing, where necessary, clear guidelines, restrictions or conditions on such supervision.

These respondents further submit that compiling a list of acts which may be delegated or performed under supervision would not adequately address the complexities of situations which present to health professionals nor would it protect the public. The College of Physicians and Surgeons in its scope of practice submission states that there will be situations where, because of the individuals involved, the site or location, or the specific nature of the presenting problem, it may not be appropriate to delegate an act which might otherwise be capable of delegation.

The Council accepts much of this submission, and believes that it would be better to take a general approach to the issue of supervision. The general thrust of the approach is that the decision as to whether an act can be performed under supervision should be left up to the health professions, in accordance with a general set of principles. The Council believes that the general principles regarding delegation be enacted into legislation when the shared scope of practice model takes effect. The principles are derived largely from the [Canadian Medical Association's Guidelines for the Delegation of a Medical Act](#) which the College of Physicians and Surgeons enclosed with its submission.

Therefore instead of dealing with supervised acts individually for each profession, the Council makes the following general recommendation:

The Council recommends that a provision be enacted which deals with general principles regarding delegation of reserved acts. The provision would apply generally, not to individual cases. It should require the following:

- The assigning health professional's governing body must provide assent to the proposed reserved act being performed by someone else;
- The reserved act to be assigned as well as the level of supervision must be clearly defined and circumscribed by the assigning health professional's governing body;
- Where the person to whom the act will be assigned is a member of a self-regulated health profession, his or her governing body must approve of the assignment.
- The instruction to perform the act must be made in writing either by way of a general written protocol or through a case-specific instruction;
- The assigning health professional must be satisfied that the individual who will be performing the act has the necessary skills and training to perform the act safely;
- The assigning health professional must ensure that the person who will be performing the act accepts the assignment.

There are ethical and legal issues involved in assigning reserved acts which will have to be addressed by all parties.

Some respondents to the consultation, for example the College of Massage Therapists, stated that they believed the Council's proposal would require a College to approve delegations on a case-by-case basis. That is not the Council's intention. As noted, the requirement for approval of the governing body is meant to apply generally and not to individual cases, and would be satisfied by, for example, a general protocol in respect of

delegation of a given act.

Several respondents to the consultation, for example, the Opticians' Association of Canada, submitted that some form of ongoing regulation in this area is necessary. Some of the suggested mechanisms were imposing a bylaw requirement or scrutiny by an independent body. The Council sees some merit to this proposal but is not prepared at this point to suggest that delegation protocols be contained in the rules or bylaws of the professions or that an independent body be given approval powers over such matters. The Council will review this matter further, and consider including such a recommendation in its final report.

The Council believes this general approach to supervised acts more accurately reflects the reality that procedures to be delegated vary from profession to profession and may include subsets and variations of reserved acts and further, may be performed under myriad circumstances and conditions.

Finally, the Council emphasizes that the issue of supervised or delegated acts arises only with respect to reserved acts. Thus, the general provision regarding supervision will not apply in respect of acts which are not reserved.

3. OTHER ISSUES

As noted, scope of practice statements and reserved acts are important elements of the new regulatory model. The Council believes, however, that the [Terms of Reference](#) do not contemplate all of the components or ramifications of the new regulatory model and that some important issues will need to be addressed in more detail prior to implementation of the new regulatory model. In this regard, the Council intends to include in its final report to the Minister recommendations regarding various issues, including the following:

(a) Health Care Services

It is important to clarify that the shared scope of practice model applies only to services being performed in the course of providing health care services. Thus, to the extent that reserved acts are performed in fields unrelated to health care, the model would not apply. The Council notes that in Ontario the general prohibition against performing a "controlled act" states that "No person shall perform a controlled act set out in subsection (2) in the course of providing health care services to an individual".

A similar issue was dealt with in a recent decision of the Supreme Court of British Columbia in which Mr. Justice Braidwood, in considering whether the Massage Practitioners Regulation had been violated, distinguished between therapeutic massage services and massage services that were not rendered in the course of delivering health care services. (see *College of Massage Therapists of British Columbia v. British Columbia Telephone Company*).

The College of Physical Therapists and the College of Massage Therapists questioned how the distinction between health care and non-health care services would be made. The shared scope of practice model is intended to regulate health care services and not for example, cosmetic services or tattoo artistry. Other regulatory mechanisms such as public health legislation are in place to address the risks associated with such activities.

The Council believes that the definition of "health profession" in section 1 of the HPA provides guidance in regard to the distinction between health care and non-health care services. That definition states:

"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

In other words "health care service" may be defined as:

exercising skill or judgment or providing 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.

In the Council's view, persons providing such services cannot perform reserved acts unless they are granted them under legislation.

(b) Significance of Reserved Acts

It is important to understand the significance of an act being reserved in the provision of health care services. Once an act is reserved in the provision of health care services, it may only be performed by members of a regulated health profession who are authorized to perform that act under their professional legislation. In contrast, if an act is not reserved, it may be performed by regulated or unregulated practitioners.

(c) General Risk of Harm

Third, there should be a general risk of harm clause, which provides:

No one, other than a qualified health professional acting within the scope of practice of his/her profession, shall deliver health services in circumstances in which it is reasonably foreseeable that serious harm may result from the delivery or omission of such services.

This clause protects patients from (a) regulated professionals who do something harmful that is outside their scope of practice, and (b) unregulated practitioners who cause patients serious harm in the course of providing health care services. The Seaton Commission recommended the adoption of just such a clause at page D-33 of its report, "Closer to Home".

(d) Exemptions

The Council believes there should be a general list of exemptions from the shared scope of practice model. For example, in Ontario the following are exempted - either partially or totally - from the controlled acts model: administering first aid and temporary assistance in an emergency; students acting under the supervision or control of a member of the relevant profession; treating a person by prayer or spiritual means; treating members of one's own household; and assisting a person with routine activities of living (this is intended for, among other things, school settings or extended care facilities for disabled persons).

The Registered Nurses' Association submits that such exemptions would undermine the shared scope of practice model. However, the Council believes that the exemptions simply recognize the reality that in certain cases reserved acts will be performed by non-health care professionals. For example, parents in some cases will administer injections to their children.

The BC Nurses' Union suggests that the exception regarding treating members of one's own household should be modified by adding a requirement for teaching and support from a health professional. The Council believes such a requirement to be far too onerous given the scope of this exemption. While the Nurses' Union proposal would mean, for example, that a parent would have to seek advice prior to administering insulin to a diabetic child, in the Council's view, persons will seek and obtain the appropriate training and advice, where necessary, without making such a requirement mandatory.

The College of Physical Therapists indicated its concern with the exception for treating members of one's own household by stating that it strongly discourages its members from treating family members. The Council emphasizes that this exception is not intended to sanction health professionals treating members of their own family. That is an issue which the Council expects will be dealt with by each profession through its standards of practice and codes of ethics. The purpose of this exception is simply to prevent the prosecution of non-health care professionals performing reserved acts in a family context.

Finally, in carrying out its initial mandate under the *Health Professions Act* of considering applications for designation from new and emerging professions, the Council made several recommendations to the Minister about acts which should be reserved to the applicant professions. Those recommendations were made prior to the issuance of the *Terms of Reference* which described in more detail the nature of the reserved acts model of regulation. The Council believes it may be necessary to review all previously granted reserved acts to ensure consistency with the recommendations which arise from the scope of practice review process, and expect that this issue will be addressed once the present review process has been completed.

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Health Professions Council Chiropractors Scope of Practice Preliminary Report

Irvine E. Epstein, Q.C., Chair
Arminée Kazanjian, Member
David MacAulay, Member

1999

This Preliminary Report should be read in conjunction with the [Post-Hearing Update](#) for the profession.

FOREWORD

This report is the result of the Health Professions Council's review of the scope of practice of chiropractic pursuant to the [Terms of Reference](#) from the Minister of Health and Minister Responsible for Seniors. Under the [Health Professions Act](#), the Health Professions Council is a six person advisory body appointed by the Government of British Columbia to make recommendations to the Minister of Health and Minister Responsible for Seniors about the regulation of health professions.

In this report the Health Professions Council examines how the existing scope of practice of chiropractic should be legislatively defined in order to reflect fairly and accurately the current state of practice and the public interest in the practice of chiropractic.

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EXECUTIVE SUMMARY

The Health Professions Council has conducted a review of the scope of practice of chiropractic.

The purpose of the review is to provide recommendations to the Minister of Health and Minister Responsible for Seniors regarding four matters: scope of practice statements, reserved acts, supervised acts, and reserved titles.

The Health Professions Council has conducted a detailed consultation process and its recommendations regarding the four elements of the scope review are as follows:

1. The Council recommends the following scope of practice statement for members of the College of Chiropractors:

Chiropractic is concerned with those aspects of the restoration and maintenance of human health which relate to assessment of the spine or other joints of the human body and the associated soft tissue or nervous system and the treatment of nervous, muscular and skeletal disorders through manipulation and adjustment by hand or devices directly related to the adjustment.

2. The Council recommends the following reserved acts for members of the College of Chiropractors:

(a) Making a diagnosis identifying as the cause of signs or symptoms of the individual, a disease, disorder or condition of the spine or other joints of the human body and their effects on associated soft tissue or nervous system.

(b) Performing the following physically invasive or physically manipulative acts:

movement of 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) Ordering or applying a hazardous form of energy: x-ray for diagnostic purposes.

3. The Council recommends the following titles be reserved for members of the College of Chiropractors: "Chiropractor" and "Doctor (Dr.)" when accompanied by the affix "chiropractor" or "chiropractic".

4. In addition the Council recommends that:

- a health care provider or institution be required to provide a copy of an x-ray at cost to a patient on request.

- members of the College of Chiropractors be granted a limited range of laboratory testing based upon satisfying the following criteria:

- the range of laboratory testing granted is based upon the scope of practice of members of the College of Chiropractors;
- the College demonstrates a relationship between the laboratory testing requested and their diagnosis;
- reasonable access to the laboratory testing required is not available from other sources; and
- the College provides further information concerning the experience, education and training in use of laboratory testing which members of the College currently possess.

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I. INTRODUCTION

A. NATURE OF THE REVIEW

This is the preliminary report of the review of the scope of practice of chiropractic by the Health Professions Council (the Council).

The review was conducted pursuant to the [Terms of Reference](#) issued in July, 1993 by the Minister of Health in accordance with section 24, now section 25 of the [Health Professions Act](#) (the HPA).¹ The [Terms of Reference](#) direct the Council to review the scopes of practice of the recognized health professions, of which chiropractic is one.

The [Terms of Reference](#), which are included as [Appendix A](#) to this report, indicate that there are four main elements to the scope of practice review:

- I. scope of practice statements which describe what the profession does, the methods it uses and the purpose for which it does it;
- II. reserved acts which are those acts that present such a significant risk of harm that they should be performed only by professionals who are qualified to perform them;
- III. supervised acts which are reserved acts, or aspects of reserved acts, which may be performed by persons supervised by practitioners; and
- IV. reserved titles which are titles that describe a profession's services and which are reserved exclusively for the health profession.

NOTE 1: During the early drafting of this Report statute references were based on RSBC 1979 and Amendments. The College of Chiropractors' brief was also based on RSBC 1979. For ease of reference, the current provisions are indicated in brackets next to old citations. The current versions refer to the [Health Professions Act](#), RSBC 1996, Chapter 193 and the [Chiropractors Act](#), RSBC 1996, Chapter 48.

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B. PROCESS FOR THE REVIEW

The general process for the review provides for an initial meeting with the profession, submission of briefs by the regulatory body and professional association for each profession, a consultation process involving all health professions and interested parties regarding each professions' submission, a draft preliminary report, public hearings and a final report.

The Council met with representatives of the British Columbia College of Chiropractors (the College) in December, 1994. The British Columbia Chiropractic Association (the Association) was also in attendance. In

September 1995, the College submitted a scope of practice brief in conjunction with the Association. Also in September a second meeting was held with representatives of the College and the Association to discuss issues with the Council prior to initiating the consultation process. The brief was then summarized and distributed to interested groups and individuals including other regulated and unregulated health professions, teaching facilities and other provinces. Many responses were received and the Council has carefully considered them in drafting this preliminary report.

Respondents to this consultation process focused on a number of issues which the Council felt warranted further investigation. In October, 1996, the Council wrote to the College to clarify concerns regarding issues raised by respondents to the consultation process and the College provided a written response. The response of the College has given the Council sufficient information to proceed with the preliminary report. The following report analyzes information obtained during the general consultation process as well as information received in response to the Council's follow-up inquiries.

This report will be circulated to all health professions and other interested parties who participated in the Council's consultation process.

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C. REGULATION OF CHIROPRACTIC

Chiropractic has been a regulated profession in British Columbia since 1934 with the enactment of the Chiropractic Act, SBC 1934, c.12. In that year, the Chiropractors' Association of B.C. was established which was renamed the British Columbia Chiropractic Association in 1970. In 1989, the British Columbia Chiropractic Association was renamed the British Columbia College of Chiropractors. Since 1934, numerous amendments have been made to the statute, including in 1984 the regulation of the use of the title "doctor" by chiropractors, the repeal of a provision in 1987 which authorized a nurse to practise chiropractic, the alteration of the definition of chiropractic in 1990 to include the use of devices directly related to the articulations of the human body, and most recently in 1993 pursuant to the Health Professions Statutes Amendment Act, 1993, c.50. The 1993 amendments included the present duties and objects clause, enhanced the College's inspection powers, and gave it interim suspension powers in professional disciplinary matters.

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II. POLICY BACKGROUND

The main impetus for a scope of practice review was the Report of the British Columbia Royal Commission on Health Care and Costs (the Seaton Commission). The Seaton Commission stated that the existing legislation governing the health professions creates persistent jurisdictional disputes and a distinct lack of cooperation among the health professions, despite the fact that all health professional colleges have the same mandate - to protect the public from preventable harm.

The Seaton Commission stated that the primary reason for the jurisdictional disputes was the present regulatory system's reliance on exclusive scopes of practice. Under the exclusive scope of practice model, the various health professions have been granted an exclusive right to practice within a legislatively defined scope of

practice. No one, other than a member in good standing of that profession, can perform acts within the profession's scope of practice unless they are granted an exemption.

The Commission concluded:

...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.

(Closer to Home, The Report of the Royal Commission on Health Care and Costs in British Columbia, Volume 2, 1991, p. D-33)

This recommendation is also consistent with legislative initiatives underway in Alberta. The Seaton Commission was not the first review body to suggest that the present legislative model of exclusive scopes of practice was inappropriate. Restricting professional monopolies (exclusive scopes of practice) was also recommended in an earlier study commissioned by the British Columbia Minister of Health. In discussing the conflicts which may arise between the professional college and the public interest, the issue of exclusive scopes of practice was raised:

It must be emphasized that any professional legislation which unduly restricts the scope of practice of skilled personnel may be contrary to the public interest in greater supply and accessibility of service through the development of team practice. Therefore, it is urged that: Professional legislation should not contain narrow restrictions or rigid definitions of scope of practice which are excessively exclusive; that measures should be taken (as indicated below) to reduce the area of inter-professional strain and conflict; and that no prosecutions for violations of scope of practice legislation should be undertaken without the prior consent of the appropriate public authority.

Insofar as may be possible with due regard for public safety, professional law should not place rigid restrictions on the scope of practice of allied health personnel, and greater flexibility should be encouraged in the allocation of roles between the health disciplines.

(Professor J.T. McLeod, "Public Regulation of the Professions" in Health Security for British Columbians, Special Report: Consumer Participation, Regulation of the Professions, and Decentralization (1974), the report of Richard D. Foulkes, B.A., M.D., F.A.P.H.A. to the Minister of Health, Province of British Columbia, Tome Three, p. 145)

Thus, the trend in regulatory policy for the health professions has been toward reducing exclusivity in order to enhance interdisciplinary practice, improve accessibility to health care services and increase consumer choice, while at the same time maintaining the fundamental objective of protecting the public.

These policy trends are clearly reflected in the [Terms of Reference](#) for the scope of practice review which provide the basis for a new regulatory framework for health professions in British Columbia. The core elements of the new framework are scope of practice statements and reserved acts .

Under the present system, scope of practice statements are exclusive. In the new system, scope statements will not be exclusive but professions may be granted reserved acts.

Reserved acts are those elements of a profession's scope of practice which present such a significant risk of harm that they should be reserved to a particular profession, or shared amongst particular professions. Thus, unlike the present system in which each profession is granted exclusivity within its entire defined scope of practice (subject to specified exceptions), only those acts which present a significant risk of harm will be reserved.

In short, the government has assigned the Council the task of creating a regulatory model based on broad, non-exclusive scope of practice statements and narrowly defined reserved acts.

The government has the responsibility to ensure that those services which are accessible are safe and that the regulatory framework for the practice of health professions protects the public from incompetent, impaired, or unethical practitioners. At the same time, the regulatory framework should not entrench a paternalistic function for professions or reserve exclusive areas of practice simply to enhance professional status and control.

The new system of overlapping scopes of practice and narrow reserved acts removes barriers to interdisciplinary practice and offers greater choice and accessibility to the public. The public interest is served by professional legislation which promotes quality in the delivery of health care services within safe parameters. Indeed, the Council's primary policy objective in conducting its review is achieving the optimum balance between safe practice and consumer choice.

With this in mind, the Council proposes to consider the chiropractic profession having regard to the four elements of the scope review.

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III. DISCUSSION OF ISSUES

The main issues raised by this review are the four elements listed above: scope of practice, reserved acts, supervised acts and reserved titles.

A. SCOPE OF PRACTICE STATEMENT

The scope statement describes what the profession does, the methods it uses, and the purpose for which it does it. Unlike the present legislative scheme, the statement itself does not grant an exclusive scope of practice. Nonetheless, the statement is important because: 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; and it informs the public about the services practitioners are qualified to perform. It is expected that the Council's recommendations will increase overlapping scopes of practice.

The Council believes that it is not necessary or useful to itemize every facet of a profession's scope of practice. Rather, a scope of practice definition should be sufficiently descriptive so that other health professions and members of the public alike can understand what the particular health professional does.

The current scope of chiropractic is defined by sections 1 [1] and 21 [9] of the [Chiropractors Act](#) (the CA), R.S.B.C. 1996, c.48:

1 In this Act ...

"chiropractic" means the branch of the healing arts that

(a) is concerned with the restoration and maintenance of health through adjustment by hand, or the use of devices directly related to the adjustment, of the articulations of the human body, and

(b) is involved primarily with the relationship of the spinal column to the nervous system;

"chiropractor" means a person whose method of treatment of the human body for disease and the causes of disease is confined solely to chiropractic.

21 (1) Subject to subsection (2), a person registered as a chiropractor under this Act must not engage in the practice of the diagnosis or treatment of the human body for disease, or the causes of disease, otherwise than as a chiropractor, unless the person

(a) first applies to have his or her name stricken from the register of members of the college, and

(b) discontinues the use of the name "chiropractor", whether by way of advertisement or in any other manner that might signify that he or she was practising as a chiropractor within the meaning of this Act.

(2) A person registered as a chiropractor under this Act may in connection with his or her practice

(a) use x-ray shadow photographs of the articulations of the human body, and

(b) if the person first applies for and obtains from the board a certificate of competency under the rules, use x-rays for the purpose only of producing shadow photographs of the articulations of the human body.

(3) A person who contravenes this section commits an offence.

The College has proposed several changes to the scope of chiropractic. They were outlined in its brief as the following:

1. The definition of "chiropractor" should be repealed. Now that "member" is defined in the [Health Professions Act](#), it is duplicative to define "chiropractor" as well.

With regard to this first point, the Council notes that the chiropractic profession is currently regulated under the CA and is not subject to the provisions of the HPA. Should the result of the Council's legislative review be a recommendation that the chiropractic profession be governed by the HPA, it may be necessary to reconsider this request at that time.

2. The current definition of chiropractic should be repealed and substituted with the following:

"chiropractic" is concerned with the restoration and maintenance of human health through the assessment and treatment of the spine, other joints of the human body, and the associated soft tissue and is involved primarily with the relationship of the spinal column to the nervous system.

3. The following new definition should be added to Section 1:

"adjustment" is a movement of the joints of the spine beyond their physiological but within their normal anatomical range of motion using a high velocity, low amplitude thrust.

4. Section 9 should be repealed and substituted with the following:

9.(1) A member may:

(a) communicate a diagnosis;

(b) offer advice on the maintenance of health;

(c) perform an adjustment by hand of the joints of the spine;

(d) use devices and therapies approved by the board to assist in the preparation for, maintenance and delivery of the adjustment;

(e) manipulate the other joints of the human body and associated soft tissues;

(f) use x-rays of the spine and other joints of the human body; and

(g) use other diagnostic imaging and laboratory testing procedures and for this purpose may refer patients to certified specialists, public or private health facilities or laboratories.

9(2) A member may not engage in the diagnosis and treatment of the human body otherwise than as specified in this Act unless he first applies to have his name stricken from the register of members of the college and discontinues the use of the name "chiropractor", whether by way of advertisement or in any other manner which might signify that he was practising as a chiropractor within the meaning of this Act.

9(3) No person other than a member may perform an adjustment of the joints of the spine for the purpose of the restoration or maintenance of human health.

9(4) Every person who contravenes this section commits an offense against this Act.

With regard to proposed s.9(2) and s.9(4), the Council will likely be considering these sections in its legislative review process in which the Council has the mandate to address barriers to interdisciplinary practice. No further

comment will be made in this report.

The Council's [Shared Scope of Practice Model Working Paper](#) was released in January 1998. Because several of the College's requests for specific acts contained in proposed s. 9 are included in the [Shared Scope of Practice Model Working Paper](#), they will be dealt with in section B of this report "Reserved Acts". These include diagnosis, movement of the joints of the spine beyond their physiological but within their normal anatomical range of motion using a high velocity, low amplitude thrust (spinal adjustment) and ordering or applying a hazardous form of energy (use of x-rays and other diagnostic imaging).

The current definition of chiropractic contained in the CA s.1 is:

that branch of the healing arts that is concerned with the restoration and maintenance of health through adjustment by hand, or the use of devices directly related to the adjustment , (emphasis added) of the articulations of the human body and that is involved primarily with the relationship of the spinal column to the nervous system.

The College has submitted its proposed scope of practice in a series of elements in proposed ss.9 and 2, including a new definition of chiropractic, rather than proposing a distinct scope of practice statement. Because these proposed changes were made in a format that was obviously intended to fit within the current CA, they presented some difficulty during the consultation process and may have been interpreted differently by different respondents.

Several respondents to the consultation commented that the College's originally proposed scope of practice was too broadly stated. The BC Medical Association (the BCMA) said that the scope was "wide ranging". The BC Health Association and the Insurance Corporation of BC (ICBC) suggested that diagnosis, diagnostic testing and advice on the maintenance of health which chiropractors provide should be restricted to "chiropractic" diagnosis and advice. The Registered Nurses Association of BC (the RNABC) commented that chiropractic advice on the maintenance of health combined with the use of other diagnostic imaging and laboratory procedures may be interpreted to mean that chiropractic practice includes ordering and interpreting any tests. It suggests that tests should be those which are related to manipulation and adjustment of the spine and joints. The College of Physicians and Surgeons of B.C. (the CPSBC) states that:

by dropping "through adjustment by hand or the use of devices directly related to the adjustment", the door would be opened for chiropractors to employ other treatments. We strongly believe that would not serve the best interests of the public. It can also be argued that retaining the words quoted would continue to inform the public of the fundamental core of chiropractic treatment, which seems to be so strongly argued for elsewhere in the submission.

The Council has noted the concerns of respondents regarding the possibility that the College's proposed definition of chiropractic might not accurately reflect current practice, nor would it be in the public interest, if references to methodology were removed from the scope of practice statement. The Council felt it was important to include methodology in light of the College's submission at page 12 of its brief that "...clinical practice rests almost entirely on the delivery of adjustment techniques and procedures..."

1. Treatment of Organic Disorders

An important issue which arose during the scope of practice consultation process is the extent to which chiropractors can treat organic disorders, as distinct from treatment of musculoskeletal disorders, and whether it is in the public interest that they be allowed to do so.

The current scope of practice contained in the CA does not restrict chiropractic to treatment of disorders of the musculoskeletal system. By implication, this would allow the treatment of organic disorders. According to the [Terms of Reference](#), the Council must consider whether this scope of practice both reflects current practice and is in the public interest.

During the consultation process, the Council received information that the treatment of organic disorders by means of spinal adjustment is currently practiced by some chiropractors in B.C. It appears that there is controversy within the profession itself with regard to the use of spinal adjustment for organic disorders. (see submission #35, appendix IV: Orthopactic Manipulation Society of North America.) The Council was unable to determine how widespread this practice is among chiropractors.

The Seaton Commission commented on the use of chiropractic for treatment of organic disorders in Closer to Home: The Report of the British Columbia Royal Commission on Health Care and Costs at page D-20:

While we recognize there is a role for chiropractors, some of the submissions they made to us suggested they could treat a wide range of illnesses including measles and leprosy. We reject this. In making the recommendation that they be permitted to treat their patients in institutions, we specifically charge the B.C. College of Chiropractors with the responsibility to make certain that inappropriate treatment does not occur, and suggest that the Ministry of Health keep a wary eye on the use of chiropractors in such circumstances.

The Workers' Compensation Board (WCB) commented that chiropractic spinal manipulation has been demonstrated to be an effective and possibly superior mode of treatment for some "musculoskeletal disorders", however it has not been demonstrated to be an effective way of treating "organic disorders". The WCB further submits that under the proposed scope, chiropractors would be entitled to diagnose and treat not only musculoskeletal conditions of the spine but also pathology in all tissues, organs and systems supplied by spinal nerves. For this reason, the WCB submits that the scope of chiropractic practice should be confined to treatment of musculoskeletal disorders stating that "*the new definition of chiropractic should be consistent with scientific evidence.*"

The Council received several submissions in support of this view. In effect, these respondents suggested that the legislative scope of practice for chiropractors be narrowed.

The Council takes note of the concerns expressed in the Seaton Commission Report and the WCB submission. Similar submissions were made by the CPSBC, the BCMA, the RNABC, ICBC and various others. The concerns were expressed in a variety of ways and several solutions proposed which ranged from confining diagnosis and testing to "*a chiropractic scope of practice*" to limiting the scope to treatment of musculoskeletal conditions with the exclusion of organic conditions.

In response to these concerns, the Council met with the College on June 17, 1998. During that meeting representatives of the College clearly stated that diagnosis and treatment of organic disorders is not part of chiropractic practice in British Columbia.

The College delivered to the Council a copy of the Clinical Guidelines for Chiropractic Practice in Canada published by the Canadian Chiropractic Association. The guidelines confirm that the vast majority of chiropractic treatment is for "neuromusculoskeletal disorders" defined at page 105 as:

conditions which display symptoms and/or signs related to two or more of the nervous, muscular and skeletal body systems. Such conditions may be contrasted with those which produce advanced pathologic states (e.g. neurofibromatosis). Neuromusculoskeletal conditions are sometimes referred to as "type M disorders," and distinguished from "type O disorders," which refer to internal organ disorders.

These guidelines are voluntary as noted in the general disclaimer, however the Council was assured by the College representatives that the treatment of organic disorders is not accepted practice in British Columbia.

The Council is satisfied that the College will fulfil its duty under s.3 [3] of the CA. In so doing, the College must make certain that inappropriate treatment does not occur. The Council relies on the College to be diligent in its duty to regulate the practice of chiropractic in the public interest. The Council notes the College's submission at page 12 and 13 of its brief which states:

The profession has a history of self-regulation characterized by its commitment to self-evaluation and change. This is buttressed by the ongoing review and development of a professional code of conduct, which includes clinical guidelines. Practicing chiropractors are required to fulfil continuing education requirements to maintain licensure as prescribed by the College. The delivery of spinal adjustment as treatment in human health is professionally and educationally monitored and updated with new knowledge, thereby ensuring the continuing protection of the public.

The Council determined that the College's suggested new definition of chiropractic should form the basis of a scope of practice statement and be modified to retain the phrase "*through adjustment by hand or devices directly related to the adjustment*". The phrase describes the distinctive methodology used in the practice of chiropractic.

The Council recommends the following scope of practice statement for members of the College of Chiropractors:

Chiropractic is concerned with those aspects of the restoration and maintenance of human health which relate to assessment of the spine or other joints of the human body and the associated soft tissue or nervous system and the treatment of nervous, muscular and skeletal disorders through manipulation and adjustment by hand or devices directly related to the adjustment.

The Council prefers this scope statement because it contains a description of intent as well as the general methodology, including the specific technique, adjustment, with which chiropractic is associated. As well, it recognizes the limitation of treatment to non-organic disease conditions.

The proposed scope statement is consistent with the intent of the scope review. It represents a concise description of services performed which accurately and fairly reflects the current state of chiropractic practice. It

describes what the profession does, the methods the profession uses, and the purpose for which the profession performs its functions.

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B. RESERVED ACTS

The rationale underlying the granting of reserved acts is to protect the public by limiting provision of those particularly dangerous acts to members of specific professions who are qualified to perform them. Only those acts which present a significant risk of harm will be reserved. The Council developed a list of reserved acts, and included it in its recently issued report, the [Shared Scope of Practice Model Working Paper](#).

Currently, the entire scope of chiropractic practice is reserved for chiropractors by s.30 [11] of the CA.

The [Terms of Reference](#) clearly state that the rationale underlying the granting of reserved acts is to protect the public by restricting performance of acts which present a significant risk of harm to members of specific professions who are qualified to perform them.

The Council wishes to emphasize that its recommendations will likely provide for the sharing of many of the reserved acts. Thus, in conducting its review of the scope of practice of chiropractic, the Council is not necessarily deciding which acts should be reserved exclusively to chiropractors. It is possible and indeed likely that several of the acts reserved to chiropractors will also be reserved to other professions. Each profession has been given the opportunity to describe which acts it is qualified to perform in the course of the Council's review of its scope of practice.

The Council has developed [a list of reserved acts](#) included in its [Shared Scope of Practice Model Working Paper](#). The [Shared Scope of Practice Model Working Paper](#) was, in large part, a result of the Council's review of information provided by the various professions during the scope of practice consultation process. The Council understands that each profession's scope of practice brief was formulated without the benefit of a proposed reserved acts list and has considered this when reviewing proposals submitted in the profession's original brief. The Council's list of Reserved Acts is included as Appendix B.

In its 1995 brief, the College initially requested only one reserved act, spinal adjustment. A review of its proposal and subsequent correspondence in October 1996 and February 1998 indicates it is requesting that chiropractors be granted the following reserved acts which are similar to [reserved acts](#) which appear in the Council's [Shared Scope of Practice Model Working Paper](#).

- spinal adjustment
- communicate a diagnosis
- ordering and application of hazardous forms of energy, including diagnostic ultrasound, electricity, magnetic resonance imaging, laser and x-ray
- putting an instrument, hand or finger(s) beyond the anal verge.

The College has also requested the use of laboratory testing procedures and CT scanning, which will be dealt with separately, as they are currently not listed as reserved acts.

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1. Spinal Adjustment

The College submits that it is in the public interest to make spinal adjustment a reserved act. The College recognizes in its brief that spinal adjustment is an act which carries a significant risk of harm.

In its proposed changes to ss. 1 [1] and 21 [9] of the CA the College has requested that chiropractors be granted the act of "*perform[ing] an adjustment by hand of the joints of the spine*". The College has also requested that "*adjustment*" be defined as "*a movement of the joints of the spine beyond their physiological but within their normal anatomical range of motion using a high velocity, low amplitude thrust*".

The Council noted the comments made by respondents concerning the wording of this proposed reserved act, referring to the definition of adjustment. The CPSBC commented that,

" . . . we are not sure of its exact meaning. We think it might mean a movement of the joints of the spine beyond the limits of what the body can voluntarily achieve by itself but falling short of disrupting the existing anatomy . . . we doubt whether the stated definition would be plainer to members of the public."

The College of Physical Therapists of BC (the CPTBC) made extensive comments and provided several definitions of manipulation which it defines as

high velocity low amplitude thrust at the limit of available motion, in the presence of a suitable end feel, not to exceed the anatomical range to: restore motion, alter the position of inter articular fragments or reduce muscle spasm.

The CPTBC also provided a summary of definitions of manipulation or adjustment in a brief but significant literature review which indicates there has been considerable difference of opinion amongst the professions regarding the definition of manipulation.

The College's proposed definition is similar to the Council's Reserved Act #2(c). After further consultation with other provinces which have included some variation of this act in their system, the Council has modified this reserved act to read: "*Movement of 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*". The Council believes this definition will be more understandable to members of the public and encompasses all of the significant features of the proposed definition.

The Council recommends that the following Reserved Act be granted to members of the College of Chiropractors:

Movement of 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.

In light of the Council's description of Reserved Act #2(c) it is unnecessary to define "adjustment".

The College has also requested that no person other than a member of the College be allowed to perform an "adjustment", as it has defined that term. At this point in its review, the Council is considering which acts on its general [list of reserved acts](#) should be granted to each profession and is not prepared to state that any acts should be reserved exclusively to one profession. When the Council completes its review of the other health professions some reserved acts may be reserved to chiropractors alone and some may be shared with other health professions.

2. Diagnosis

The College proposes that "*communicate a diagnosis*" be included in its scope of practice. The Council's Reserved Act #1 is "*making a diagnosis identifying a disease, disorder or condition as the cause of signs or symptoms of the individual*". The Council does not consider "communicate" to be part of the reserved act. However, it is clear that the College is requesting the reserved act, "*making a diagnosis...*".

In the College's "Reply to Submissions" of May, 1996, the College describes its rationale for including diagnosis in the scope of practice section. The College submits that diagnosis in its unrestricted form already exists in the chiropractic scope of practice. The current CA, s.10(3) [7(2)], requires all chiropractors to be trained in "diagnosis and symptomatology". The College notes:

This requirement is not new nor is it limited or modified. Training in diagnosis is an extensive part of a chiropractor's core education. The public interest in minimizing the risk of harm demands that chiropractors engage in the diagnostic process before recommending and commencing chiropractic treatment...Diagnosis in an unrestricted form already exists within the chiropractic scope of practice.

In its letter to the Council of October 31, 1996, the College clarified the scope of diagnostic assessment used by chiropractors. The College states:

Chiropractors should be able to use or order any diagnostic test or imaging procedure capable of providing information relevant to the treatment of the spine, the related nervous system, and any other joints of the human body.

Diagnosis and treatment are different functions within the patient and chiropractor relationship. The scope of diagnostic assessment is broader than the scope of treatment.

Diagnostic assessment is not limited to the spine and joints of the human body. The broader scope of diagnostic assessment enables the chiropractor to screen for risks and

contraindications to chiropractic treatment which is in the public's interest.

After consideration of the submissions made by respondents to the consultation process as well as additional information submitted by the College on October 31st, 1996, the Council has determined that the following reserved act which describes the nature of diagnosis in the practice of chiropractic be recommended for members of the College:

The Council recommends that the following Reserved Act be granted to members of the College of Chiropractors:

Making a diagnosis identifying as the cause of signs or symptoms of the individual, a disease, disorder, or condition of the spine or other joints of the human body and their effects on the associated soft tissue or nervous system.

Any reserved acts which are granted to a profession can only be performed by a member of that profession's regulatory body while acting within his or her professional scope of practice. Describing diagnosis in this manner reflects the scope of chiropractic practice and will facilitate chiropractic practice and encourage referral to other qualified practitioners when a disease, disorder, or condition which is beyond the scope of chiropractic is suspected or confirmed by a chiropractor's pretreatment diagnostic assessment.

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3. Ordering and Application of Hazardous Forms of Energy, Including Diagnostic Ultrasound, Electricity, Magnetic Resonance Imaging, Laser and X-Ray

a) Use of X-Ray for Diagnostic Purposes

In s.9(1)(f) of its submission, the College requested that "*a member may...use x-rays of the spine and other joints of the human body*".

The College submits that traditionally chiropractors are trained to utilize the results from x-rays and administer x-ray as a diagnostic tool. This practice is currently regulated under the CA.

The risk of harm from the use of x-rays has been well documented and the ordering or application of a hazardous form of energy, including x-ray, is contained in Reserved Act #4 of the Council's [Shared Scope of Practice Model Working Paper](#).

The Council considers that chiropractors should continue to utilize this diagnostic tool, as they have indicated it is traditionally within their training and expertise. This involves applying x-ray procedures directly to a patient, usually in the chiropractor's office. In addition, the Council believes that chiropractors should be granted the reserved act "ordering" the application of x-ray procedures to be performed by a technician, usually in a separate diagnostic radiology clinic, and that chiropractors be provided with the results of that x-ray.

The Council recommends that the members of the College of Chiropractors be granted the following Reserved Act: ordering or applying a hazardous form of energy: x-ray for diagnostic purposes.

The Council notes the concerns expressed by the Seaton Commission with regard to chiropractor's access to the results of x-rays which were ordered by other health care practitioners and would like to highlight the Commission's commentary and recommendation 30 at page D-20 of Closer to Home: The Report of the BC Royal Commission on Health Care and Costs :

A second matter frequently brought to the commission's attention was the availability of x-rays. Patients and chiropractors alike argued that it is inappropriate for a patient who has already had an x-ray to have to obtain a second one because the first was not made available to the chiropractor. This seems inefficient and wasteful. Therefore the commission recommends that:

- 30. A physician or institution be required to provide a copy of an x-ray at cost to a patient on request.*

The Council believes that unnecessary duplication of x-ray services is not in the public interest and poses a risk of harm to the patient since this involves application of a hazardous form of energy. Additionally, the x-ray results belong to the patient who should be able to release them to the practitioner of his or her choice. Therefore, the Council accepts the Seaton Commission recommendations quoted above.

The Council recommends that a health care provider or institution be required to provide a copy of an x-ray at cost to a patient on request.

The Council recognizes that, to reduce the risk of harm involved in the application of x-ray, that all such procedures should, ideally be performed in a setting where it is possible to monitor the total amount that a particular patient has received. This is a separate risk to the patient, over and above the risks involved in the application of a single x-ray which must be done according to strict protocols determined by the standards of practice of the professional involved.

The issue of access to diagnostic facilities will be discussed further at Section E "Other Issues" of this report.

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b) Use of MRI Procedures, Lasers, Electricity, and Diagnostic Ultrasound

The Council's Reserved Acts Discussion Paper includes "Reserved Act #4: Applying or ordering the application of a hazardous form of energy" including diagnostic ultrasound, electricity, magnetic resonance imaging, lithotripsy, laser and x-ray.

In its October 31, 1996 letter, the College listed specific diagnostic imaging it is requesting for use by chiropractors. They are: CT scanning, magnetic resonance imaging and "other forms of new imaging procedures used in support of differential diagnosis". **In its February 4, 1998 letter to the Council, the**

College additionally requested the use of diagnostic ultrasound, electricity and laser. All of these are included in the [Shared Scope of Practice Model Working Paper](#) in Reserved Act #4, with the exception of CT scanning.

The Council acknowledges that the results from diagnostic imaging procedures such as those specifically mentioned (magnetic resonance imaging and diagnostic ultrasound) could on occasion be helpful to a chiropractor's diagnostic screening process prior to administration of treatment. It appears from the College's correspondence that a chiropractor may wish to utilize laser and electricity in treating patients, however, the College has not documented the education or training of chiropractors in use of these technologies or whether they are currently utilized by chiropractors in their practice. This is necessary before the Council can consider any recommendations with regard to these procedures.

The Council has concerns that the College has not documented the relationship between diagnosis as performed within the scope of chiropractic practice and the use of MRI, diagnostic ultrasound, and "*other forms of new imaging used in support of differential diagnosis*". The Council is not prepared to assume that because chiropractors are trained in a certain kind of diagnostic process that they have the training to expand their scope of practice to include such new technology as MRI and diagnostic ultrasound procedures which have a limited application, at best, when ordered by a member of the CPSBC. Nor is the Council prepared to recommend an undefined and open-ended reserved act such as the use of "*other forms of new imaging used in support of differential diagnosis*" which is proposed to be determined by the College. An analysis of the risk of harm and the need for chiropractors to utilize such testing was not attempted by the College in its submission. In the absence of submissions about the manner in which a chiropractor would utilize such technologies, the risk of harm and the public interest in chiropractors utilizing such technologies, and their training and education to do so, the Council cannot currently recommend that members of the College of Chiropractors be granted this reserved act as it applies to MRI, laser, electricity, and diagnostic ultrasound.

In general, the Council views results of diagnostic testing to be the property of the patient. If a patient wishes to share those results with his or her chiropractor, that patient should not have artificial barriers to receipt of that information and sharing it with any health practitioner of the patient's choice. However, the issue of ordering hazardous forms of energy and interpretation of test results has implications for public safety. These risks include duplication of testing which may involve a patient's exposure to a hazardous form of energy and inaccurate test interpretation. Both can result in risk of harm to the patient. The Council must balance the patient's freedom of choice in health care practitioners with these risks involved in unrestricted access to utilization of these hazardous forms of energy. For this reason diagnosis and ordering or applying hazardous forms of energy are currently listed as reserved acts in the Council's [Shared Scope of Practice Model Working Paper](#). It is in the public interest to protect the use of such testing to ensure that it is properly interpreted and communicated to the patient.

The Council is not prepared to recommend that members of the College of Chiropractors be granted this Reserved Act, other than with respect to x-ray.

The College has submitted that it has the responsibility for determining the adequacy of the training and preparation of chiropractors to be registered and to continue to perform within their defined scope of practice. The Council recognizes that under s.3(2) [3(2)] of the CA the College does have this duty. The College has a long history of determining the adequacy of the training and the competency of its members.

The College pointed out that the use of new and emerging technologies for diagnostic assessment will always be subject to certification and approval by the College under the CA.

The Council relies on the College to fulfil its role in registration of qualified practitioners and assessment of continuing competence under the CA to determine that all chiropractors are sufficiently able to utilize diagnostic tools with appropriate training and safeguards for patient safety. However, the Council believes any new or emerging technologies should be considered by the government as they arise, on a case-by-case basis, should they present a significant risk of harm or fall within one of the reserved acts, before a reserved act involving such technology is granted to any profession. Additionally, a profession must document its training and education to perform such reserved acts.

The Chiropractors commented, at the June meeting, that there was no risk of harm in the use of MRI. Until the Council has evidence that there is risk of harm in MRI, no recommendation can be made. The Council's Interim Report on Scope of Practice has recommended that the Ministry of Health strike a task force to define "hazardous forms of energy".

The Council will consider recommending in its final report that before new or emerging technologies are used by any health profession a system be in place to consider such technologies on a case by case basis. The consideration will evaluate the risk of harm and the need for inclusion in the Reserved Act system. This evaluation could also apply to existing technologies and professions which have acquired new training or education to perform them.

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4. Putting an Instrument, Hand or Finger(s) Beyond the Anal Verge.

In recent communication with the Council, the College has documented the use of this procedure in conjunction with reserved act 2(c) "movement of 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;

The Council recommends that members of the College of Chiropractors of British Columbia be granted the Reserved Act: putting an instrument, hand or finger(s) beyond the anal verge for purposes of performing Reserved Act 2(c).

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C. SUPERVISED ACTS

The [Criteria and Guidelines](#) which are attached to the [Terms of Reference](#) state that although reserved acts may only be performed by certain professions, it may be appropriate for other persons to perform them, or aspects of them, under the supervision of members of those professions. The [Criteria and Guidelines](#) also indicate that where the Council is satisfied that a reserved act may be performed under supervision, it may recommend training and qualification requirements, limitations regarding where the act may be performed and the degree of supervision which should be exercised.

On the issue of Supervised Acts, the College has submitted the following:

The issue of supervised acts as defined in the Health Professions Council Revised [Terms of Reference](#) does not apply to chiropractors. Only registered chiropractors may perform the proposed reserved act of the adjustment. The skill and experience necessary are unique to chiropractors; therefore, it is not something which can or should be delegated or supervised...

...A chiropractic office assistant cannot diagnose or undertake the treatment of a patient by adjustment. He or she may undertake lesser acts...in all respects the chiropractic office assistant is supervised by the chiropractor.

The Council makes no comment except to note its general position on supervised acts which is contained in the [Shared Scope of Practice Model Working Paper](#) attached as [Appendix B](#) to this Report.

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D. RESERVED TITLES

Reserved titles are titles reserved exclusively to a health profession. Reserved titles afford a means for consumers to identify the different types of health care providers, to distinguish the qualified from the unqualified, and to differentiate those practitioners who are regulated from those who are not. Titles must adequately serve the public in describing the practitioner and the services being provided and must distinguish the practitioner from others performing services outside the jurisdiction of the college.

The current title protection for chiropractors is contained in s.19 and 20 [8 and 8.1] of the CA which reads:

19 (1) A person other than a chiropractor registered under this Act as a member of the college must not

(a) engage in the practice of a chiropractor, or

(b) use the title "chiropractor", or any word, title or designation, abbreviated or otherwise, to imply that he or she is engaged in the practice of a chiropractor.

(2) A person who contravenes subsection (1) commits an offence.

20 (1) A chiropractor registered under this Act, who holds the academic qualification of Doctor of Chiropractic granted by a college of chiropractic for a course of studies accepted by the board as qualification for registration under this Act, may display or make use of the title "doctor" or the abbreviation "Dr.", but only as "Doctor of Chiropractic", "Dr. of Chiropractic", "Chiropractic Doctor" or "Chiropractic Dr.".

(2) Despite subsection (1), a chiropractor must not use the title "doctor" or the abbreviation "Dr." in such a way as to suggest an occupation relating to the treatment of human ailments, other than as permitted under this Act.

The College proposes the following:

- *that the titles, "doctor" and "doctor of chiropractic" and the abbreviations "Dr." and "D.C." be continued to be used by chiropractors in the province.*

The Canadian Chiropractic Association, Canadian Memorial Chiropractic College and the College of Chiropractors of Alberta supported the College's position on reserved titles. ICBC commented that the title "doctor" should be used in conjunction with "chiropractic" to avoid confusing the public. The College of Physical Therapists of B.C. commented that the title "doctor" should be used in conjunction with "chiropractic" in the interest of accuracy.

In Ontario, chiropractors are allowed to refer to themselves as "doctor". In Quebec, chiropractors who use the title "doctor" must add the qualifier "chiropractic".

D.C. is an academic degree and the policy of the HPC is that this not be reserved, however it can be used by anyone who has earned the degree.

The Council recommends that "Chiropractor" and "Doctor (Dr.)" when used with the affix "chiropractor" or "chiropractic", be reserved for chiropractors.

E. OTHER ISSUES

1. Use of Laboratory Testing Procedures and CT Scanning:

In proposed s.9(1)(g) the College has requested that "*a member may...use...laboratory testing procedures and for this purpose may refer patients to certified specialists, public or private health facilities or laboratories.*"

Laboratory testing refers to blood and other specimen or tissue analysis performed in a medical laboratory, usually by a medical laboratory technician.

The Council's [Shared Scope of Practice Model Working Paper](#) at this time does not list ordering or using laboratory testing as a reserved act.

In its original submission, the College requested the use of laboratory testing, generally, i.e., without qualification. In support of its request, the College subsequently submitted a portion of the *Final Report of the Ontario Laboratory Services Review Commission* (the *Ontario Report*), which contains a list of laboratory tests which are being considered for use by chiropractors in Ontario. The College supports the *Ontario Report* and relies on it for documentation of its requested reserved act.

The Council has recommended that chiropractors be granted the Reserved Act "*making a diagnosis identifying as the cause of signs or symptoms of the individual, a disease, disorder, or condition of the spine or other joints of the human body and their effects on associated soft tissue or nervous system.*" Therefore, it may be in the public interest for chiropractors to utilize certain laboratory testing if there is a relationship to their diagnostic process.

A preliminary review of the recommendations contained in the *Ontario Report* indicates that the laboratory tests

considered by that committee may be appropriate for use by chiropractors in British Columbia.

Ontario has not to date adopted the recommendation of the *Ontario Report*. To date, all medical laboratory testing in Ontario must be on order of a medical doctor, with recent consideration and approval of orders of nurse practitioners.

While the Council is prepared to consider the College's request for use of laboratory tests in the context of their reserved act of diagnosis, as previously described, the Council does not find that the College submissions have set out the relationship between the laboratory testing requested and diagnosis as performed by a chiropractor. However, the following excerpts from the Journal of Canadian Chiropractic Association² at pp.222, 228 and 229 support use of laboratory testing by chiropractors:

Table 1 presents a suggested list of tests which chiropractors should have access to in order to be able to better respond to the needs of their patients. Diagnosis is a responsibility which can be adequately fulfilled only if the necessary knowledge and the tools are available. Clearly, even within the seemingly narrower confines of diagnosis of neuromusculoskeletal problems, it is necessary to rule out some possibilities while increasing the likelihood of the occurrence of others.

It is important to note that in all the possible scenarios suggested, ordering of the tests is contemplated only in the context of a primary musculoskeletal problem for which the patient would seek chiropractic help. This is consistent with current legislation defining the scope of practice in Ontario and most other provinces in Canada . . . Depending on the outcome of the test(s), and taking into account all other information that would help formulate a diagnosis, the practitioner may decide to proceed with treatment, refer, or refer and continue with concomitant treatment. However, a strong argument can be made, that as primary health care providers, the role of chiropractors should extend beyond the realm of diagnostics to include screening and monitoring.

This would enhance the public interest. It is interesting that although clinical laboratory tests have been accessible to chiropractors, particularly in the United States, for some time there are no studies investigating their usefulness and utilization.

NOTE 2: H. Stephen Injeyan, MSc, PhD, DC, Allan C. Gotlib, BSc., DC, John P. Crawford, MSc, PhD(Path), DC, FCCSS(C), 1997. "The Clinical Laboratory in Chiropractic Practice: What Tests to Order and Why?". Journal of Canadian Chiropractic Association: 41(4).

Although diagnosis is considered to be within the scope of chiropractic practice, chiropractors have not previously been allowed to use laboratory testing to perform diagnosis. The College has not shown that its members are educated, trained or experienced in the use and interpretation of the specific laboratory tests being considered in Ontario and requested by the College. Based upon the information before it, the Council has concerns about whether members of the College are sufficiently trained and educated to interpret the laboratory testing requested.

The following issues were raised by respondents to the consultation process in discussing the submission made by the College with regard to diagnostic imaging and laboratory procedures.

The RNABC took the position that "use other diagnostic imaging and laboratory procedures... may be

interpreted to mean chiropractic practice includes ordering and interpreting any tests". The RNABC suggested this could be addressed by qualifying s.9(1)(g) so that it is clear that the tests are those which are related to manipulation and adjustment of the spine and joints. Other respondents took similar views.

The Council observes that the chiropractic scope statement clearly defines the area of chiropractic practice and limits the testing accordingly.

The BCMA and ICBC were concerned about higher costs and duplication of services if chiropractors were to include other diagnostic imaging and laboratory procedures in their scope of practice.

The Council recommends to the Minister of Health that members of the College of Chiropractors be granted a limited range of laboratory testing, based upon satisfying the following criteria:

the range of laboratory testing granted is based upon the scope of practice of members of the College of Chiropractors;

the College demonstrates a relationship between the laboratory testing requested and their diagnosis;

reasonable access to the laboratory testing required is not available from other sources; and

the College provides further information concerning the experience, education and training in use of laboratory testing which members of the College currently possess.

Neither Alberta nor Ontario recognize CT scanning as a controlled act or restricted activity. The Council does not include it in the Council's Shared Scope of Practice Model Working Paper as a reserved act.

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2. Access to Laboratory and other Diagnostic Facilities

An important issue which has been mentioned during the chiropractors' scope of practice review is restriction of access to use of diagnostic facilities. This is important because the Council is recommending x-ray and laboratory testing be granted to chiropractors. These barriers to interdisciplinary practice will be discussed further in the Council's legislative review, as it applies to each profession's legislation.

The general policy embodied in the [Terms of Reference](#), is to encourage interdisciplinary practice and freedom of choice among safe options in health care. With this policy in mind, any health practitioner trained to diagnose and treat his or her patients, should be allowed access to all available diagnostic tools if that professional is adequately trained to interpret such testing and if such tests are relevant and necessary for the professional to carry out the diagnostic process he or she is entitled to perform, i.e, the tests are relevant to the nature of

diagnosis the profession is granted. These will be discussed in detail as each profession's preliminary scope report is issued.

Historically, the Ministry of Health has relied on the CPSBC to ensure the quality of laboratory services through its Diagnostic Accreditation Program. Because the CPSBC views the operation of a laboratory as part of the practice of medicine, the Medical Practitioners Act (the MPA) and Rules are currently applied to the practice of laboratory medicine. The 1996 MPA, specifically s. 93, has been interpreted by the CPSBC as prohibiting laboratory physicians from accepting referrals from non-physicians. This section would presumably operate the same way for a situation where a chiropractor or other non-physician wanted to order an x-ray since the persons who are charged with the administration and operation of these testing facilities and the interpretation of the test results are also physicians.

The Council is considering the issue of control of access to laboratory and diagnostic imaging facilities in its legislative review. The general thrust of the legislative review is to ensure that the core principles of professional regulation are embodied in the governing statutes of health professions, whether under their current acts or under the HPA. One of the core principles is that barriers to interdisciplinary practice are not in the public interest. In this light, the Council will consider whether the currently restricted access to diagnostic facilities is in the public interest.

The Council recognizes that the final decision with regard to use of laboratory testing and diagnostic imaging is up to the Government. There may be other issues such as cost and duplication of services which are not within the Council's mandate.

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IV. RECOMMENDATIONS

1. The Council recommends the following scope of practice statement for members of the College of Chiropractors:

Chiropractic is concerned with those aspects of the restoration and maintenance of human health which relate to assessment of the spine or other joints of the human body and the associated soft tissue or nervous system and the treatment of nervous, muscular and skeletal disorders through manipulation and adjustment by hand or devices directly related to the adjustment.

2. The Council recommends the following reserved acts for members of the College of Chiropractors:

(a) Making a diagnosis identifying as the cause of signs or symptoms of the individual, a disease, disorder or condition of the spine or other joints of the human body and their effects on associated soft tissue or nervous system.

(b) Performing the following physically invasive or physically manipulative acts:

movement of 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) Ordering or applying a hazardous form of energy: x-ray for diagnostic purposes.

3. The Council recommends the following titles be reserved for members of the College of Chiropractors: "Chiropractor" and "Doctor (Dr.)" when accompanied by the affix "chiropractor" or "chiropractic".

4. In addition the Council recommends that:

a health care provider or institution be required to provide a copy of an x-ray at cost to a patient on request.

- members of the College of Chiropractors be granted a limited range of laboratory testing based upon satisfying the following criteria:

1. the range of laboratory testing granted is based upon the scope of practice of members of the College of Chiropractors;
2. the College demonstrates a relationship between the laboratory testing requested and their diagnosis;
3. reasonable access to the laboratory testing required is not available from other sources; and
4. the College provides further information concerning the experience, education and training in use of laboratory testing which members of the College currently possess.

Last Revised: March 08, 2002

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Health Professions Council POST-HEARING UPDATE OF PRELIMINARY REPORT: CHIROPRACTORS

Irvine E. Epstein, Q.C., Chair
Arminée Kazanjian, Member
David MacAulay, Member

March 2001

This Post-Hearing Update should be read in conjunction with the [Preliminary Report](#) for the profession.

The Council issued its *Chiropractors Scope of Practice (Preliminary Report)* in August 1998. The public hearing was held on 31 May 1999. The following are changes to the *Preliminary Report* which arose from the submissions made either at the public hearing or in subsequent written submissions.

I. SCOPE OF PRACTICE

The Council's *Preliminary Report* recommended that chiropractors be granted the following scope of practice:

Chiropractic is concerned with those aspects of the restoration and maintenance of human health which relate to assessment of the spine or other joints of the human body and the associated soft tissue or nervous system and the treatment of nervous, muscular and skeletal disorders through manipulation and adjustment by hand or devices directly related to the adjustment.

A. Treatment of Organic Diseases

In June 1998, prior to the public hearing, the Council met with representatives of the British Columbia College of Chiropractors (College). The purpose of the meeting was to discuss concerns that had been raised by respondents to the consultation process with regard to treatment of organic diseases by chiropractors. The College provided the Council a copy of the *Clinical Guidelines for Chiropractic Practice in Canada* published by the Canadian Chiropractic Association. The guidelines confirm that the vast majority of chiropractic treatment is for "neuromusculoskeletal disorders" defined at page 105 as:

conditions which display symptoms and/or signs related to two or more of the nervous, muscular and skeletal body systems. Such conditions may be contrasted with those which produce advanced pathologic states (e.g. neurofibromatosis). Neuromusculoskeletal conditions are

sometimes referred to as "type M disorders," and distinguished from "type O disorders," which refer to internal organ disorders.

These guidelines are voluntary as noted in the general disclaimer. However, College representatives assured the Council that the treatment of organic disorders is not accepted practice in British Columbia.

Subsequently, respondents to the Council's *Preliminary Report* reasserted that current chiropractic practice includes treating organic conditions, such as otitis media in children and sinusitis. At the public hearing, two speakers who presented material on behalf of the College indicated that chiropractors do not treat organic disorders but may treat neuromusculoskeletal symptoms resulting from an organic condition, such as cancer. The speakers indicated that this would be done in the course of "co-treatment" in which a medical practitioner treats the underlying organic disease, disorder or condition.

The contradictory written and oral submissions indicate that there is a division in practice which is not sanctioned by the profession's regulatory body and educators. In accordance with testimony of the College and a representative of the only chiropractic educational institution in Canada, it is clear that the treatment of organic diseases, disorders and conditions is not within the scope of practice of chiropractors. Although they may treat the symptoms of organic disease, they do not treat the etiology of the disease, and co-treatment is required if symptoms of organic conditions are treated by a chiropractor. The Council believes it is in the public interest to make this distinction explicit to the public by a limitation to the scope of practice of chiropractic.

The Council has given careful consideration to the submissions made by the College and to the *Clinical Guidelines for Chiropractic Practice in Canada* and accordingly recommends the following scope of practice statement:

The Health Professions Council recommends the following scope of practice for chiropractors:

The practice of chiropractic is concerned with those aspects of the restoration and maintenance of human health which relate to assessment of the spine or other joints of the human body and the associated soft tissue or nervous system, and the treatment of non-organic diseases or disorders directly related to the neuromusculoskeletal system through manipulation and adjustment by hand or devices.

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II. RESERVED ACTS

In its *Preliminary Report*, the Council recommended the following reserved acts for chiropractors:

1. *Making a diagnosis identifying as the cause of signs or symptoms of the individual, a disease, disorder or condition of the spine or other joints of the human body and their effects on associated soft tissue or nervous system.*
2. *Performing the physically invasive or physically manipulative act of movement of 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.

3. *Performing the physically invasive or physically manipulative act of putting an instrument, hand or finger(s) beyond the anal verge for purposes of performing Reserved Act 2(c).*
4. *Ordering or applying a hazardous form of energy: x-ray for diagnostic purposes.*

The Council did not recommend reserved act 4—applying or ordering a hazardous form of energy, other than X-ray—for chiropractors. The Council's decision was based upon absence of submissions from the College about chiropractors' education and training to utilize the technologies requested.

The College subsequently clarified at the public hearing that although it had requested in its 4 February 1998 letter that it be granted reserved act 4, its members would not order or administer all hazardous forms of energy authorized by that Act. It specifically clarified that its members do not require the use of diagnostic ultrasound. The College also presented written and oral submissions about chiropractic training in utilization of CT and MRI for differential diagnosis. College representatives testified that chiropractors do not interpret CT and MRI but, rather, rely on expert radiologists who interpret the testing. Chiropractors are seeking the reserved act of "ordering" certain hazardous forms of energy, specifically MRI and CT.

As the College has presented evidence of education and training in the use of MRI and CT for differential diagnosis, the Council recommends the following reserved act, in addition to those already recommended:

The Health Professions Council recommends the following reserved act for chiropractors:

4. **Ordering or applying a hazardous form of energy: X-ray for diagnostic purposes; ordering the application of a hazardous form of energy: MRI and CT scan.**

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III. OTHER ISSUES

A. Use of Laboratory Testing Procedures

The College requested that "a member may...use...laboratory testing procedures and for this purpose may refer patients to certified specialists, public or private health facilities or laboratories."

Laboratory testing refers to blood and other specimen or tissue analysis performed in a medical laboratory, usually by a medical laboratory technician.

In its original submission, the College requested the use of laboratory testing generally, i.e., without qualification. In support of its request, the College subsequently submitted a portion of the *Final Report of the Ontario Laboratory Services Review Commission* (the *Ontario Report*), which contains a list of laboratory tests being considered for use by chiropractors in Ontario. The College relied on the Ontario Report for documentation of its requested reserved act.

The Council has recommended for chiropractors reserved act 1, "making a diagnosis identifying as the cause of signs or symptoms of the individual, a disease, disorder or condition of the spine or other joints of the human body and their effects on associated soft tissue or nervous system." Therefore, it may be in the public interest for chiropractors to utilize certain laboratory testing if there is a relationship to their diagnostic process.

A preliminary review of the recommendations contained in the *Ontario Report* indicates that the laboratory tests considered by that committee may be appropriate for use by chiropractors in British Columbia.

The Council recommended in its *Preliminary Report* the use of laboratory tests by chiropractors, subject to certain criteria, finding that:

While the Council is prepared to consider the College's request for use of laboratory tests in the context of their reserved act of diagnosis, as previously described, the Council does not find that the College submissions have set out the relationship between the laboratory testing requested and diagnosis as performed by a chiropractor.... The College has not shown that its members are educated, trained or experienced in the use and interpretation of the specific laboratory tests being considered in Ontario and requested by the College. Based upon the information before it, the Council has concerns about whether members of the College are sufficiently trained and educated to interpret the laboratory testing requested.

The College made submissions at the public hearing, specifically those of Dr. S. Injeyan who instructs chiropractic students in the use of laboratory testing, which indicated that chiropractors use laboratory testing for differential diagnosis, often to rule out contraindications to chiropractic treatment or for purposes of referring patients who need active medical treatment before or in lieu of chiropractic treatment. Based upon Dr. Injeyan's testimony, the Council has reconsidered its previous position and has determined that it would be in the public interest for chiropractors to have access to a limited range of laboratory testing.

Because the College has now demonstrated the relationship between chiropractors' education and training, laboratory testing requested and chiropractic diagnosis, the Council has revised the recommendation with regard to laboratory testing.

The Health Professions Council recommends that members of the British Columbia College of Chiropractors be allowed to order or access the results of a limited range of laboratory testing, based upon satisfying the following criteria:

- **Reasonable access to the laboratory testing results is not available from other sources,**
- **the range of laboratory testing ordered is based upon the scope of practice of members of the British Columbia College of Chiropractors, and**
- **the range of laboratory testing to be available to chiropractors shall be prescribed by regulation.**

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Health Professions Council Dental Technicians Scope of Practice Preliminary Report

Irvine E. Epstein, Q.C., Chair
Arminée Kazanjian, Member
David MacAulay, Member

June 1999

This Preliminary Report should be read in conjunction with the [Post-Hearing Update](#) for the profession.

FOREWORD

This report is the result of the Health Professions Council's review of the scope of practice of dental technicians pursuant to the [Terms of Reference](#) from the Minister of Health and Minister Responsible for Seniors. Under the [Health Professions Act](#), the Health Professions Council is a six-person advisory body appointed by the Government of British Columbia to make recommendations to the Minister of Health and Minister Responsible for Seniors about the regulation of health professions.

In this report the Health Professions Council examines how the existing scope of practice of dental technology should be legislatively defined in order to reflect fairly and accurately the current state of practice and the public interest in the practice of dental technicians.

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EXECUTIVE SUMMARY

The Health Professions Council has conducted a review of the scope of practice of dental technicians.

The purpose of the review is to provide recommendations to the Minister of Health and Minister Responsible for Seniors regarding four matters: scope of practice statements, reserved acts, supervised acts, and reserved titles.

The Health Professions Council has conducted a detailed consultation process and its recommendations regarding the four elements of the scope review are as follows:

1. The Council recommends the following scope of practice statement for members of the College of Dental Technicians:

The practice of dental technology is the fabrication or alteration of a dental appliance or device, in accordance with a prescription from a dentist or denturist, and the repair of such appliances or devices.

2. The Council recommends the following reserved act be granted to members of the College of Dental Technicians:

Dispensing prescribed appliances for dental conditions, provided such dispensing can be performed without intraoral procedures.

3. The Council recommends the title "dental technician" be reserved for members of the College of Dental Technicians.

With regard to the issue of supervised acts, the College of Dental Technicians has submitted a letter, which refers to their employment of "dental technician assistants", who are also registrants of the College of Dental Technicians, under certain conditions. The Council is not satisfied on the basis of this material that dental technologists do in fact delegate their reserved act to others. Acts, which are not reserved, may be performed by anyone. Reserved acts may be delegated to anyone, or done under supervision, in accordance with the prescribed protocols included as [Appendix C](#) to this report. The College of Dental Technicians has submitted its Supervision Guidelines (not included in the web edition - Appendix D) for dental technicians who supervise assistants.

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I. INTRODUCTION

A. THE NATURE OF THE REVIEW

This is the preliminary report of the review of the scope of practice of dental technicians (DTs) by the Health Professions Council (the Council).

The review was conducted pursuant to [Terms of Reference](#) issued by the Minister of Health and Minister Responsible for Seniors in accordance with section 24, now section 25 of the [Health Professions Act](#), RSBC 1996, c. 183 (the HPA). The [Terms of Reference](#) direct the Council to review the scopes of practice of the recognized health professions, of which DTs are one.

The [Terms of Reference](#), which are included as [Appendix A](#) to this report, indicate that there are four main elements to the scope of practice review:

- i. scope of practice statements which describe what the profession does, the methods it uses and the purpose for which it does it;
- ii. reserved acts which are those acts that present such a significant risk of harm that they should be performed only by professionals who are qualified to perform them;
- iii. supervised acts which are reserved acts, or aspects of reserved acts, which may be performed by persons supervised by health professionals; and
- iv. reserved titles, which are titles that describe a profession's services and which, are reserved exclusively

for the health profession.

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B. THE PROCESS FOR THE REVIEW

The general process for the review provides for an initial meeting with the profession(s), submission of briefs by the regulatory body and professional association for each profession, a consultation process involving all health professions and interested parties regarding each professions' submission, drafting of a preliminary report, public hearings and a final report.

The Council met with representatives of the College of Dental Technicians of BC (the College), the BC Registered Dental Technicians Association (BCRDTA) and Commercial Dental Laboratory Association of BC (CDLABC) on March 24, 1997.

This report will be circulated to all health professions and other interested parties who participated in the Council's consultation process. A public hearing will be held in November 1999 after which a final report will be issued. Persons or organizations who have made written responses to either the original consultation letter or to this preliminary report will be invited to speak at the hearing.

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C. THE REGULATION OF DENTAL TECHNOLOGY

Dental technicians have been regulated by statute in British Columbia since 1958 with the passage of the *Dental Technicians Act*. In 1962 an amendment provided for registration of technicians as dental technicians or dental mechanics. In 1979 the Act was replaced with the *Dental Technicians and Denturists Act* which reserved titles and provided for an exclusive scope of practice.

In 1993 the Denturists Association of BC (whose members were regulated under that Act) applied to the Council for designation under the HPA as a separate self-regulated health profession. The Council recommended designation and the former Act was repealed in 1994. Concurrently therewith, the College of Denturists was established by Regulation to the HPA to regulate the practice of denturism. The dental technicians likewise applied to the Council for designation but that application was not investigated because the Minister of Health also designated the College of Dental Technicians under the HPA in 1995. The application for designation formed the basis for the review of the scope of practice of dental technology. Modifications and additional submissions were received by the Council in April, July and December, 1996; October, 1998; and February, 1999.

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II. THE POLICY BACKGROUND

The main impetus for a scope of practice review was the Report of the British Columbia Royal Commission on Health Care and Costs (the Seaton Commission). The Seaton Commission stated that the existing legislation governing the health professions creates persistent jurisdictional disputes and a distinct lack of cooperation among the health professions, despite the fact that all health professional colleges have the same mandate - to protect the public from preventable harm.

The Seaton Commission stated that the primary reason for the jurisdictional disputes was the present regulatory system's reliance on exclusive scopes of practice. Under the exclusive scope of practice model, the various health professions have been granted an exclusive right to practice within a legislatively defined scope of practice. No one, other than a member in good standing of that profession, can perform acts within the profession's scope of practice unless they are granted an exemption.

The Commission concluded:

...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 BC were to follow the Ontario initiative.

(Closer to Home, The Report of the Royal Commission on Health Care and Costs in British Columbia, Volume 2, 1991, p. D-33)

This recommendation is also consistent with legislative initiatives underway in Alberta. The Seaton Commission was not the first review body to suggest that the present legislative model of exclusive scopes of practice was inappropriate. Restricting professional monopolies (exclusive scopes of practice) was also recommended in an earlier study commissioned by the British Columbia Minister of Health. In discussing the conflicts which may arise between the professional college and the public interest, the issue of exclusive scopes of practice was raised:

It must be emphasized that any professional legislation which unduly restricts the scope of practice of skilled personnel may be contrary to the public interest in greater supply and accessibility of service through the development of team practice. Therefore, it is urged that: Professional legislation should not contain narrow restrictions or rigid definitions of scope of practice which are excessively exclusive; that measures should be taken (as indicated below) to reduce the area of interprofessional strain and conflict; and that no prosecutions for violations of scope of practice legislation should be undertaken without the prior consent of the appropriate public authority.

Insofar as may be possible with due regard for public safety, professional law should not place rigid restrictions on the scope of practice of allied health personnel, and greater flexibility should be encouraged in the allocation of roles between the health disciplines.

(Professor J.T. McLeod, Public Regulation of the Professions in Health Security for British Columbians, Special Report: Consumer Participation, Regulation of the Professions, and Decentralization (1974), the report of Richard D. Foulkes, B.A., M.D., F.A.P.H.A. to the Minister of Health, Province of British Columbia, Tome Three, p. 145)

Thus, the trend in regulatory policy for the health professions has been towards reducing exclusivity in order to enhance interdisciplinary practice, improve accessibility to health care services and increase consumer choice,

while at the same time maintaining the fundamental objective of protecting the public.

These policy trends are clearly reflected in the Terms of Reference for the scope of practice review which provide the basis for a new regulatory framework for health professions in British Columbia. The core elements of the new framework are scope of practice statements and reserved acts.

Under the present system, scope of practice statements are exclusive. In the new system, scope statements will not be exclusive but professions may be granted reserved acts.

Reserved acts are those elements of a profession's scope of practice which present such a significant risk of harm that they should be reserved to a particular profession, or shared amongst particular professions. Thus, unlike the present system in which each profession is granted exclusivity within its entire defined scope of practice (subject to specified exceptions), only those acts which present a significant risk of harm will be reserved.

In short, the government has assigned the Council the task of creating a regulatory model based on broad, non-exclusive scope of practice statements and narrowly defined reserved acts.

The government has the responsibility to ensure that those services which are accessible are safe and that the regulatory framework for the practice of health professions protects the public from incompetent, impaired, or unethical practitioners. At the same time, the regulatory framework should not entrench a paternalistic function for professions or reserve exclusive areas of practice simply to enhance professional status and control.

The new system of overlapping scopes of practice and narrow reserved acts removes barriers to interdisciplinary practice and offers greater choice and accessibility to the public. In the Council's view, the public interest is served by professional legislation which promotes quality in the delivery of health care services within safe parameters. Indeed, the Council's primary policy objective in conducting its review is achieving the optimum balance between safe practice and consumer choice.

With this in mind, the Council proposes to consider the practice of dental technology having regard to the four elements of the scope review: scope of practice statements; reserved acts; supervised acts; and reserved titles.

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III. DISCUSSION OF ISSUES

The Council has reviewed the scope of practice of DTs with respect to the four stated elements as directed by the Council's Terms of Reference. Each of the elements is discussed in the following sections.

A. SCOPE OF PRACTICE

The scope statement describes what the profession does, the methods it uses, and the purpose for which it does it. Unlike the present legislative scheme, the statement itself does not grant an exclusive scope of practice. Nonetheless, the statement is important because: 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; and it informs the public about the services

practitioners are qualified to perform. It is expected that the Council's recommendations will increase overlapping scopes of practice.

The current scope of practice for DTs is contained in the Dental Technicians Regulation under the HPA:

A registrant may, if the services can be performed without intraoral procedures or the taking of impressions,

- a. *make, produce, reproduce, construct, furnish, supply, alter and repair a denture, bridge or prosthetic appliance or thing to be used in, on, in connection with, or in the treatment of a human tooth, jaw or associated structure or tissue for a person in accordance with a prescription to perform any of those services for that person, and*
- b. *make structural repairs to a removable dental prosthesis or replace teeth in a denture without a prescription.*

The scope of practice proposed in the 1994 application by DTs is:

Practitioners of dental technology should be permitted to provide the following tasks or services:

1. *make, produce, reproduce, construct, furnish, supply, alter and repair complete dentures, removable partial dentures, fixed prosthodontics, fixed and removable orthodontic appliances or any other things to be used in connection with or in the treatment of the human tooth, jaw, or associated structure or tissue*
2. *repair full or partial dentures that do not require intra-oral procedures*
3. *follow written prescriptions from the dentist*
4. *perform dental laboratory procedures*
5. *obtain impressions and fabricate casts under prescription*
6. *select dental materials for fabrication into dental prostheses*
7. *practice infection control in dental laboratory*
8. *practice quality control in dental laboratory*
9. *Maintain laboratory equipment and instruments*
10. *assess current appliances for mechanical defects, wear, and inappropriate design*
11. *instruct and supervise registered dental assistants*
12. *store, handle, and dispose of hazardous materials*

13. *research product application, new materials and techniques*
14. *participate in co-operative education programs*
15. *consult and participate with respect to diagnosis and appropriate remedy with the dentist*
16. *select, arrange and customize teeth for aesthetic results by prescription*
17. *make, repair, reline, replace or furnish full or partial dentures and, for that purpose, carry out nonsurgical intraoral procedures including the taking of impressions and occlusal registrations that are necessary, by prescription.*

The applicants proposed the following general description of DTs' scope of practice:

the design, construction, repair or alteration of dental prosthetic, restorative and orthodontic devices.

THE COUNCIL BELIEVES THAT IT IS NOT NECESSARY OR USEFUL TO ITEMIZE EVERY FACET OF A PROFESSION'S SCOPE OF PRACTICE. RATHER, A SCOPE OF PRACTICE DEFINITION SHOULD BE SUFFICIENTLY DESCRIPTIVE SO THAT OTHER HEALTH PROFESSIONS AND MEMBERS OF THE PUBLIC ALIKE CAN UNDERSTAND WHAT THE PARTICULAR HEALTH PROFESSIONAL DOES.

The Council recognizes that the application brief which formed the basis of the consultation process was written without benefit of the Council's [Shared Scope of Practice Model Working Paper](#) (The Working Paper) which was issued in 1998. However, the scope of practice proposed, which lists a variety of specific acts, clearly requests an expanded scope of practice in its proposal that DTs be allowed to perform intra-oral procedures under prescription by a dentist.

In addition to filling prescriptions for dental devices, the College requests that its members be granted the reserved act of fitting such an appliance for dental conditions by its request to perform "*nonsurgical intraoral procedures including the taking of impressions and occlusal registrations that are necessary, by prescription.*" (Emphasis added.) The College has proposed practice limits which would limit provision of services by:

- a. *a written prescription/authorization from a dentist or other health care professional for all services except those that do not require intraoral procedures including:*
 1. *repairs to removable dental prostheses;*
 2. *replacement of teeth in a denture; and*
 3. *fabrication of full upper and lower dentures.*
- b. *completion of a clinical oral pathology course prior to fabrication of full upper and lower dentures and carrying out non-surgical intra-oral procedures.*
- c. *a prohibition that no RDT [registered dental technician] should perform any procedures that require invasion of tooth or tissue structures.*

The proposal for intra-oral procedures was the source of the majority of the comments received during the consultation process. That proposal includes an implied request for the reserved act, "*fitting an appliance or device for dental conditions*," to which further reference will be made in the reserved acts section of this report.

The Denturists Association of BC (DABC) submits that a DT does not have the education and training to conduct an intra-oral examination or to provide any type of intra-oral procedure and points out that a DT is currently prohibited from obtaining an impression by the DT Regulation which prohibit intra-oral procedures and the taking of impressions. The DABC further asserts that DTs have no knowledge, experience or history of legally providing intra-oral services. The DABC supports any movement by denturists or DTs regulatory bodies that would allow individuals to complete each other's training program and licensing procedure but is concerned that similar dual licensing processes did not function well in two other provinces.

The New Brunswick Dental Technicians Association (NBDTA) states that DT are not trained to perform any intra-oral procedure. It also states that DTs should not design intra-oral devices.

The BC Federation of Dental Societies (BCFDS) comments that the proposed scope of practice goes beyond the current level of education and training of DTs, and represents an expansion in the traditional scope of practice for DTs in the following areas:

1. *"obtain impressions and fabricate casts under prescription" [bullet 5]; and*
3. *"make, repair, reline, replace or furnish full or partial dentures ." [bullet 17]*

The concerns of the BCFDS are based on the following factors:

1. *Currently, taking impressions or placing prostheses are done by dentists not by DTs. With the proposed expansion in scope the DT would, upon prescription from the dentist, take the impression, fabricate the prosthesis, set and make adjustments as required.*
2. *While DTs have been trained to fabricate and repair prostheses, the BCFDS believes they have not received the necessary training to diagnose a patient's prosthetic needs, the taking of impressions and the placement of a prosthesis.*
3. *The BCFDS also states that if the provision of full dentures by DTs is to be considered, the current curriculum at VCC for DTs would have to incorporate that part of the denturists' curriculum which covers full dentures.*
4. *It is imperative that all registered, certified, or licensed DTs receive the necessary education and training to provide full dentures if it is included in their scope of practice.*
5. *The BCFDS also has a concern with the provision of partial dentures by DTs, even under prescription. For a DT to provide partial dentures would require a substantial increase in education and training.*
6. *The BCFDS also believes that taking impressions is an intra-oral activity and should not be included in the scope of practice of DTs. Further, should DTs provide full dentures, they must complete a clinical oral pathology course, and even then, this would not enable them to diagnose. Finally, the BCFDS seeks clarification on what constitutes an "intraoral procedure."*

The Certified Dental Assistants Provincial Board (CDAPB) states that the current curriculum of DTs does not include competencies related to providing intra-oral procedures. In sum, the CDAPB argues that changes to the DTs' scope of practice should not be considered until they have a proven record of their ability to self-regulate based on the existing scope of practice.

The College of Denturists of BC (CDBC) questions whether it is in the public interest to allow DTs to provide intra-oral services (the provision of intra-oral services and repairs directly to the public). Currently, members of the public have three options to access denture services: through a general dentist, a prosthodontist, or a denturist. The CDBC believes that the increase in risk to the public far outweighs the benefits of allowing DTs with insufficient training to provide services directly to the public. It recommends that a full program review of the existing DT program be completed and an analysis of the similar learning outcomes between the programs be utilized to assess the additional training requirements needed for a DT to qualify to challenge denturist licensure examinations. The CDBC emphasizes that it endorses the multi-disciplinary approach to licensing requirements of respective colleges.

The College of Dental Surgeons of BC (CDSBC) suggests that the new college of DTs be allowed to be fully established and functioning before any proposed changes to scope of practice be considered and that any change in scope of practice demands that considerably more education, training and experience is necessary before DT's can safely serve the public.

The CDSBC also stresses that dentists have the ultimate responsibility for the service provided to the patient. It sees no reason for giving dentists part of the responsibility and a balance of it to the DTs.

The CDSBC believes that with the proper education and training, the duties listed could be safely undertaken by DTs but with the final seating and evaluation provided by the dentist who then would be ultimately responsible for the prosthesis, its fit and function. Further, if expansion into full upper and/or lower denture care is to include direct patient care and not by prescription from a dentist, the CDSBC insists that completion of a clinical oral pathology course prior to fabrication of full upper and lower dentures and carrying out non-surgical intraoral procedures be mandatory to protect the public, and that no RDT should perform any procedures that require invasion of tooth or tissue structures.

The College of Dental Technologists of Ontario points out that in January 1994 it became one of 21 self-regulatory health colleges in Ontario under the *Regulated Health Professions Act*, SO 1991, c.18, and that the scope of practice for DTs in Ontario is the following:

the practice of dental technology is the design, construction, repair or alteration of dental prosthetic, restorative or orthodontic devices.

However, DTs in Ontario do not perform intraoral procedures.

The Dental Hygiene Department at Vancouver Community College (VCC) notes that intra-oral procedures are already within the scope of practice of dentists, dental hygienists, certified dental assistants and denturists. VCC points out that intra-oral procedures would require knowledge of related science courses and the need for patient care knowledge and skills such as professionalism, communication, ethical and clinical decision-making, emergency care procedures, infection control and other quality of service factors.

VCC points out that the submission by the applicant does not specify what type of impressions are referred to - preliminary or final - which require different types of knowledge.

VCC posits that allowing DTs to perform intra-oral procedures such as the taking of impressions with or without a prescription will impact the education of DTs. The program will require extensive changes to the didactic and practice components. VCC previously updated the denturists' educational program. A similar upgrading can be done for DTs.

New Brunswick Health and Community Services comments that the proposed scope of practice by the applicants is a slightly expanded scope of practice which is in contrast to the DTs scope in New Brunswick. NBHCS remarks that necessary training standards should be established before DTs may perform the expanded scope of practice.

The Council is not satisfied that intraoral procedures are currently within the scope of practice of DTs or that DTs are educated and trained to provide any type of intraoral procedure. The Council has not been provided with any evidence of public demand for such services from DTs and the submissions received indicate that there are a number of other professions which provide such services to the public. The Council notes that all professions which currently perform intraoral procedures do so as a necessary adjunct for the purpose of performing within their defined scopes of practice. The current scope of DT practice does not require intraoral procedures or any patient contact whatsoever.

In response to the scope of practice requested, the College of Dental Surgeons of BC expressed concern about DTs request for responsibility for "design and fabrication of the prosthesis as outlined in the prescription":

This may be misleading; the statement more correctly should read, "fabricate the prosthesis according to the design established in the prescription." Reference to design and diagnosis must be mindful of the following facts:

- a. *The design of a prosthesis is determined as a result of an examination of the patient's aesthetic, phonetic, functional, and psychological requirements; and, therefore, cannot be carried out in the absence of the patient.*
- b. *Diagnosis, by definition, requires the presence of the patient as well. It is the result of clinical, radiological, psychological, and health history examination - all of which is beyond the scope of the dental technicians' education and training, and comprise a major portion of the dental school curriculum. . .*

. . . The appropriateness of design is determined by matching of the appliance to the needs of the patient. The extent to which this "match" occurs determines appropriateness and this, currently, is a dentist function and responsibility . . .

. . . One should not lose sight of the fact that dental students, through the Faculty of Dentistry and the professor employed there, a PhD in Materials Science, are very much aware of the potential problems associated with materials used in the mouth. The dental materials courses provided by all Faculties of Dentistry in Canada specifically deal with this issue.

Therefore, the Council recommends the following scope of practice be granted to members of the College of Dental Technicians: the practice of dental technology is the fabrication or alteration of a dental appliance or device, in accordance with a prescription from a dentist or denturist, and the repair of such appliances or devices.

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B. RESERVED ACTS

The rationale underlying the granting of reserved acts is to protect the public by limiting provision of those particularly dangerous acts to members of specific professions who are qualified to perform them. Only those acts which present a significant risk of harm will be reserved. The Council developed a list of reserved acts ([Appendix B](#)) and included it in a report it recently issued, the [Working Paper](#). The Council emphasizes that reserved acts may be shared among members of qualified professions.

The College, in its submissions to the Council which were made prior to the Council's [Working Paper](#), requested the following exclusive scope of practice: "all prosthetic appliances which involve tooth structure or implants should be exclusively fabricated, made, relined, repaired, replaced or furnished by a registered dental technician." The Council no longer uses the term "exclusive scope of practice" and adopted the term "reserved act" in its [Working Paper](#). The Council recognizes that the College's submission was made without benefit of the [Working Paper](#) and takes the exclusive scope request for a request for a reserved act which should be restricted to members of the College.

Section 5 of the Dental Technicians Regulation under the HPA grants the following "reserved acts" to DTs:

(1) *Subject to section 14 of the Act, no person other than a registrant may, for another,*

(a) make, produce, reproduce, construct, furnish, supply, alter or repair a prosthetic denture, bridge, appliance or thing to be used in, on, in connection with, or in the treatment of a human tooth, jaw or associated structure or tissue, or

(b) make, repair, reline, replace or furnish upper or lower full dentures.

The Council's reserved act 6 as listed in the Working Paper consists of three parts:

- prescribing appliances or devices for vision, hearing or dental conditions;
- dispensing such a prescribed appliance or device for dental conditions;
- fitting such appliances or devices for dental conditions, or fitting contact lenses.

The Council's [Working Paper](#) did not list "make, produce, reproduce, construct, furnish, supply, alter or repair a prosthetic denture, bridge, appliance or thing to be used in, on, in connection with, or in the treatment of a human tooth, jaw or associated structure or tissue, or make, repair, reline, replace or furnish upper or lower full dentures" as a reserved act, despite the fact that the Dental Technicians Regulation defines it as a reserved act for DTs. However, the Council commentary to Reserved Act 5 recognized that:

The special training and skill involved in prescribing the devices described above is well documented in the submissions received to date. The risks associated with fitting contact lenses and dental appliances relate to the close contact with the skin, oral structures, mucous membranes or corneal surfaces involved in such fitting. The

filling of a prescription for an appliance for dental problems requires special knowledge and skill regarding materials suitable for sustained use within the oral cavity including knowledge about contraindications, allergic responses and hazardous substances. All of these activities present significant risks of harm in the delivery of health care to individuals. (Emphasis added.)

Reserved act 6 is intended to include filling a prescription for a dental appliance or device. It did not include an express definition of the words prescribing nor dispensing as was done with reserved act 5 which defines those terms in connection with drugs. Accordingly, to avoid misunderstanding Council's intentions, reserved act 6 has now been amended by adding the following definitions:

For the purposes of this reserved act, the following definitions shall apply:

"prescribing": ordering the fabrication or alteration of appliances or devices for vision, hearing, or dental conditions.

"dispensing": filling a prescription by fabricating or altering a dental appliance or device.

Therefore, the Council recommends that "dispensing a prescribed appliance or device for dental conditions" be granted to members of the College of Dental Technicians, provided such dispensing can be performed without intraoral procedures.

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C. SUPERVISED ACTS

The [Criteria and Guidelines](#) attached to the [Terms of Reference](#) state that although reserved acts may only be performed by professions to whom they have been specifically granted, it may be appropriate for other persons to perform them or aspects of them, under the supervision of members of those professions. The [Criteria and Guidelines](#) also indicate that where Council is satisfied that a reserved act may be performed under supervision it may recommend training and qualification requirements, limitations regarding where the act may be performed and the degree of supervision required.

While the Council has recommended a reserved act be granted to DTs, it is not satisfied that in the practice of the profession this reserved act is one which the profession does in fact delegate to others. The College has submitted a letter which refers to DTs' employment of "dental technician assistants", who are also registrants of the College, under certain conditions. Using trained assistants in the performance of the professional activities is not the same as delegating to others the actual performance of the reserved act.

The Council has already developed protocols which should be applied by every profession which seeks to delegate to others any of its reserved acts or aspects of them. These protocols are attached as [Appendix C](#) to this report. Should this profession in fact delegate its reserved act in practice it should only do so in accordance with these protocols. The College has submitted its Supervision Guidelines for DTs who supervise assistants.

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D. RESERVED TITLES

Reserved titles are titles reserved exclusively to a health profession. Reserved titles afford a means for consumers to identify the different types of health care providers to distinguish the qualified from the unqualified, and to differentiate those practitioners who are regulated from those who are not. Titles must adequately serve the public in describing the practitioner and the services being provided and must distinguish the practitioner from those performing services outside the jurisdiction of the college.

The original application requested three titles for DTs:

Certified dental technician

Registered dental technologist

Registered dental technician

In a subsequent submission the College amended this to request only one title for its members: registered dental technician.

Council's practice is to avoid the use of terms such as registered or certified unless there is an overriding public interest in retaining such terms, as may, for example, derive from long-time usage ("Registered Nurse" is an example.) In keeping with this practice the Council makes the following recommendation:

Therefore, the Council recommends the title "dental technician" be reserved for members of the College of Dental Technicians.

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E. OTHER ISSUES

1. Exemption from the *Dental Technicians Regulation*

The *Dental Technicians Regulation* contains the following exemption for persons under supervision of a dentist, Canadian Government employees and wholesale suppliers:

5. (2) Subsection (1) does not apply to a person who performs the services of a dental technician where,

(a) the services are performed under the direct supervision and in the office of a dentist, and

(b) the services are performed exclusively for the practice of the dentist.

(3) Subsection (1) does not apply to a person who,

(a) provides any services referred to in subsection (1) in the course of his or her employment by the Government of Canada or by any agent of the Government of Canada, or

(b) is engaged solely in the business of manufacturing, fabricating or supplying in commercial quantities articles to be used by registrants, denturists, dentists or medical practitioners.

The College has expressed concern over section 5(2) of the *Dental Technicians Regulation*, also referred to as the "in-house exemption." The College states that Section 5(2) exempts a person from the requirement of registering with the College and thus allows the provision of DT services by persons who are not subject to the College's jurisdiction. The College requests this section be repealed.

The College argues that this exemption is not in the public interest. Further, Rule 5.06(f) of the *Dentist Act Rules* elaborates on the "use of auxiliary personnel." The College argues that a dentist is not qualified to assess the skills and training necessary to provide competent dental technician services.

These concerns are not directly related to this report which deals with the scope of practice of DTs. It is properly the subject of the scope of practice of dentists. Under the [Shared Scope of Practice model](#), only reserved acts are restricted to professions and each reserved act may be allotted to more than one profession. None of them is exclusive in itself. Furthermore, every profession may in fact be permitted to delegate its reserved acts to other persons whether they are members of a regulated health profession or not, so long as the required protocols are observed.

In point of fact the Council has recommended that dentists be granted the reserved act of "*prescribing appliances, or dispensing or fitting such prescribed appliances, for dental conditions.*" Accordingly, as the profession of dentistry has this reserved act it may delegate its performance to others.

The Council notes that in Ontario, dispensing a prescribed dental appliance is not a controlled act. However, the *Regulated Health Professions Act*, SO 1991, c.18, contains other provisions that are related to regulation of scopes of practice. Linda Bohnen, in her book, *Regulated Health Professions Act, a Practical Guide*, addresses this issue at p. 27:

Section 32 regulates the manufacturing of dental appliances such as dentures, bridges, crowns and orthodontic devices. Most of these appliances are manufactured in commercial dental laboratories, for which there is no licensing scheme or other system of regulation in Ontario. Section 32 requires that the technical aspects of the design, construction, alteration and repair of dental appliances be supervised by a dental technologist or dentist. There are exceptions for the construction of removable dentures by denturists and for laboratories in hospitals and dental and denturist schools.

Breach of . . . [section] 32 is an offence, punishable by a fine of up to \$5,000 for a first offence and up to \$10,000 for a subsequent offence.

Section 32 of the *Regulated Health Professions Act* states:

32.--(1) No person shall design, construct, repair or alter a dental prosthetic, restorative or orthodontic device unless,

(a) the technical aspects of the design, construction, repair or alteration are supervised by a member of the College of Dental Technologists of Ontario or the Royal College of Dental Surgeons of Ontario; or

(b) the person is a member of a College mentioned in clause (a).

(2) A person who employs a person to design, construct, repair or alter a dental prosthetic, restorative or orthodontic device shall ensure that subsection (1) is complied with.

(3) No person shall supervise the technical aspects of the design, construction, repair or alteration of dental prosthetic, restorative or orthodontic device unless he or she is a member of the College of Dental Technologists of Ontario or the Royal College of Dental Surgeons of Ontario.

The College will have the opportunity to challenge the awarding of this reserved act to dentists at the dentists scope hearing.

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2. Prescription Process and Interdisciplinary Practice

The respondents to the consultation process mentioned two other issues which affect DT practice. They are: concerns about the original prescription from the dentist being available to the DT who is fabricating an appliance or device for a denturist; and current restrictions on DT ability to perform work for denturists.

A January 6, 1999 letter from Keith Takei of All-Star Dental Laboratories Ltd. stated that:

It is not clear from the Health Professions Council Report whether dental technicians can provide work in respect of a partial denture to a denturist where the denturist has a written prescription of a dentist. Therefore, if changes to legislation as recommended by the Health Professions Council are passed, we recommend that the legislation clearly provide that dental technicians are able to supply work to denturists where there is a written prescription of a dentist.

The Council's intention in the [Denturism Report](#) and in [Revised Recommendation Five](#) was to allow denturists to work cooperatively with dentists and DTs in the provision of dentures to the public. If there are any limitations or impediments to this process which exist in the procedures involved with either access to the dentist's originating prescription or in authorizing DTs to perform work for denturists, it is the Council's recommendation that those barriers to interdisciplinary practice be removed.

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V. RECOMMENDATIONS

1. The Council recommends the following scope of practice statement for members of the College of Dental Technicians:

The practice of dental technology is the fabrication or alteration of a dental appliance or device, in accordance with a prescription from a dentist or denturist, and the repair of such appliances or devices.

2. The Council recommends the following reserved act be granted to members of the College of Dental Technicians:

Dispensing prescribed appliances for dental conditions, provided such dispensing can be performed without intraoral procedures.

3. The Council recommends the title "dental technician" be reserved for members of the College of Dental Technicians.

With regard to the issue of supervised acts, the College of Dental Technicians has submitted a letter, which refers to their employment of "dental technician assistants", who are also registrants of the College of Dental Technicians, under certain conditions. The Council is not satisfied on the basis of this material that dental technologists do in fact delegate their reserved act to others. Acts, which are not reserved, may be performed by anyone. Reserved acts may be delegated to anyone, or done under supervision, in accordance with the prescribed protocols included as Appendix C to this report. The College of Dental Technicians has submitted its Supervision Guidelines (Appendix D) for dental technicians who supervise assistants.

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APPENDIX C RECOMMENDATION REGARDING SUPERVISED ACTS

The Council recommends that a provision be enacted which sets out the duties of a health professional and his or her regulatory college when delegating a reserved act. The provision should require the following:

- The assigning health professional's governing body must provide assent to the proposed reserved act being performed by someone else;
- The reserved act to be assigned as well as the level of supervision must be clearly defined and circumscribed by the assigning health professional's governing body;
- Where the person to whom the act will be assigned is a member of a self-regulating health profession, his or her governing body must approve of the assigning of the reserved act;

- The instruction to perform the act must be made in writing either by way of a general written protocol or through a case-specific instruction;
- The assigning health professional must be satisfied that the individual who will be performing the act has the necessary skills and training to perform the act safely;
- The assigning health professional must ensure that the person who will be performing the act accepts the assignment.

Last Revised: March 08, 2002

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Health Professions Council POST-HEARING UPDATE OF PRELIMINARY REPORT: DENTAL TECHNICIANS

Irvine E. Epstein, Q.C., Chair
Arminée Kazanjian, Member
David MacAulay, Member

March 2001

This Post-Hearing Update should be read in conjunction with the [Preliminary Report](#) for the profession.

The Council issued its *Dental Technicians Scope of Practice (Preliminary Report)* in June 1999. The public hearing was held on 2 November 1999. The following are changes to the *Preliminary Report* which arose from the submissions made either at the public hearing or in subsequent written submissions.

I. SCOPE OF PRACTICE

The Council's *Preliminary Report* recommended the following scope of practice for dental technicians:

The practice of dental technology is the fabrication or alteration of a dental appliance or device, in accordance with a prescription from a dentist or denturist, and the repair of such appliances or devices.

A. Inclusion of "Medical Practitioner"

The Council received submissions that indicate that certain medical practitioners write prescriptions for dental appliances or devices. The Council has modified the scope of practice statement to include "medical practitioner."

B. Intraoral Procedures At the public hearing, representatives of the College of Dental Technicians of British Columbia (the College) and of the Commercial Dental Laboratory Association of British Columbia continued to request an expanded scope of practice which would allow dental technicians to perform intraoral procedures and to provide direct services to the public "on prescription" of a dentist. The Commercial Dental Laboratory Association of British Columbia submitted a post-hearing letter outlining a distinction between minor and major intraoral procedures. Both the College and the Commercial Dental Laboratory Association of British Columbia conceded that there was no current training program in place for this form of advanced or expanded practice, but stated that there were dental technicians who had attended seminars and other types of post-graduate

training to learn how to perform these procedures. The Commercial Dental Laboratory Association of British Columbia stated that laboratories were performing intraoral procedures, such as custom staining and bite adjustments, on the referral and request of dentists. The College submitted a post-hearing letter indicating it had reviewed an outline provided by the Commercial Dental Laboratory Association of British Columbia for an educational course for dental technicians. The College indicated that "[T]his course addresses the additional requisite education and skills necessary in the event dental technicians seek licensure for increased scope of practice services." However, it appears that this training has not yet been implemented.

The Council has given careful consideration to the submissions made by the College and the Commercial Dental Laboratory Association of British Columbia. According to submissions made by the Commercial Dental Laboratory Association of British Columbia, dental technicians are requesting a wide variety of intraoral procedures, ranging from custom staining to all manner of impressions to fitting appliances, which may require bite adjustments. Although some dental technicians may be performing intraoral procedures as required and if referred by a dentist, these are not currently within dental technology's scope. Intraoral procedures would require extensive additional training. All submissions from the dental technology profession, from other dental health professions and from educators of dental practitioners are in agreement on this. In addition to the technical aspects of intraoral procedures, there are issues concerning patient relations and professional ethics which would require additional education and monitoring by the College.

No evidence was presented to the Council to indicate a public interest in dental technicians providing intraoral procedures. Evidence was presented that some dentists find it convenient to refer patients to a dental technician for some specific procedures, such as custom staining or repairs, alterations and even fitting appliances. The submissions from the dentistry profession indicated that dental technicians should not be performing procedures in or below the surface of the teeth, such as would be required for fitting a partial denture.

The College and the Commercial Dental Laboratory Association of British Columbia indicated concern that dental technicians may be operating "illegally" if they perform intraoral procedures without an expanded scope of practice. Under the Council's shared scope of practice model, if a dentist requires such services from a dental technician, the dentist may delegate these procedures to the dental technician following the delegation principles outlined in the Council's *Final Report on the Scope of Practice Review*. It is also possible that an advanced practice dental technology training program could be implemented that would allow dental technicians to achieve the necessary level of post-graduate training for advanced practice and public safety. At this point, the Council is not prepared to recommend the granting of this expanded scope of practice.

The Health Professions Council recommends the following scope of practice for dental technicians:

The practice of dental technology is the fabrication or alteration of a dental appliance or device, in accordance with a prescription from a dentist, denturist or medical practitioner, and the repair of such appliance or device.

II. OTHER ISSUES

A. Delegation to Unlicensed Persons

At the public hearing, the College continued to advance its concerns about the issue of removal of the current "in house" exemption contained in section 5(2) of the *Dental Technicians Regulation*. Subsequently, the Council defined "dispense" to include "fabricate" and granted "dispensing" to dentists. In addition, the Council's

delegation protocol allows for delegation of a reserved act to an unlicensed person. The College submitted numerous letters which discussed the risk of harm in allowing dentists to fabricate without qualifications to do so, although they acknowledge that some dentists (orthodontists) are qualified to do so.

Under the current *Dental Technicians Regulation* to the *Health Professions Act*, non-registrants are prohibited from performing the services provided by dental technicians for anyone. This restriction is subject to an exemption which applies to a person who performs the services of a dental technician under direct supervision and in the office of a dentist and exclusively for the practice of the dentist. (Reg. 509/95, Sec. 5)

The College requests the retention of the prohibition and the elimination of the exemption. It is concerned with the delegation by dentists of this reserved act to non-registrants as a dentist, under the proposed changes recommended by the Council, could hire any number of unlicensed persons and set up a laboratory, outside his or her office, to fabricate dental appliances on a commercial basis.

The College of Dental Surgeons of B.C. objects only to the effect of the prohibition if it would prevent its members from performing these services themselves. The Council has recommended granting to dentists the reserved act of dispensing prescribed appliances or devices for dental conditions. This reserved act has been defined as including "fabrication."

After consideration of the submissions made to the Council, it recommends that the prohibition and the exemption be retained in the following form:

The Health Professions Council recommends that no person other than a registrant of a regulated health profession acting within their scope of practice may, for another, dispense prescribed appliances or devices for dental conditions unless such person performs such services under direct supervision in the office of a dentist or medical practitioner, and exclusively for the practice of the dentist or medical practitioner.

B. Barriers to Interdisciplinary Practice

At the public hearing and in subsequent submissions, the Council was made aware of certain restrictions imposed upon denturists and dental technicians working together, which are reflected in current practice.

After reviewing submissions from the College and the College of Denturists of British Columbia, the Council makes the following observations:

The Council sees no impediment to denturists passing on the dentist's prescription for partial dentures or dentures over implants to dental technicians for the fabrication of the appliance or device. Denturists were designated before the reserved acts system was developed. Denturists do not have the reserved act of "prescribing." Therefore, until the *Denturists Regulation* grants them this reserved act and the *Dental Technicians Regulation* includes denturists among those from whom dental technicians may receive prescriptions, dental technicians may provide their services to denturists by following the delegation protocol as recommended by the Council in its *Final Report on the Scope of Practice Review*.

Last Revised: March 08, 2002

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Health Professions Council Dentists Scope of Practice Preliminary Report

Irvine E. Epstein, Q.C., Chair
Arminée Kazanjian, Member
David MacAulay, Member

July 1998

This Preliminary Report should be read in conjunction with the [Post-Hearing Update](#) for the profession.

FOREWORD

This report is the result of the Health Professions Council's review of the scope of practice of dentistry pursuant to the [Terms of Reference](#) from the Minister of Health and Minister Responsible for Seniors. Under the [Health Professions Act](#), the Health Professions Council is a six person advisory body appointed by the Government of British Columbia to make recommendations to the Minister of Health and Minister Responsible for Seniors about the regulation of the health professions.

In this report the Health Professions Council examined how the existing scope of practice of dentistry should be legislatively defined in order to reflect fairly and accurately the current state of practice and the public interest in the practice of dentistry.

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EXECUTIVE SUMMARY

The Health Professions Council has conducted a review of the scope of practice of dentistry.

The purpose of the review is to provide recommendations to the Minister of Health and Minister Responsible for Seniors regarding four matters: scope of practice statements, reserved acts, supervised acts, and reserved titles.

The Health Professions Council has conducted a detailed consultation process and its conclusions and recommendations regarding the four elements of the scope review are set out in this report. For a summary of the recommendations, see page 30 of this report.

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I. INTRODUCTION

This is the preliminary report of the review of the scope of practice of dentistry by the Health Professions Council (the Council).

The review was conducted pursuant to [Terms of Reference](#) issued by the Minister of Health and Minister Responsible for Seniors in accordance with section 24 now section 25 of the [Health Professions Act](#) (the HPA). The [Terms of Reference](#) direct the Council to review the scopes of practice of the recognized health professions, of which dentistry is one.

The [Terms of Reference](#), which are included as [Appendix A](#) to this report, indicate that there are four main elements to the scope of practice review:

- i. scope of practice statements which describe what the profession does, the methods it uses and the purpose for which it does it;
- ii. reserved acts which are those acts that present such a significant risk of harm that they should be performed only by professionals who are qualified to perform them;
- iii. supervised acts which are reserved acts, or aspects of reserved acts, which may be performed by persons supervised by health professionals; and
- iv. reserved titles which are titles that describe a profession's services and which are reserved exclusively for the health profession.

The general process for the review provides for an initial meeting with the profession, submission of briefs by the regulatory body and professional association for each profession, a consultation process involving all health professions and interested parties regarding each professions' submission, drafting of a preliminary report, public hearings and a final report.

The Council met with representatives of the regulatory college for dentistry, the College of Dental Surgeons of B.C. (the College) in April, 1995 and with representatives of the professional association, the B.C. Federation of Dental Societies (the Federation) in May, 1995. The College submitted its written brief in October, 1995 and the Federation in March, 1996. The submissions were then summarized and distributed to interested groups and

individuals including other regulated and unregulated health professions, teaching facilities and other provinces. Many responses were received. In addition, the Council requested additional information from the College and the Federation, and met with representatives of both groups in July, 1998. The Council has carefully considered all of this information in drafting this preliminary report.

This report will be circulated to all health professions and other interested parties who participated in the Council's consultation process.

Throughout this report, the Council makes reference to the College and Federation submission and to the responses received during the consultation process. The Council has abbreviated its references to many of the responses received and for ease of reference, the Council has included the following glossary and abbreviations used:

College of Dental Surgeons of B.C.	College
B.C. Federation of Dental Societies	Federation
British Columbia Medical Association	BCMA
B.C. Dental Hygienists' Association	BCDHA
College of Dental Hygienists of B.C.	CDHBC
UBC Dental Hygiene Degree Completion Program	UBC Dental Hygiene
Vancouver Community College	VCC

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II. THE POLICY BACKGROUND

The main impetus for a scope of practice review was the Report of the British Columbia Royal Commission on Health Care and Costs (the Seaton Commission). The Seaton Commission stated that the existing legislation governing the health professions creates persistent jurisdictional disputes and a distinct lack of cooperation among the health professions, despite the fact that all health professional colleges have the same mandate - to protect the public from preventable harm.

The Seaton Commission stated that the primary reason for the jurisdictional disputes was the present regulatory system's reliance on exclusive scopes of practice. Under the exclusive scope of practice model, the various health professions have been granted an exclusive right to practice within a legislatively defined scope of practice. No one, other than a member in good standing of that profession, can perform acts within the profession's scope of practice unless they are granted an exemption.

The Commission concluded:

...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.

(Closer to Home, The Report of the Royal Commission on Health Care and Costs in British Columbia, Volume 2, 1991, p. D-33)

This recommendation is also consistent with legislative initiatives underway in Alberta.

The Seaton Commission was not the first review body to suggest that the present legislative model of exclusive scopes of practice was inappropriate. Restricting professional monopolies (exclusive scopes of practice) was also recommended in an earlier study commissioned by the British Columbia Minister of Health. In discussing the conflicts which may arise between the professional college and the public interest, the issue of exclusive scopes of practice was raised:

It must be emphasized that any professional legislation which unduly restricts the scope of practice of skilled personnel may be contrary to the public interest in greater supply and accessibility of service through the development of team practice. Therefore, it is urged that: Professional legislation should not contain narrow restrictions or rigid definitions of scope of practice which are excessively exclusive; that measures should be taken (as indicated below) to reduce the area of interprofessional strain and conflict; and that no prosecutions for violations of scope of practice legislation should be undertaken without the prior consent of the appropriate public authority.

Insofar as may be possible with due regard for public safety, professional law should not place rigid restrictions on the scope of practice of allied health personnel, and greater flexibility should be encouraged in the allocation of roles between the health disciplines.

(Professor J.T. McLeod, "Public Regulation of the Professions" in Health Security for British Columbians, Special Report: Consumer Participation, Regulation of the Professions, and Decentralization (1974), the report of Richard D. Foulkes, B.A., M.D., F.A.P.H.A. to the Minister of Health, Province of British Columbia, Tome Three, p. 145)

Thus, the trend in regulatory policy for the health professions has been towards reducing exclusivity in order to enhance interdisciplinary practice, improve accessibility to health care services and increase consumer choice, while at the same time maintaining the fundamental objective of protecting the public.

These policy trends are clearly reflected in the [Terms of Reference](#) for the scope of practice review which provide the basis for a new regulatory framework for health professions in British Columbia. The core elements of the new framework are scope of practice statements and reserved acts.

Under the present system, scope of practice statements are exclusive. In the new system, scope statements will not be exclusive but professions may be granted reserved acts.

Reserved acts are those elements of a profession's scope of practice which present such a significant risk of harm that they should be reserved to a particular profession, or shared amongst particular professions. Thus, unlike the present system in which each profession is granted exclusivity within its entire defined scope of practice (subject to specified exceptions), only those acts which present a significant risk of harm will be reserved.

In short, the government has assigned the Council the task of creating a regulatory model based on broad, non-exclusive scope of practice statements and narrowly defined reserved acts.

The government has the responsibility to ensure that those services which are accessible are safe and that the regulatory framework for the practice of health professions protects the public from incompetent, impaired, or unethical practitioners. At the same time, the regulatory framework should not entrench a paternalistic function for professions or reserve exclusive areas of practice simply to enhance professional status and control.

The new system of overlapping scopes of practice and narrow reserved acts removes barriers to interdisciplinary practice and offers greater choice and accessibility to the public. In the Council's view, the public interest is served by professional legislation which promotes quality in the delivery of health care services within safe parameters. Indeed, the Council's primary policy objective in conducting its review is achieving the optimum balance between safe practice and consumer choice.

With this in mind, the Council proposes to consider the practice of dentistry having regard to the four elements of the scope review.

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III. DISCUSSION OF ISSUES

The main issues raised by this review are the four elements listed above: scope of practice, reserved acts, supervised acts and reserved titles.

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A. SCOPE OF PRACTICE

The scope statement **describes** what the profession does, the methods it uses, and the purpose for which it does it. Unlike the present legislative scheme, the statement itself does not grant an exclusive scope of practice. Nonetheless, the statement is important because: 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; and it informs the public about the services practitioners are qualified to perform. It is expected that the Council's recommendations will increase overlapping scopes of practice.

The Council believes that it is not necessary or useful to itemize every facet of a profession's scope of practice. Rather, a scope of practice definition should be sufficiently descriptive so that other health professions and members of the public alike can understand what the particular health professional does.

1. Current Scope of Practice

The current scope of practice of dentistry is set out in the definition of practice of dentistry in s. 67 [64] of the [Dentists Act](#):

67(1) A person is deemed to be practising the profession of dentistry within the meaning of the Act who, for a fee, salary, reward or commission paid or to be paid by an employer to him, or for a fee, money or compensation paid or to be paid either to himself or an employer, or any other person, does any of the following:

- (a) examines, diagnoses or advises on any condition of the tooth or teeth, jaw or jaws of any person;
- (b) directly or indirectly takes, makes, performs or administers any or any part of an impression, operation or treatment of any impression, operation or treatment of any kind of, for, or on the tooth or teeth, jaw or jaws, or of, for, or on any disease or lesion of the tooth or teeth, jaw or jaws, or their malposition, of any person;
- (c) fits any artificial denture, tooth or teeth in, to, or on the jaw or jaws of any person;
- (d) supplies or offers to supply to any person artificial teeth, dentures or repairs.

(2) This section does not interfere with any of the following:

- (a) the privileges conferred on physicians and surgeons by any Act relating to the practice of medicine and surgery in British Columbia;
- (b) the ordinary vending or calling of a druggist;
- (c) the privileges conferred by the council on registered students, dental interns, dental hygienists, certified dental assistants or qualified members of classes of persons to whom dentists may delegate duties and procedures under the rules.

(3) Unless registered under this Act a person must not, in British Columbia, directly or indirectly offer to practise, or hold himself or herself out as being qualified or entitled to practise the profession of dentistry either in British Columbia or elsewhere.

(4) A person must not, in British Columbia, directly or indirectly hold out or represent any other person not registered under this Act as practising or as qualified or entitled or willing to practise the profession of dentistry in British Columbia or elsewhere, or circulate or make public anything designed or tending to induce the public to engage or employ as a dentist any person not registered under this Act.

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2. The College of Dental Surgeons' Proposed Scope of Practice

The College proposes an updated definition of the practice of dentistry which states:

Dentistry is that branch of the healing arts and sciences which is concerned with the maintenance of health and the assessment, diagnosis, management, treatment and prevention of any disease, disorder, dysfunction or condition of the orofacial complex and associated structures.

According to the College, this definition is general in nature and intended to encompass all current aspects of dental practise, including general and specialty practise, with specifics to be addressed in the Rules and Dental Practice Guidelines.

The College states that the proposed definition encompasses the expansion of the scope of dental practise which has occurred in areas such as orthodontics, orthognathic surgery, cleft lip/palate repair, sophisticated prosthetics following cleft repair, the placement of implants to support prostheses, surgery in the temporomandibular joint, facial cosmetic surgery, support of the immunosuppressed patient following cancer treatment and with HIV or other infections, trigger point injections for orofacial pain, specialized diagnosis and treatment for facial pain and lesions of the mouth.

The College also states that a significant difference between the current definition and the proposed definition is the use of the term "orofacial complex" in the new definition which is intended to address the fact that treatments rendered by dentists and dental specialists are not restricted to the oral cavity, but involve the entire orofacial region.

Most respondents to the consultation offer no objection to the College's proposed scope statement. However, the BC Dental Hygienists' Association (BCDHA), the College of Dental Hygienists of BC (CDHBC) and the Director of the UBC Dental Hygiene Degree Completion Program (UBC Dental Hygiene) submit that the proposed definition refers to dentistry as a whole rather than specifically to dentists. The CDHBC suggests, for example, that the scope statement should be redrafted to refer to dentists as opposed to dentistry as scope statements should refer to practitioners, not fields of endeavour.

Similarly, UBC Dental Hygiene states that the statement should refer to the practice of dentistry, not the field or discipline of dentistry. UBC Dental Hygiene states that this is an important distinction as giving dentists control over dentistry may confuse the public because many of the allied dentistry professions' services would fall within the definition. The Council believes it important that the scope statements for all professions follow a consistent format which describes the nature of the practice of members of a particular college. In the case of dentists, they practice dentistry, and that should be reflected in the scope statement. Further, with regard to the concern about "control" of dentistry, the Council notes that unlike the present regulatory system, the statement is not exclusive, but descriptive and it is expected that as a result of the Council's review, there will be an increase in overlapping scopes of practice.

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a) The Orofacial Complex

The British Columbia Medical Association (the BCMA) submits that the College's proposed scope is too broad:

We have no concerns whatsoever about dentists or oral surgeons performing operations or

procedure on any tooth bearing structure, however, when the soft tissues of the face are involved, such as in facial cosmetic surgery, cleft lip and palate repairs and other facial structures adjacent to the teeth bearing structures such as the nose, the parotid glands, the thyroid and the eyes, then we are very concerned. Proximity of structures does not imply expertise in operations on those structures.

...

[F]acial cosmetic surgery is extremely delicate, fraught with severe and debilitating complications, and requires total medical care of the patients on occasions and it is for this reason that plastic Surgeons perform a minimum of six years training in Medicine and Plastic and Reconstructive Surgery to perform these procedures. They are not procedures which should be done without full medical training and should they wish to do facial cosmetic surgery, a residency in plastic and Reconstructive Surgery should be undertaken. The limitations on dentists therefore should be, care of any tooth bearing structure.

The Council received a response to the BCMA's submission from the BC Society of Orthodontists. It states:

My purpose [in writing the Council] is to strongly oppose any restriction being placed on Oral and Maxillofacial Surgeons with regard to Orthognathic Surgery and Cleft Palate Surgery.

Orthognathic surgery involves surgery to the whole maxillo facial complex, usually in conjunction with and at the request and prescription of an orthodontist.

...

Cleft Palate Surgery usually involves multiple surgical procedures along with orthodontic and other adjunctive services. Certain aspects of cleft surgery have been traditionally in the domain of Plastic Surgeons ie. lip closure. There are other areas eg. grafting of cleft sites and orthognathic surgery, which in orthodontic opinions are best treated by Oral and Maxillofacial Surgeons. There are several technical reasons for this (eg. the tissues surrounding the teeth must be dealt with in specific ways to ensure the vitality of these teeth and to allow unerupted teeth to erupt through the bone graft).

As a result of this correspondence the Council requested further information from the College and the Federation. The College's response focusses on the practice of oral and maxillofacial surgery which is the speciality within dentistry most involved with the orofacial complex. The College outlines in detail the training required of these specialists, including a minimum four year post-doctoral program. The program includes a residency which includes training in medical, surgical and anaesthesia services. The College states:

Because of this specialized education, oral and maxillofacial surgeons are licensed and credentialed to perform procedures that are also often performed by physicians.

The College notes that the credentialling process involves both the College and hospitals where oral and maxillofacial surgeons practice. Further, the College has provided a detailed list of services on the orofacial complex performed by oral and maxillofacial surgeons which are covered by the Medical Services Plan.

In considering this matter, the Council is satisfied that the College's proposal to include the term orofacial

complex in the scope of practice statement is appropriate in light of the current practice of dentistry and particularly the specialist practice of oral-maxillofacial surgery. Based on the information provided by the College regarding the expansion of the practice of dentistry, the Council is satisfied that dentists provide services in regard to the entire orofacial complex, not just the teeth-bearing structures. The Council further notes that in Ontario the scope of practice statement for dentistry includes the "oral-facial" complex.

Of course, not all dentists perform procedures on the entire orofacial complex, but in the Council's view it is appropriate to include the term in the scope statement which is intended to be a general statement describing the practice of dentistry. The Council also notes that the Code of Ethics for dentistry includes the obligation not to perform treatments or procedures that are beyond one's education, training and experience. Further, as the Council indicated in its preliminary report on the scope of practice of medicine, one of a College's primary duties is to ensure that all of its members practice within their level of competence. Based on the information provided, the Council is satisfied that the College is fulfilling its role in regard to procedures in the orofacial complex.

An issue related to the performance of procedures on the orofacial complex is hospital admitting privileges. Representatives of the College and the Federation have indicated that, at present, dentists do not have admitting privileges and must arrange admissions through the patient's medical practitioner. This practice is problematic because it causes duplication of service, greater bureaucracy and the potential for communication difficulties. In the Council's view, to the extent that access to hospitals is necessary in order to carry out the scope of practice of oral and maxillofacial surgery, dentists should be granted hospital admitting privileges.

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b) Advanced Credentialling

The College acknowledges that there are areas in which the scope of dental practise overlaps with medical practise. It also recognizes that not every member is qualified through education and training to perform all areas of practice. A task force of the College [Report of the Task Force on the Practice of Dentistry, September 5, 1995] has recommended a credentialling process to establish requirements for various levels of practice:

Category A procedures requires no additional education or speciality training and encompasses all members.

Category B procedures requires additional education and training beyond the core requirements.

Category C procedures requires additional education and training and an evaluation of performance by the College.

The Rules and Dental Practice Guidelines would list the procedures that fall into each category.

While many respondents including the BCDHA, CDHBC, Camosun College, Open College, supported the advanced credentialling proposal in principle they felt that they did not have sufficient detail to enable them to make useful comments. The CDHBC submitted that such a system should be "legislated" and not simply left to the Dental Practice Guidelines.

The Council is of the view that the several categories or levels of practice should not be set out in the scope of practice statement which is intended to be a general description of the services provided by members of the College.

This is not to say that the College's advanced credentialling proposal is without merit. Indeed, the College's proposal is entirely consistent with its mandate which includes the duty to ensure that its members practice within their level of competency. However, the Council cautions that while the intention of such an initiative are laudable, such a program also has the potential, depending on how the categories are drafted, to decrease the availability of services contrary to the public interest. Therefore, in the Council's view, any such program must be developed with wide consultation, both from within and outside the profession. Further, in the Council's view, the details of such a program should be set out in the Rules which require government approval.

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c) The Health Professions Council's Conclusion Regarding Scope of Practice

In summary, the Council recommends the following scope of practice statement for the practice of dentistry:

The practice of dentistry is the maintenance of health through the assessment, diagnosis, management, treatment and prevention of any disease, disorder or condition of the orofacial complex and associated structures.

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B. RESERVED ACTS

The rationale underlying the granting of reserved acts is to protect the public by limiting provision of those particularly dangerous acts to members of specific professions who are qualified to perform them. Only those acts which present a significant risk of harm will be reserved. The Council developed a [list of reserved acts](#), and included it in a report it recently issued, the [Shared Scope of Practice Model Working Paper](#).

Both the College and Federation were afforded the opportunity to make submissions regarding that document. The list is the Council's working list of activities which present such a significant risk of harm that they should be reserved to regulated health professionals. The Council's general list is attached as [Appendix B](#) to this report.

As the Council has noted, the purpose of the profession-specific reviews is to determine which parts of the list each profession will be granted. Further, a major reason for adoption of a general list was to ensure consistency in wording across the professions.

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1. The College of Dental Surgeons and the B.C. Federation of Dental Societies Proposals

The College proposes that the following acts be reserved for dentists:

1. Conducting an examination, arriving at a diagnosis, and communicating that diagnosis and the resulting treatment plan with regard to the identified disease or disorder of the orofacial complex to persons requesting such service.
2. Performing any procedure on tissues of the orofacial complex that would penetrate the epidermis or the surface of a mucous membrane or the surface of the teeth, or removing tissue from the skin, mucous membrane or the teeth including the scaling of teeth.
3. Harvesting of tissue for the purpose of surgery on the orofacial complex.
4. Correcting a fracture of a bone or bones of the orofacial complex or correction of a dislocation of a joint of the orofacial complex.
5. Administering a substance by injection or inhalation.
6. Applying or ordering the application of a prescribed form of energy.
7. Prescribing or dispensing drugs.
8. Fitting, dispensing, or adjusting a dental prosthesis, or an orthodontic or periodontal appliance, or a device used inside the mouth to protect teeth from abnormal functioning.

In its submission, the College noted that these tasks or portions thereof may be conferred on more than one profession.

The Federation agrees with the College's proposed list of reserved acts with some very minor wording changes (adding "in the course of providing dental services" to some of the acts), and also suggests the following act be added to the list:

- Reordering or revision of the position, contour or colour of teeth.

The Council notes that, for the most part, the College's proposed reserved acts are similar to the Council's proposed reserved acts.

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2. Responses to Consultation

For the most part, the respondents to the consultation supported the proposed reserved acts, and there were no major objections. However, the following matters were raised.

First, the BCDHA, the CDHBC and UBC Dental Hygiene noted that "scaling of teeth" does not remove tissue and is therefore not properly included within the College's proposed reserved act (2). The Council tends to agree with these comments as they relate to the wording of the College's proposal. However, the College's proposed reserved act 2(c) is worded differently than the similar reserved act which appears as 2(a) on the Council's list of reserved acts attached as [Schedule B](#). Scaling of teeth is encompassed with the Council's reserved act 2(c) which includes "procedures in or below the surface of the teeth". The Council notes that no respondent objected to this act being granted to dentists.

Second, the BCDHA, the CDHBC, UBC Dental Hygiene and Camosun College submitted that the reserved act of prescribing a hazardous form of energy should be clarified. For example, the BCDHA submitted that specific substances should be listed. The Council requested clarification from the College and the Federation regarding this reserved act. The College responded as follows:

The College does not have a specific list and feels that it would be counter-productive to produce a list. Any list would quickly become out-of-date. Examples of prescribed energy would include the exposure of radiographs by ionizing radiation, curing of filling materials by application of a specific light, the use of electrical stimulation of nerves such as TENS (transelectrical neural stimulation) to induce or assist in local anaesthesia or pain control, the management of facial pain by ultra sound, the use of lasers to cut, remove or surface tissue, the process of magnetic resonance imaging, etc. This list is not exhaustive and innovations in treatment will cause it to change frequently.

A similar response was received from the Federation:

The Federation does not have a list of specific treatments although it does produce a suggested Fee Guide which lists 900 procedures. The Fee Guide includes the application of some forms of energy such as radiographs and electric anaesthesia, but it is not exhaustive, as it excludes some forms of energy if they are prescribed as part of a procedure such as the cutting of tissue with a laser.

As noted above the Council has developed a [list of reserved acts](#) which it is using as a guide for the profession specific reviews. In the latest version of the list, set out in the Council's [Shared Scope of Practice Model Working Paper](#), the Council indicated that the reserved act of "applying or ordering a hazardous form of energy" would be left non-exhaustive for the present. As stated, once the review process is complete this act should be more clearly defined to set out the types of energy that fall within it. The Council did, however, set out a preliminary list of the types of substances it felt fell within the act, including diagnostic ultrasound, magnetic resonance imaging and x-ray. Based on the present wording of this act, the Council is satisfied that it should be granted to the profession of dentistry. However, in light of the College and Federation responses, and in particular the difficulties they have noted with defining the term "hazardous forms of energy", the Council will be recommending that the Ministry consult with persons who have some expertise in this area, in order to determine which forms of hazardous energy should be included within this act.

Third, UBC Dental Hygiene and Kootenay College felt that the term "harvesting of tissue" was vague. The Council requested further information on this issue, and the College and Federation recently provided clarification of this term. The College stated:

The term "harvesting" is used to describe the process of surgically removing soft or hard tissues from one location in the body in order that it might be utilized in the reconstruction of other parts

of the body. Dentists and physicians harvest tissues for reconstructive and other surgery. In dentistry, oral and maxillofacial surgeons, periodontists, and some other specialists and general practitioners with expanded training, will harvest soft tissues from various areas in the oral cavity in order to acquire soft tissue for periodontal and other oral surgery. At other times, bone may be harvested from the skeleton of the maxilla or mandible to be used in the oral cavity to restore a small area of missing bone which has occurred as a result of pathology, developmental defect or natural atrophy of tissue.

The Council believes that the term "harvesting" is appropriate, and its meaning clear. The Council is also satisfied that it falls within the scope of practice of dentistry and is the type of act which presents a significant risk of harm and therefore should be reserved.

Fourth, the BCDHA questioned whether the proposed reserved act of fitting and dispensing, as worded by the College, has the potential to limit commercially available products such as mouthguards. The Council tends to agree with these concerns. In contrast to the College's proposal which refers to any device used inside the mouth to protect the teeth from abnormal functioning, the Council's reserved act list includes only "prescribed" appliances. In the Council's view this ensures that the reserved act focusses on the significantly harmful aspects of such services, and does not include services related to devices or appliances such as mouthguards which present little risk of harm. In short, the Council believes that the College's proposal regarding this particular act is too broadly stated.

A similar concern was raised with respect to the Federation's proposal to reserve "reordering or revision of the position, contour or colour of teeth". The CDHBC felt that the Federation's proposed reserved act had the potential to limit the availability of commercially available products such as whiteners.

The Federation clarified its intention regarding this reserved act as follows:

As to the 'revision of tooth colour', this encompasses a wide range of procedures from commercially available products for bleaching of endodontically treated teeth to the polishing of teeth, a procedure routinely provided during most recall dental visits. In making this proposal, the intent was not to include the over-the-counter products, as Health Canada has already determined that these products are safe. We do not believe that designating 'revision of tooth colour' as a reserved act would negate Health Canada's decisions.

In our view, including the 'revision of tooth colour' as a reserved act for dentistry would include those procedures which use products not commercially available, i.e. over the counter, which can only be prescribed by a dentist. Procedures such as bleaching and polishing involve corrosive and/or abrasive agents which can have serious consequences on the health of gums and tooth enamel. Given the potential harm and the fact that only dentists are trained to prescribe and perform these tasks, the Federation included 'revision of tooth colour' as a reserved act.

Similarly, the College states:

Those products that are not offered for sale over the counter are under the control of the Health Canada approval process are not subject to control by the College or the HPC and would not be affected by this reserved act. Our intention is to reserve to dentists the control of the procedures and chemicals not offered over the counter and which are in general much stronger.

The Council appreciates that while the College's and the Federation's intentions may not have been to reserve commercially available products, that is the effect of the proposal as currently worded.

The proposal regarding revision of tooth colour is not currently on the Council's list. In the Council's view the risks described by the College and Federation from products not available over the counter does not warrant reservation as those products are not, in any event, available to the public and are already subject to an approval process through Health Canada. Further, in the Council's view the risks associated with the other aspects of this proposed reserved act, "reordering or revising the position or contour of teeth" are already encompassed within other reserved acts which are on the current list. For example, revising the contour or position of teeth would clearly fall within the Council's reserved act of fitting appliances or devices for dental conditions. In summary, the Council is of the view that the Federation's proposed reserved act of "reordering or revision of the position, contour or colour of teeth" is unnecessary.

Finally, The British Columbia Naturopathic Association supports the proposed reserved acts but indicates that some acts should be shared with naturopaths as they also perform some procedures in the orofacial complex. The Council wishes to emphasize that each profession will be afforded the opportunity, in the course of the Council's review of each profession's scope of practice, to establish its competencies to perform the various acts. In this report, the Council is simply concerned with the dentists' scope of practice and which reserved acts will be included in their scope of practice.

3. The Council's Conclusions Regarding Reserved Acts

The Council has reviewed the College and Federation proposals along with the responses to consultation, and proposes the following list of reserved acts for dentists:

- I. Making a diagnosis identifying a disease, disorder or condition of the orofacial complex as the cause of signs or symptoms of the individual.**
- II. Performing the following physically invasive acts:**
 - 1. procedures on tissues of the orofacial complex that would penetrate the epidermis or the surface of a mucous membrane, and procedures in or below the surface of the teeth including the scaling of teeth;**
 - 2. harvesting of tissue for the purpose of surgery on the orofacial complex;**
 - 3. setting a fracture of a bone of the orofacial complex or reducing a dislocation of a joint of the orofacial complex;**
 - 4. administering a substance by injection or inhalation.**
 - 5. Applying or ordering the application of a hazardous form of energy.**
 - 6. Prescribing, compounding or dispensing by any means a drug listed in Schedule I or II of the Pharmacists, Pharmacy Operations and Drug Scheduling Act.**
 - 7. Prescribing appliances, or dispensing or fitting such prescribed appliances, for dental**

conditions.

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C. SUPERVISED ACTS

The [Terms of Reference](#) imply that the Council will, for each reserved act granted to each profession, determine the circumstances in which the act may be performed by someone other than a member of that profession. The Council considered this issue in detail in its recent preliminary report regarding the scope of practice of medicine. The Council first noted the submissions of the College of Physicians and Surgeons:

In its submission, the College makes a compelling argument that legislation is a blunt instrument to deal with this issue. The College states that the issue of delegation and supervision is a question of individual competence and the circumstances of each case, and that supervision of certain acts can be addressed only after a careful review of all the circumstances surrounding a particular act and by imposing, where necessary, clear guidelines, restrictions or conditions on such supervision.

The College further submits that compiling a list of acts which may be delegated or performed under supervision would not adequately address the complexities of medical situations which present to physicians nor would it protect the public. The College notes that there will be situations where, because of the individuals involved, the site or location, or the specific nature of the presenting problem, it may not be appropriate to delegate an act which might otherwise be capable of delegation.

The Council accepted this submission and stated as follows:

The Council accepts much of this submission, and believes that it would be better to take a general approach to the issue of supervision. The general thrust of the approach is that the decision as to whether an act can be performed under supervision should be left up to the health professions, and that a set of principles embodying the duties of the delegating professional and his or her regulatory college be established and enacted into legislation when the shared scope of practice model takes effect. The principles are derived largely from the CMA's Guidelines for the Delegation of a Medical Act which the College enclosed with its submission.

As a result, the Council stated that supervised acts would not be dealt with individually for each profession, and made the following general recommendation regarding this issue:

The Council recommends that a provision be enacted which sets out the duties of a health professional and his or her regulatory college when delegating a reserved act. The provision should require the following:

- *The assigning health professional's governing body must provide assent to the proposed reserved act being performed by someone else;*

- *The reserved act to be assigned as well as the level of supervision must be clearly defined and circumscribed by the assigning health professional's governing body;*
- *Where the person to whom the act will be assigned is a member of a self-regulating health profession, his or her governing body must approve of the assigning of the reserved act;*
- *The instruction to perform the act must be made in writing either by way of a general written protocol or through a case-specific instruction;*
- *The assigning health professional must be satisfied that the individual who will be performing the act has the necessary skills and training to perform the act safely;*
- *The assigning health professional must ensure that the person who will be performing the act accepts the assignment.*

The Council believes this general approach to supervised acts more accurately reflects the reality that procedures to be delegated vary from profession to profession and may include subsets and variations of reserved acts and further, may be performed under a myriad of circumstances and conditions.

In its preliminary report on the scope of practice of medicine the Council also noted the following:

- *Although this term of reference refers to "supervised" acts, it is intended to encompass any situation where someone other than the person to whom the reserved act has been granted performs that act. In other words, this term of reference refers to both delegation and supervision.*
- *This proposal is not intended to apply on a case-by-case basis. The requirement for approval of the governing body is meant to apply generally and not to individual cases, and would be satisfied by, for example, a general protocol in respect of delegation of reserved acts.*

In the Council's view, this general position should be applied to all professions. The general position is largely a recognition that the a regulatory body is in the best place to determine when other health professionals can perform services under supervision, and thus a regulatory body should be charged with determining when delegation is appropriate in accordance with the principles set out above.

In reviewing the submissions received regarding the scope of practice of dentistry some further issues arose with respect to the issue of supervised acts.

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1. The College of Dental Surgeons' Submission

The College notes that its Rules currently deal with the issue of delegation and supervision. It submits that, when considering the reserved acts listed in the previous section, the following tasks may be performed by other

persons under the level of supervision indicated.

- Scaling and root planing of teeth by dental hygienists under indirect supervision.
- Injecting local anesthetic by dental hygienists under direct supervision.
- Exposing patients to ionizing radiation in the process of radiographing the teeth, jaws, face, or other portions of the orofacial complex by dental hygienists, certified dental assistants, and by dental assistants who have training approved by the College of Dental Surgeons. This requires indirect supervision of dental hygienists and direct supervision of certified dental assistants and dental assistants.

The College also states that other procedures have been considered or are under ongoing consideration by the Allied Dental Personnel Education Committee of the College of Dental Surgeons. Examples would be the fitting by dental hygienists of periodontal appliances to protect the teeth from abnormal functioning; the fitting of removable dental prostheses by certified dental assistants; the scaling of teeth, supragingivally, by certified dental assistants; and other procedures which may be identified. The College expects that the level of supervision will be appropriately established if these procedures are approved by the Council of the College, and amendments to the Rules are made to include new procedures.

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2. Responses to Consultation

This element of the scope review elicited a considerable number of responses which may fairly be summarized as falling into three categories, all of which relate to the issue of the impact of the College's Rules on allied health professionals.

First, several responses, from the Vancouver Community College (VCC), the BCDHA, the CDHBC, UBC Dental Hygiene and Kootenay College expressed concern about the College's statement that its Allied Dental Personnel Education Committee was actively considering whether other procedures may be delegated or supervised. For example, the CDHBC stated:

[W]e are concerned that the wording referring to "other procedures" lacks sufficient specificity and seems to leave the future determination of those procedures to the College council.

The BCDHA elaborated on this concern as follows:

Our association is very concerned that such procedures are brought forward by a committee ... which is not housed on that side of the College that has public interest and regulatory matters as its prime consideration. Scaling of teeth by certified dental assistants is an excellent example of a procedure it would not be in the public interest to approve yet a push to approve this could easily be driven by economic interests. (Scaling is currently a reserved act for dental hygienists, but dentists may wish to save money by delegating this highly skilled procedure to dental assistants because they receive lower wages than dental hygienists).

In summary, the general concern appears to be that the College by its decisions could have a negative impact on the practice of other health professionals, and such decisions ought to be subjected to greater public scrutiny.

The Council firmly believes that the regulatory body is in the best position to determine when tasks or services which fall within the scope of practice of dentistry may be delegated, and that in making such decisions, it is cognizant of its primary duty to act in the public interest. The Council's proposal, set out above, provides further guidance regarding the issue of whether a task may be delegated, and in particular requires that the assigning health professional be satisfied that the individual who will be performing the act has the necessary skills and training to perform the act safely. The proposal also requires that where the person to whom the act will be assigned is a member of a regulated health profession, his or her governing body must approve of the assigning of the reserved act. Finally, the Council notes that the [Dentists Act](#) Rules regarding auxiliary professions must be approved by cabinet and thus are subjected to heightened scrutiny.

A second, related concern was expressed about the College's indication that it was considering whether supragingival scaling should be delegated to dental assistants. VCC, Douglas College and East Kootenay Community College all indicated that before such a decision is implemented, the College must ensure that the appropriate training and education requirements are in place. Douglas College submitted:

The specific examples cited have not been discussed or acted upon, at this time. Any duty that is delegated by the Dentist to any level of auxiliary that may cause harm to the public or the provider must be supported by educational requirements, demonstration of competence and knowledge of the procedure.

VCC submitted:

There is mention (bottom p.6) of the consideration of other procedures by the Allied Dental Personnel Education Committee), e.g. fitting of periodontal appliances by Dental Hygienists and the sealing of teeth by Dental Assistants. VCC is very mindful of its' purpose in providing the educational requirements for the dental personnel yet, CONSIDERABLE dialogue and collaboration should occur between the Ministries of Health, MOEST [Ministry of Education, Skills and Training] and the educational institutions when new procedures are being considered for any of the dental groups. For instance, in 1972 there were five duties required of a CDA, and in 1996, the number has risen to approximately 20, yet the program length has remained at 10 months. This dialogue should include the resources of time and money required for the development of curricula, time frame for implementation of such education, as well as the requirements for formal upgrading for existing dental personnel through a continuing education process. It comes increasingly difficult to continue including more procedures in programs that are already very full.

The Council agrees with these statements, and believes that the decision to delegate tasks or services that are reserved must only be done after a careful analysis of the issues including consultation with all affected parties. In the Council's view, the principles it has outlined above provide the necessary framework for this to occur. Finally, the Council notes that the scope of practice of certified dental assistants is not within the Council's mandate and has not been considered in this report.

The third category of response was that which submitted that all references to dental hygienists should be removed from the College Rules as dental hygiene is an independent self-governing profession. This basic point was made by the CDHBC, the BCDHA, UBC Dental Hygiene, and the Open Learning Agency. The BCDHA stated:

In our view it would be best to simply omit the references to dental hygienists as the [Health Professions Act](#), the [Dental Hygienists Regulation](#) and the [College of Dental Hygienists Bylaws](#) govern practice quite explicitly.

The basis for the concern appeared to be the potential for the College of Dental Surgeons to dictate the scope of practice of dental hygiene. As stated by the CDHBC:

[W]e find it surprising that the College would be considering changes to dental hygienists' scope of practice over which it does not have jurisdiction. For example, if the College amended its Rules to add a new procedure to hygienists' scope of practice but the CDHBC did not also add this procedure, our registrants could not perform the service legally.

The Council acknowledges these concerns and the potential that the College's Rules can affect dental hygienists, but in its view, as long as the [Dentists Act](#) Rules are consistent with the legislation governing dental hygiene, there is no reason why the Rules cannot refer to dental hygienists. Indeed, it is important that dentists are aware of their obligations when delegating particular services to allied professionals. The Council appreciates the concerns expressed, however, and believes that the College's Rules must not impose any restrictions on the practice of dental hygiene, or any other regulated health profession, which are not already found in the legislation governing that profession.

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D. RESERVED TITLES

Reserved titles are titles reserved exclusively to a health profession. Reserved titles afford a means for consumers to identify the different types of health care providers, to distinguish the qualified from the unqualified, and to differentiate those practitioners who are regulated from those who are not. Titles must adequately serve the public in describing the practitioner and the services being provided and must distinguish the practitioner from others performing services outside the jurisdiction of the college.

The [Dentists Act](#) does not specifically reserve any specific titles but section 80 [78] of that Act creates an offence for falsely using a title implying or calculated to lead people to infer that he is a dentist.

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1. Proposed Reserved Titles

The College proposes that the following titles be reserved exclusively for those who function under the [Dentists Act](#) and Rules:

Dentist
General Dentist

Dental Surgeon
Certified Dental Assistant (CDA)
Dental Assistant
Doctor of Dental Surgery (D.D.S.)
Doctor of Dental Medicine (D.M.D.)
Bachelor of Dental Surgery (B.D.S.)
Fellow of the Royal College of Dentists (F.R.C.D.)

(NOTE: the Federation proposes that this be a Specialty title)

With respect to the title, "Doctor (Dr.)", while neither the College nor the Federation request exclusivity in this title, they suggest that protection of the public interest requires this title be protected in a variety of Acts so that it cannot be used to mislead the public as to qualifications.

On the issue of specialty titles, the College proposes the following reserved titles:

*Oral & Maxillofacial Surgery - Oral & Maxillofacial Surgeon
Orthodontics - Orthodontist
Endodontics - Endodontist
Paediatric Dentistry - Paediatric Dentist
Pedodontics - Pedodontist
Periodontics - Periodontist
Prosthodontics - Prosthodontist
Oral Pathology - Oral Pathologist
Oral Radiology - Oral Radiologist
Dental Public Health
Oral Medicine*

The Federation agrees with the proposed reserved titles suggested by the College and indicated above, with the following addition to the list of speciality titles:

Master of Science in Dentistry (M.S.D.)

MOST OF THE RESPONDENTS SUPPORTED GENERALLY THE PROPOSED TITLES; HOWEVER THERE WERE SOME COMMENTS ON VARIOUS ISSUES.

The BCDHA, the CDHBC, Open Learning Agency and a representative of the UBC MSc Program in Dental Science object to the reservation of educational titles. For example, the BCDHA states:

The other titles refer to academic credentials and individuals who have received them should be entitled to use them regardless of whether they are currently functioning under the [Dentists Act](#) and Rules.

The Council tends to agree with these comments, and as it indicated in its previous report on the practice of medicine, the Council does not believe there is a public interest in the reservation of educational titles. Further, the Council also indicated in that report that, in its view, there is no public interest in the reservation of speciality titles. The Council does not believe that reserving the lengthy list of speciality titles would assist the public. In this regard the Council tends to agree with the submission from the province of New Brunswick which states that reserving many different titles to describe essentially the same practitioner may be confusing to the public.

VCC believes there is confusion in the public between CDA's and dental assistants, although it did not elaborate on this concern. The Council received further clarification from the College regarding the titles certified dental assistant and dental assistant:

In British Columbia, the College exclusively manages and superintends the practice of certified dental assisting as required by section 4(2)(c) of the [Dentists Act](#) and article 10.03(a)(ii) and (b)(i), (ii), (iii) and (iv) of the Rules made under the [Dentists Act](#). An applicant for registration first receives a diploma from a recognized dental assisting program and then applies to the College with their credentials for registration and licensure as a certified dental assistant. Such registration and licensure is only available through the College of Dental Surgeons as identified in article 10.01(b) of the Rules under the [Dentists Act](#).

In light of this submission, the Council accepts that the title "certified dental assistant" should be reserved in order to distinguish the registered from the unregistered provider of such services.

As to the title "dental assistant", the College states:

The purpose of the title "dental assistant" is that, while the College does not regulate dental assistants, it does hold dentists accountable through the Rules for any duties delegated to dental assistants. Dental assistants have various levels of training: some are trained on the job, some have formal educational training. The dentist must ensure that the dental assistant is properly trained to perform the delegated duties and only under the personal supervision of the dentist.

Thus, a dental assistant is someone who works with a dentist, but whose qualifications and training may vary widely. There is no process for official review of the person's qualifications. Although the Council accepts the College's submission that it is important to hold dentists accountable for the persons they employ in their offices, the Council does not believe this requires the reservation of such a generic title. This is not to say, however, that the Rules should not employ the term dental assistant, simply that the public interest does not require reservation of the title. In the Council's view, titles should only be reserved where they would serve to inform the public about their holder's training and qualifications.

The Council believes that the titles "dental surgeon" and "dentist" adequately serve the public in describing dental practitioners and the services they provide. The Council also believes that members of the College should be entitled to use the title "Doctor" or "Dr.". Finally, the Council accepts that the title "certified dental assistant" should be reserved.

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2. The Health Professions Council's Conclusion Regarding Reserved Titles

Therefore, the Council recommends the following:

- I. **that the titles, "dental surgeon", "dentist", and "doctor", "certified dental assistant" and any affix of those titles be reserved; and**
- II. **that registrants of the College be granted the use of those reserved titles for which they are qualified.**

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IV. RECOMMENDATIONS

RECOMMENDATION 1:

The Council recommends the following scope of practice statement for the practice of dentistry:

The practice of dentistry is the maintenance of health through the assessment, diagnosis, management, treatment and prevention of any disease, disorder or condition of the orofacial complex and associated structures.

RECOMMENDATION 2:

The Council proposes the following reserved acts for dentists:

1. Making a diagnosis identifying a disease, disorder or condition of the orofacial complex as the cause of signs or symptoms of the individual.
2. Performing the following physically invasive acts:
 - I. procedures on tissues of the orofacial complex that would penetrate the epidermis or the surface of a mucous membrane, and procedures in or below the surface of the teeth including the scaling of teeth;
 - II. harvesting of tissue for the purpose of surgery on the orofacial complex;
 - III. setting a fracture of a bone or bones of the orofacial complex or reducing a dislocation of a joint of the orofacial complex;
 - IV. administering a substance by injection or inhalation.
 - V. Applying or ordering the application of a hazardous form of energy.

VI. Prescribing, compounding or dispensing by any means a drug listed in Schedule I or II of the Pharmacists, Pharmacy Operations and Drug Scheduling Act.

VII. Prescribing appliances, or dispensing or fitting such prescribed appliances, for dental conditions.

RECOMMENDATION 3:

THE COUNCIL RECOMMENDS THAT A PROVISION BE ENACTED WHICH SETS OUT THE DUTIES OF A HEALTH PROFESSIONAL AND HIS OR HER REGULATORY COLLEGE WHEN DELEGATING A RESERVED ACT. THE PROVISION SHOULD REQUIRE THE FOLLOWING:

The assigning health professional's governing body must provide assent to the proposed reserved act being performed by someone else;

- I. The reserved act to be assigned as well as the level of supervision must be clearly defined and circumscribed by the assigning health professional's governing body;
- II. Where the person to whom the act will be assigned is a member of a self-regulating health profession, his or her governing body must approve of the assigning of the reserved acts.
- III. The instruction to perform the act must be made in writing either by way of a general written protocol or through a case-specific instruction;
- IV. The assigning health professional must be satisfied that the individual who will be performing the act has the necessary skills and training to perform the act safely;
- V. The assigning health professional must ensure that the person who will be performing the act accepts the assignment.

RECOMMENDATION 4:

On reserved titles, the Council recommends the following:

- I. that the titles, "dental surgeon", "dentist", and "doctor", "certified dental assistant" and any affix of those titles be reserved; and
- II. that registrants of the College be granted the use of those reserved titles that apply to them.

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Health Professions Council POST-HEARING UPDATE OF PRELIMINARY REPORT: DENTISTS

Irvine E. Epstein, Q.C., Chair
Arminée Kazanjian, Member
David MacAulay, Member

March 2001

This Post-Hearing Update should be read in conjunction with the [Preliminary Report](#) for the profession.

The Council issued its *Dentists Scope of Practice (Preliminary Report)* in July 1998. The public hearing was held on 14 September 1999. The following are changes to the *Preliminary Report* which arose from the submissions made either at the public hearing or in subsequent written submissions.

I. SCOPE OF PRACTICE

The Council's *Preliminary Report* recommended the following scope of practice for dentists:

The practice of dentistry is the maintenance of health through the assessment, diagnosis, management, treatment and prevention of any disease, disorder or condition of the orofacial complex and associated structures.

The Council has determined that, as a general matter, scope of practice statements should not contain or attempt to list the reserved acts granted to a profession. Accordingly, the Council has removed the term "diagnosis" from the scope of practice statement for dentists.

There is no doubt, however, that dentists may perform diagnosis as that reserved act has been granted to them.

The Health Professions Council recommends the following scope of practice for dentists:

The practice of dentistry is the maintenance of health through the assessment, management, treatment and prevention of any disease, disorder or condition of the orofacial complex and associated structures.

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II. RESERVED ACTS

In its *Preliminary Report*, the Council recommended the following reserved acts for dentists:

1. *Making a diagnosis identifying a disease, disorder or condition of the orofacial complex as the cause of signs or symptoms of the individual.*
2. *Performing the following physically invasive acts:*
 - a. *procedures on tissues of the orofacial complex that would penetrate the epidermis or the surface of a mucous membrane, and procedures in or below the surface of the teeth, including the scaling of teeth;*
 - b. *harvesting of tissue for the purpose of surgery on the orofacial complex;*
 - c. *setting a fracture of a bone of the orofacial complex or reducing a dislocation of a joint of the orofacial complex;*
 - d. *administering a substance by injection or inhalation.*
3. *Applying or ordering the application of a hazardous form of energy.*
4. *Prescribing, compounding or dispensing by any means a drug listed in Schedule I or II of the Pharmacists, Pharmacy Operations and Drug Scheduling Act.*
5. *Prescribing appliances, or dispensing or fitting such prescribed appliances, for dental conditions.*

A. Fabricating Dental Appliances

In its *Preliminary Report*, the Council made the following recommendation:

The Council ... proposes the following ... reserved (act) for dentists:

*Prescribing appliances, or **dispensing** or fitting such prescribed appliances, for dental conditions. (Emphasis added.)*

In the *Dental Technicians Scope of Practice (Preliminary Report)*, issued in June 1999, the Council defined "dispensing" to include fabricating appliances. Therefore, the effect of the Council's recommendation on dentistry was that fabricating appliances for dental conditions would be granted to dentists.

The College of Dental Technicians of British Columbia strongly opposed this recommendation.

In support of its position, the College of Dental Technicians of British Columbia stated that dentists are not trained and educated to perform the act of fabricating or manufacturing dental appliances. Further, it pointed out that under the Council's delegation protocol with respect to supervised acts, a dentist would be able to hire an untrained person who is not a registered dental technician to fabricate and manufacture dental appliances as long as the dentist supervises the process. In a subsequent submission, the College of Dental Technicians of British Columbia stated that giving dentists the authority to fabricate dental appliances expands dentists' scope of practice beyond its current limits. At the public hearing, the College of Dental Technicians of British Columbia submitted that fabricating dental appliances is dangerous and should not be granted to dentists.

Dr. Perry Trester spoke at the hearing on behalf of the College of Dental Surgeons of British Columbia and the Association of Dental Surgeons of British Columbia. He indicated that dentists perform fabrication routinely, including making mouthguards, repairing dentures, relining dentures, making surgical splints and many other services. Dr. Trester stated that fabrication is a fundamental part of dentists' scope of practice, particularly orthodontists. With regard to the allegation that dentists hire untrained people, he stated that it would make no sense to hire untrained people who could not perform proper services. He stated that dentists are fundamentally responsible for the patient's well-being and, as such, ensure that patients are not unduly exposed to risk. Dr. Trester did, however, concede that very few dentists perform the type of fabrication services carried out by dental technicians.

The Council has carefully reviewed the submissions and presentations on the issue of fabricating dental appliances. The Council is satisfied that fabricating dental appliances is an integral part of the practice of dentistry. While there is some risk of harm in the practice of fabricating, dentists are more than qualified to address these risks should they arise.

That said, as Dr. Trester suggested, most dentists do not perform the more sophisticated fabrication procedures performed by dental technicians. As a result, most dentists either send fabrication requests out to dental technology laboratories or hire individuals in their offices to perform these services. Pursuant to the current *Dental Technicians Regulation* under the *Health Professions Act*, non-registrants are prohibited from performing services provided by dental technicians for anyone. This restriction is subject to an exemption which applies to a person who performs the services of a dental technician under direct supervision and in the office of a dentist and exclusively for the practice of the dentist (Reg. 509/95, Sec. 5).

The College of Dental Technicians of British Columbia requests the retention of the prohibition and the elimination of the exemption. It is concerned that under the new regulatory model, dentists will be entitled to delegate this reserved act to anyone they consider to be adequately trained. This issue was considered in more detail in the review of dental technology. In the Council's post-hearing changes for that profession, the Council recommended the following:

No person other than a registrant of a regulated health profession acting within their scope of practice may, for another, dispense prescribed appliances or devices for dental conditions unless such person performs such services under direct supervision in the office of a dentist or medical practitioner and exclusively for the practice of the dentist or medical practitioner.

B. Polishing

Prior to the public hearing, the College of Dental Surgeons of British Columbia (College) submitted that the act of polishing should be a reserved act and granted to dentists, dental hygienists and certified dental assistants. The College of Dental Hygienists of British Columbia stated that with the reserved acts model as currently worded, this service will be in the public domain and would create an unnecessary risk of harm. Dr. Trester, speaking on behalf of the dental profession, stated that polishing can involve soft tissue, and that there is a risk

of tissue damage and infection if the service is not performed properly. The Council has reviewed this issue, including the documentation submitted by the College, and finds that polishing does not raise a significant risk of harm and should not be a reserved act.

C. Should "Attachments" be Added to Dispensing Dental Appliances

In its *Preliminary Report*, the Council recommended the following reserved act for dentists:

The Council ... proposes the following ... reserved (act) for dentists:

Prescribing appliances, or dispensing or fitting such prescribed appliances, for dental conditions.

Prior to the public hearing, the College proposed that the placing of orthodontic appliances which are attached to the teeth, on the surface of the teeth, be reserved and therefore proposed the following change to this reserved act:

*Prescribing appliances, or dispensing or fitting such prescribed appliances for dental conditions
of the orofacial complex, including all attachments to the teeth.*

During the public hearing, Dr. Trester stated "attachments" should be added to this reserved act for the purpose of clarity. He was concerned that the present wording of the act may exclude attachments. In the Council's view, "attachments to the teeth" is included in the reserved act of "prescribing appliances, or dispensing or fitting such prescribed appliances, for dental conditions," and need not be listed separately.

D. Invasive Acts (Reserved Act 2)

The Council did not address the issue of invasive acts in its *Preliminary Report* because the BC Federation of Dental Societies and the College did not request any of the invasive acts on the Council's list of reserved acts. However, prior to the hearing, the College revised its original request and proposed that the following reserved act be granted to dentists:

Putting an instrument, hand or finger(s)

- i. *beyond the external ear canal,*
- ii. *beyond the point in the nasal passages where they normally narrow,*
- iii. *beyond the pharynx,*
- iv. *beyond the opening of the urethra, or*
- v. *into an artificial opening into the body.*

The submission also listed various procedures which required dentists to perform these reserved acts. None of the participants at the public hearing objected to this proposal.

In the Council's view, the inclusion of these reserved acts reflects the current scope of practice of dentistry.

The Health Professions Council recommends the following reserved act for dentists:

2(e) Performing the physically invasive or physically manipulative act of putting an instrument, hand or finger(s)

- i. into the external ear canal,
- ii. beyond the point in the nasal passages where they normally narrow,
- iii. beyond the pharynx,
- iv. beyond the opening of the urethra for purposes of catheterization, or
- vii. into an artificial opening into the body.

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Health Professions Council Emergency Medical Assistants Scope of Practice Preliminary Report

Irvine E. Epstein, Q.C., Chair
Arminée Kazanjian, Member
David MacAulay, Member

March 1999>

This Preliminary Report should be read in conjunction with the [Post-Hearing Update](#) for the profession.

FOREWORD

This report is the result of the Health Professions Council's review of the scope of practice of emergency medical assistance pursuant to the [Terms of Reference](#) from the Minister of Health and Minister Responsible for Seniors. Under the [Health Professions Act](#), the Health Professions Council is a six person advisory body appointed by the Government of British Columbia to make recommendations to the Minister of Health and Minister Responsible for Seniors about the regulation of health professions.

In this report the Health Professions Council examines how the existing scope of practice of emergency medical assistants should be legislatively defined in order to reflect fairly and accurately the current state of practice and the public interest in the practice of emergency medical assistance.

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EXECUTIVE SUMMARY

The Health Professions Council has conducted a review of the scope of practice of emergency medical assistance.

The purpose of the review is to provide recommendations to the Minister of Health and Minister Responsible for Seniors regarding four matters: scope of practice statements, reserved acts, supervised acts, and reserved titles.

The Health Professions Council has conducted a detailed consultation process and its recommendations regarding the four elements of the scope review are as follows:

1. The practice of emergency medical assistance is the performance of prehospital emergency procedures necessary for the preservation of life and health for which training and medical direction or supervision are provided.
2. The Council does not recommend any reserved acts be granted to emergency medical assistants.
3. The Council recommends the titles "emergency medical assistant" and "paramedic" be reserved for registrants who are licensed by the Board.

I. INTRODUCTION

A. THE NATURE OF THE REVIEW

This is the preliminary report of the review of the scope of practice of emergency medical assistance by the Health Professions Council (the Council).

The review was conducted pursuant to [Terms of Reference](#) issued by the Minister of Health and Minister Responsible for Seniors in accordance with section 25 [24] of the [Health Professions Act](#) (the HPA). The [Terms of Reference](#) direct the Council to review the scopes of practice of the recognized health professions, of which EMA is one.

The [Terms of Reference](#), which are included as [Terms of Reference](#) to this report, indicate that there are four main elements to the scope of practice review:

- i. scope of practice statements which describe what the profession does, the methods it uses and the purpose for which it does it;
- ii. reserved acts which are those acts that present such a significant risk of harm that they should be performed only by professionals who are qualified to perform them;
- iii. supervised acts which are reserved acts, or aspects of reserved acts, which may be performed by persons supervised by health professionals; and
- iv. reserved titles which are titles that describe a profession's services and which are reserved exclusively for the health profession.

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B. THE PROCESS FOR THE REVIEW

The general process for the review provides for an initial meeting with the profession(s), submission of briefs by the regulatory body and professional association for each profession, a consultation process involving all health professions and interested parties regarding each professions' submission, drafting of a preliminary report, public hearings and a final report.

On January 27, 1995, the Council met with representatives of the Emergency Medical Licensing Board (the Board), the British Columbia Ambulance Service (BCAS) and the Canadian Union of Public Employees, Local 873. These three groups then jointly submitted the scope of practice review brief ("the joint submission") for emergency medical assistants.

This report will be circulated to all health professions and other interested parties who participated in the Council's consultation process.

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C. THE REGULATION OF EMERGENCY MEDICAL ASSISTANTS

Prior to 1974, emergency medical services were essentially unregulated. They were provided by a variety of public and private bodies.

In 1974, the issue of ambulance service was reviewed by the Foulkes Commission and referred to in its report, "Health Security for British Columbians, Special Report: Consumer Participation, Regulation of the Professions, and Decentralization". As a result of the Foulkes Commission recommendations, in 1974 the government established the Emergency Health Services Commission (the Commission) under the [Health Emergency Act](#) (HEA). The Commission was given exclusive jurisdiction to provide emergency services throughout the province, and to deal with all matters related to ambulance services, including recruiting and training.

In the years following its inception, problems arose which were associated with the Commission acting both as employer and licensing body. In 1991, the Board was established and given the mandate to examine, register and license emergency medical assistants (EMAs), and investigate complaints made against them.

There are at the present time, two bodies involved in the regulation of emergency services in British Columbia under the HEA, the Commission and the Board.

The Commission is made up of senior government employees appointed by the Lieutenant Governor in Council. Pursuant to the HEA the Commission is for all purposes an agent of government, and it is required to submit an annual report to the Minister about its operation.

The Commission's role is set out in section 5(1) [5(1)] of the HEA:

Power and authority of commission

5 (1) The commission has the power and authority to do one or more of the following:

- A. *provide emergency health services in British Columbia;*
- B. *establish, equip and operate emergency health centres and stations in areas of British Columbia that the commission considers advisable;*
- C. *assist hospitals, other health institutions and agencies, municipalities and other organizations and persons, to provide emergency health services and to train personnel to provide services, and to enter into agreements or arrangements for that purpose;*
- D. *establish or improve communication systems for emergency health services in British Columbia;*
- E. *make available the services of medically trained persons on a continuous, continual or temporary basis to those residents of British Columbia who are not, in the opinion of the commission, adequately served with existing health services;*

- F. *recruit and train emergency medical assistants;*
- G. *provide ambulance services in British Columbia to be known as the British Columbia Ambulance Service;*
- H. *perform any other function related to emergency health services as the Lieutenant Governor in Council may order.*

The Commission has a very broad mandate, dealing with virtually all matters related to emergency services, including, under section 5(1)(f) [5(1)(f)] of the HEA, the responsibility for recruiting and training all EMAs. All EMAs are government employees.

The Commission is essentially the board of directors for the BCAS which is part of the Ministry of Health. The BCAS is the operational arm of the Commission, and provides it with support. The Commission has also established a medical advisory committee consisting of selected medical personnel and educators. The advisory committee's role is to discuss medical protocols and process issues, and to make recommendations to the Commission.

The Board, like the Commission, is made up of Lieutenant Governor in Council appointees. The Board has three members, one of whom must be an emergency medical assistant and another of whom must be a medical practitioner. The third, in practice, has been a lawyer experienced in labour law. The Board reports to and is funded by the Minister.

The Board's role is set out in section 6(5) [5.1(4)] of the HEA:

Emergency Medical Assistants Licensing Board

6(5) Subject to this Act and the regulations, the board has the power and authority to do the following:

- a. *examine, register and license emergency medical assistants;*
- b. *set terms and conditions for a licence under this section;*
- c. *investigate complaints;*
- d. *delegate to one or more persons the power and authority to act under one or more of the provisions of paragraphs (a), (b) and (c).*

The Board's main functions are licensing and discipline.

Support for the Board's activities is provided by the EMA Licensing Branch of the Ministry of Health. The Branch has several full time staff, including a Registrar who manages the Board's activities.

The regulatory functions for EMAs are shared by the Commission and the Board, with support from various personnel within the Ministry of Health.

The regulatory structure for EMAs indicates that the profession is not, in fact, a self-regulating profession.

Self-regulating professions are typically governed by officers and directors elected by members of the profession who are given the power, among other things, to set entry and practice standards, and administer a disciplinary regime. In a self-regulatory system, government effectively delegates its administrative and regulatory authority to the profession so that it may govern itself in the public interest.

In contrast, the profession of EMA is regulated both directly and indirectly by government, through the Commission and the Board. The regulatory regime is essentially a government administered licensing and certification system. Of the professions subject to the Council's scope of practice review the profession of EMA is unique in this regard.

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II. THE POLICY BACKGROUND

The main impetus for a scope of practice review was the Report of the British Columbia Royal Commission on Health Care and Costs (the Seaton Commission). The Seaton Commission stated that the existing legislation governing the health professions creates persistent jurisdictional disputes and a distinct lack of cooperation among the health professions, despite the fact that all health professional colleges have the same mandate - to protect the public from preventable harm.

The Seaton Commission stated that the primary reason for the jurisdictional disputes was the present regulatory system's reliance on exclusive scopes of practice. Under the exclusive scope of practice model, the various health professions have been granted an exclusive right to practice within a legislatively defined scope of practice. No one, other than a member in good standing of that profession, can perform acts within the profession's scope of practice unless they are granted an exemption.

The Commission concluded:

...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.

(Closer to Home, The Report of the Royal Commission on Health Care and Costs in British Columbia, Volume 2, 1991, p. D-33)

This recommendation is also consistent with legislative initiatives underway in Alberta. The Seaton Commission was not the first review body to suggest that the present legislative model of exclusive scopes of practice was inappropriate. Restricting professional monopolies (exclusive scopes of practice) was also recommended in an earlier study commissioned by the British Columbia Minister of Health. In discussing the conflicts which may arise between the professional college and the public interest, the issue of exclusive scopes of practice was raised:

It must be emphasized that any professional legislation which unduly restricts the scope of practice of skilled personnel may be contrary to the public interest in greater supply and

accessibility of service through the development of team practice. Therefore, it is urged that: Professional legislation should not contain narrow restrictions or rigid definitions of scope of practice which are excessively exclusive; that measures should be taken (as indicated below) to reduce the area of interprofessional strain and conflict; and that no prosecutions for violations of scope of practice legislation should be undertaken without the prior consent of the appropriate public authority.

Insofar as may be possible with due regard for public safety, professional law should not place rigid restrictions on the scope of practice of allied health personnel, and greater flexibility should be encouraged in the allocation of roles between the health disciplines.

(Professor J.T. McLeod, "Public Regulation of the Professions" in Health Security for British Columbians, Special Report: Consumer Participation, Regulation of the Professions, and Decentralization (1974), the report of Richard D. Foulkes, B.A., M.D., F.A.P.H.A. to the Minister of Health, Province of British Columbia, Tome Three, p. 145)

Thus, the trend in regulatory policy for the health professions has been towards reducing exclusivity in order to enhance interdisciplinary practice, improve accessibility to health care services and increase consumer choice, while at the same time maintaining the fundamental objective of protecting the public.

These policy trends are clearly reflected in the [Terms of Reference](#) for the scope of practice review which provide the basis for a new regulatory framework for health professions in British Columbia. The core elements of the new framework are scope of practice statements and reserved acts.

Under the present system, scope of practice statements are exclusive. In the new system, scope statements will not be exclusive but professions may be granted reserved acts.

Reserved acts are those elements of a profession's scope of practice which present such a significant risk of harm that they should be reserved to a particular profession, or shared amongst particular professions. Thus, unlike the present system in which each profession is granted exclusivity within its entire defined scope of practice (subject to specified exceptions), only those acts which present a significant risk of harm will be reserved.

In short, the government has assigned the Council the task of creating a regulatory model based on broad, non-exclusive scope of practice statements and narrowly defined reserved acts.

The government has the responsibility to ensure that those services which are accessible are safe and that the regulatory framework for the practice of health professions protects the public from incompetent, impaired, or unethical practitioners. At the same time, the regulatory framework should not entrench a paternalistic function for professions or reserve exclusive areas of practice simply to enhance professional status and control.

The new system of overlapping scopes of practice and narrow reserved acts removes barriers to interdisciplinary practice and offers greater choice and accessibility to the public. In the Council's view, the public interest is served by professional legislation which promotes quality in the delivery of health care services within safe parameters. Indeed, the Council's primary policy objective in conducting its review is achieving the optimum balance between safe practice and consumer choice.

With this in mind, the Council proposes to consider the practice of emergency medical assistance having regard to the four elements of the scope review.

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III. DISCUSSION OF ISSUES

The main issues raised by this review are the four elements listed above: scope of practice, reserved acts, supervised acts and reserved titles.

The Council's [Terms of Reference](#) direct it to review these four elements with regard to EMAs.

A. SCOPE OF PRACTICE STATEMENT

The scope statement describes what the profession does, the methods it uses, and the purpose for which it does it. Unlike the present legislative scheme, the statement itself does not grant an exclusive scope of practice. Nonetheless, the statement is important because: 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; and it informs the public about the services practitioners are qualified to perform. It is expected that the Council's recommendations will increase overlapping scopes of practice. The Council's Working Paper, issued in January 1998, indicates that "a scope of practice statement will define an individual profession's activities in broad, non-exclusive terms."

The Council believes that it is not necessary or useful to itemize every facet of a profession's scope of practice. Rather, a scope of practice definition should be sufficiently descriptive so that other health professions and members of the public alike can understand what the particular health professional does.

Unlike the other professions subject to the Council's scope of practice review, emergency medical assistance does not have a specifically defined scope of practice. Instead, various provisions in the HEA set out the Commission's powers to describe the services provided by various levels of EMAs.

The joint submission to the Council asserts that the present scope of practice which is contained in s. 5(1) of the HEA should be retained, as follows:

5 (1) The commission has the power and authority to do one or more of the following:

(a) provide emergency health services in British Columbia;

(b) establish, equip and operate emergency health centres and stations in areas of British Columbia that the commission considers advisable;

(c) assist hospitals, other health institutions and agencies, municipalities and other organizations and persons, to provide emergency health services and to train personnel to provide services, and to enter into agreements or arrangements for that purpose;

(d) establish or improve communication systems for emergency health services in British Columbia;

- (e) make available the services of medically trained persons on a continuous, continual or temporary basis to those residents of British Columbia who are not, in the opinion of the commission, adequately served with existing health services;
- (f) recruit and train emergency medical assistants;
- (g) provide ambulance services in British Columbia to be known as the British Columbia Ambulance Service;
- (h) perform any other function related to emergency health services as the Lieutenant Governor in Council may order.

The joint submission for the EMA scope of practice states:

The HEA and Regulations clearly give the Emergency Health Services Commission full responsibility for pre-hospital emergency care procedures. Section 5(1) of the Act outlines this responsibility including the power and authority to "provide emergency health services in the Province" and to "establish, equip and operate emergency health centres and stations in areas of the Province".

Section 5(2) of the Act specifically states that "no person shall, except with the written consent of the commission and on terms it may specify, do anything that the Commission is given the power to do under subsection (1)."

Restricting scope of practice to the Commission is an important component to ensuring consistent, appropriate and available treatment to the general public anywhere in the Province. Through the existence of an intricate infrastructure involving physician driven protocols, regional and provincial dispatch and standard equipment and policy, actions of EMAs operating independently in emergency situations are controlled and appropriate.

As the single employer, the Commission has developed protocols and procedures, on the basis of recommendations put forth by the Medical Advisory Committee, which will apply to all EMAs in the Province.

...No change is felt to be necessary for the current EMA scope of practice definition. Although section 5 of the Act can be interpreted as granting broad powers for emergency health services, it has effectively provided government with the tools to deal with a constantly changing environment.

Section 6 of the HEA identifies the function and responsibilities of the EHSC. Section 6 also states that an EMA "may perform emergency procedures that he has been trained for and that he considers necessary to preserve the person's life or health until the services of a medical practitioner are available." The Regulations under the HEA, Schedules A to G, Appendix B, further define the procedures which are authorized for use by EMAs. The joint submission comments at page 2:

Many of the protocols and procedures performed by EMAs are medically invasive procedures as can be seen in the descriptions of general training requirements defined in Schedules A to G or

the Regulations. Normally, these medical procedures would be restricted to qualified medical physicians under the [Medical Practitioners Act](#). Section 6 of the HEA, however...allows for the "link" provided by EMAs between the patient in need of immediate attention and the physician who has been trained to provide the highest level of care.

The British Columbia Medical Association (BCMA) comments that:

BCMA has no concerns about the scope of practice being proposed as it represents the status quo...physicians working with the BC Ambulance Service must have confidence in the ability of any crew member they are directing either by radio or by use of protocols...the EMA must remember that he or she is always responsible to a physician...the physician knows the level to which the EMA has been trained and licensed EMAs are supervised by a designated ER physician. There is no process for controlling unlicensed EMAs. The current monitoring system ensures that the EMAs only do what they are trained to do, yet at the same time provide a level of service that is not available from anyone else.

The Council notes that several respondents to the consultation process commented that the scope of practice definition proposed was not a scope statement. Registered Nurses Association of British Columbia (RNABC) commented that:

...section 5 of the HEA...describes the powers of the EHSC in relation to the provision of emergency health services...This appears to be a scope of setting statement rather than a scope of practice statement...This approach to defining scope of practice is problematic as it does not clearly identify the boundaries of practice for EMAs. The result is lack of clarity regarding what is within the EMAs scope of practice and in what setting, i.e., pre-hospital or other, they are legally authorized to practice. Section 5(1)(e) provides another example of the confusion created by using the powers of the commission to defining EMA scope of practice. This section allows for the provision of services of medically trained persons to residents of the Province who are not, in the opinion of the commission, adequately served with existing health services. This provision could result in EMAs providing, in addition to emergency health services, health services that are outside the proposed scope of practice.

New Brunswick Health and Community Services commented that the proposed scope of practice:

...appears to limit the services of EMAs to circumstances where a physician is not available, the procedure is an emergency one, and there is an immediate threat to life...in practice..fewer than 10% of ambulance calls involve life-threatening situations...."emergency procedure" is not defined, we wonder if EMAs would be providing services which would not always be considered "emergency procedures"...who would have the ability/authority to define a situation as life-threatening, thereby "legitimizing" the provision of emergency procedures by EMA's? Perhaps this could be addressed by allowing an EMA to make such a decision on the basis of a "reasonable apprehension" that a situation is life-threatening....the proposed scope of practice would seem to rule out what has become a growing practice in both the U.S and some parts of Canada - using EMAs in hospital emergency departments, industrial safety settings, police lock-ups, etc., in a primary care role rather than just in mobile emergency response units). In some of these settings, a physician may be present.

Ian Brethour, Registrar, EMA Licensing responded to the comments of RNABC and New Brunswick Ministry of Health with regard to the "scope of setting" limitations placed upon EMA practice in BC:

*...it is necessary to define the setting for EMA activity in this way...With other professions, the consumer can make reasonable and responsible choices as to who, what, where and when practitioner care will be accessed. In contrast, an EMA is often required to provide care to an individual who is not in a position to make a choice...consequently an infra structure exists to ensure that the general public is provided the best immediate care in a timely manner, ultimately finishing with a team of hospital physicians and nurses with the equipment and expertise to continue providing the best care possible....Considerable effort has been made to ensure that EMA actions are standardized and the most appropriate for any given situation. Specifically, this includes the Act and Regulations; EMA Licensing Board policy; and **detailed protocols and procedures based on the recommendations of a team of physicians comprising the Medical Advisory Committee.** (emphasis added)*

The scope of practice definition required by the terms of reference must describe what the profession does, the methods it uses and the purposes for which it performs its functions. In the Council's view, the submission made on behalf of EMAs describes the profession's function as the provision of pre-hospital emergency services and limits the settings in which those services can take place, however, does not refer to the methods EMAs use or the purpose of the services provided. The current scope of practice statement contained in the HEA s.5.(1), s.6 and the Regulation is not exclusive although it is limited in setting and it does not resemble other scope of practice statements set out in legislation governing self-regulating professions.

The Council notes that no other province provides a scope of practice statement for EMAs of the type that is required by the Council's [Terms of Reference](#).

The Ontario Ministry of Health made no comment on the scope of practice statement proposed in the joint submission. EMAs have made three unsuccessful attempts to become a self-regulating profession under the Regulated Health Professions Act in Ontario. The major stumbling block has been the "lack of a unique body of practice" EMAs are regulated under the Ambulance Act and since 1998 the Services Improvement Act has shifted the funding for ambulance services to the upper-tier municipalities. In 2000, these municipalities will become responsible for contracting or directly delivering land ambulance services.

The Ontario Ministry of Health, Emergency Health Services Branch, regulates the practice of EMAs (Paramedics 1 and 2) and provided the Council with a copy of their Basic Life Support Standards which "explicitly define the BLS scope of practice for Paramedic 1s". The standards document does not set out a scope of practice statement but rather lists specific health services and acts. As a matter of policy, the Ministry also allows Paramedic 1s to practice selected Advanced Life Support (ALS) controlled acts as defined and regulated by the College of Physicians and Surgeons of Ontario. The Ministry approves Paramedics to practice these advanced skills when certain system prerequisites, e.g. base hospital medical direction and quality assurance, are in place. The Ministry is currently studying the ALS scope of practice of paramedic 2s and anticipates that the findings will provide an "informed scientific basis for defining the ALS scope of practice".

In Quebec and Prince Edward Island, ambulance services are regulated under public health acts which provide for basic categories of ambulance drivers and ambulance attendants. The training requirements are up to a maximum of 120 hours in Quebec for an ambulance attendant. The Ministry of Health and Social Services of Quebec states that it has no plans to extend the scope of practice of its ambulance attendants and comments that "scientific literature did not show significant differences on mortality and morbidity between care delivered by paramedics and non-paramedic EMTs". Prince Edward Island is setting up a new regulatory system for ambulance operations and workers, including a "paraprofessional called EMT -- licensed for a basic set of skills/procedures upon completing an accredited community-college program".

The Nova Scotia Department of Health, Emergency Health Services commented with regard to the proposed scope of practice statement that:

[we recommend] something be inserted...concerning the authorization or extension of the authority by a physician (Medical Control) through protocols or standing orders to allow these Acts to be performed. We further recommend that some limitation [be] placed on those Acts falling under the medical control arm of the Emergency Health Services Branch, and not be legislated. The rapid changes in technology have produced very unwieldy legislation severely handcuffing physicians and pre-hospital care providers in moving quickly to implement such changes in the interest of patient care. Our approach in Nova Scotia has been to produce enabling legislation while leaving the flexibility to manipulate and change policies relating to delegated acts as required.

In Alberta, Emergency Medical Technicians (EMTs) are regulated under the EMT Regulation of the Health Disciplines Act (HDA). This Regulation sets out explicit health services EMAs may perform. The Regulation also establishes Alberta Prehospital Professions Association which is given through the HDA certain powers and functions, including registration/licensing, membership fees, maintenance of competence of its members and complaint and discipline powers. In all cases these services are performed "under medical control and with an ongoing medical audit". There are three other pieces of legislation which affect EMTs in Alberta. The Ambulance Services Act sets out licensing requirements for persons operating an ambulance service. The Municipal Government Act sets out the municipality's power to establish ambulance operations within its jurisdiction. Ambulance services in Alberta are provided by both private and public/municipal entities. The Regional Health Authorities Act sets out provisions dealing with the transportation of patients to hospitals from the different health regions. A descriptive scope of practice statement is contained in the proposed Health Professions Act which will be reintroduced in the legislature in Spring 1999:

In their practice, emergency medical technicians, emergency medical technologists and emergency medical responders do one or more of the following:

- (a) assess an individual's health status to determine the need, priority and method of treatment and transportation in order to provide a range of emergency services, and*
- (b) provide restricted activities authorized by the regulations.*

In the Council's view, the scope of practice proposed for EMAs in the joint submission does not meet the Council's [Terms of Reference](#). However, the text of s.6 of HEA most closely approximates the scope statement required. In the Council's view it fairly and accurately describes the current scope of EMA practice. The Council has included the critical requirement of direction and/or supervision of an EMA by a member of the CPSBC and the existing setting limitation in the following scope of practice statement:

RECOMMENDATION 1: The practice of emergency medical assistance is the performance of prehospital emergency procedures necessary for the preservation of life and health for which training and medical direction or supervision are provided.

B. RESERVED ACTS

The rationale underlying the granting of reserved acts is to protect the public by limiting provision of those particularly dangerous acts to members of specific professions who are qualified to perform them. Only those acts which present a significant risk of harm will be reserved. The Council developed a list of reserved acts (Appendix C), and included it in a report it recently issued, the Council's [Shared Scope of Practice Model Working Paper](#) (SSPMWP).

The joint submission on behalf of EMAs proposes that the current "exclusive scope of practice" governing the practice of the profession as set out in section 5 of the HEA be retained as the reserved act(s) granted to EMAs:

Section 5(1) identifies the broad powers utilized by the EHSC. Except for medical practitioners (section 6 of the Act), only EMAs are authorized to provide emergency services to the general public. No one else can perform these activities unless specifically granted permission to do so by the EHSC (Section 5(2) of the Act.)... Although section 5 of the Act appears to include more than pre-hospital care, section 5(1)(c) limits EHSC activity to the pre-hospital setting; it is to "assist" hospital and other health institutions...Consequently, no change to existing legislation in regard to reserved act(s) is proposed...There are no reserved acts that could be performed jointly in the pre-hospital emergency care setting with other regulated professions. This area of activity needs to remain solely with EMAs employed by the EHSC...

The Council is not in a position to grant reserved acts to EMAs except under supervision of a member of the CPSBC and which have been specifically delegated by the CPSBC to EMAs and which meet the criteria set out in the SSPMWP for delegation of reserved acts:

The Council recommends that a provision be enacted which sets out the duties of a health professional and his or her regulatory college when delegating a reserved act. The provision should require the following:

- *The assigning health professional's governing body must provide assent to the proposed reserved act being performed by someone else;*
- *The reserved act to be assigned as well as the level of supervision must be clearly defined and circumscribed by the assigning health professional's governing body;*
- *Where the person to whom the act will be assigned is a regulated health professional, his or her governing body must approve of the assigning of the reserved act;*
- *The instruction to perform the act must be made in writing either by way of a general written protocol or through a case-specific instruction;*
- *The assigning health professional must be satisfied that the individual who will be performing the act has the necessary skills and training to perform the act safely;*
- *The assigning health professional must ensure that the person who will be performing the act accepts the assignment.*

EMAs are not qualified to independently perform reserved acts, but they are qualified by their training to perform any that are delegated to them by the CPSBC. Reserved acts that are delegated may also be delegated in the same manner to other qualified professionals. For example, registered nurses will continue to be able to perform reserved acts delegated to them in outpost settings as detailed under protocols and procedures jointly approved by the CPSBC and the RNABC.

RECOMMENDATION 2: The Council does not recommend any reserved acts be granted to emergency medical assistants.

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C. SUPERVISED ACTS

The issue of supervised or delegated acts arises only when a profession has been granted a reserved act(s). The Council is not currently recommending any reserved acts be granted to EMAs, consequently there is no need to discuss the joint submission on this issue.

D. RESERVED TITLES

Reserved titles are titles reserved exclusively to a health profession. Reserved titles afford a means for consumers to identify the different types of health care providers, to distinguish the qualified from the unqualified, and to differentiate those practitioners who are regulated from those who are not. Titles must adequately serve the public in describing the practitioner and the services being provided and must distinguish the practitioner from others performing similar services.

The use of the title "Emergency Medical Assistant (E.M.A.)" is currently reserved in the [Health Emergency Act](#) only to individuals who are licensed by the Board. First responders are referred to as E.M.A.F.R. and ambulance attendants are identified as E.M.A.F.A., 1, 2, or 3 depending on the level of training acquired.

The joint submission proposes that all ambulance attendants who have attained the level of E.M.A. 1, 2, or 3 (Advanced Life Support, "A.L.S.", and Infant Transport Team, "I.T.T.") should be referred to as Paramedic 1, Paramedic 2, Paramedic A.L.S., and Paramedic I.T.T., respectively. Individuals who are initially hired by British Columbia Ambulance Service with a first aid certificate should retain the title of E.M.A.F.R. and E.M.A.F.A., respectively.

The joint submission provided the following rationale:

For years the general public has had a clear perception of what a paramedic is in much the same manner as a medical practitioner, registered nurse or ophthalmologist. The same, however, cannot be said for the title of emergency medical assistant.

The title of Paramedic provides a clearer image to the general public that the individual providing pre-hospital emergency care has in fact received appropriate training to do so. It is a term that is used elsewhere in and outside Canada to refer to practitioners in pre-hospital emergency care.

Use of the title paramedic by anyone not registered with the E.M.A. Licensing Board would be detrimental to the public interest. Services provided in the pre-hospital care setting are often under emergent and life threatening conditions. Consequently, the general public must have confidence help being provided is not only suitably qualified but that it will result in the best possible outcome.

The proposed changes to title will also help to distinguish the different roles played by first responders and ambulance attendants. Although the importance of having first responders located throughout the Province has been clearly recognized, it is important that the general public is able to identify that first responders are not equipped or trained to provide the same services provided by ambulance attendants. The initial contact provided by first responders when they are first on the scene coupled with being able to provide assistance to higher trained ambulance attendants when they arrive ensures that there is a continuation of patient care. The continuum of care for the patient is completed once the patient arrives at the emergency department where a physician can take over.

The Council notes that no respondents to the consultation process opposed the use of the title "paramedic". The RNABC, the BCMA and the British Columbia Society of Medical Laboratory Technologists (BCSMLT) support the reserved title "paramedic". "Paramedic" is reserved in Ontario for EMAs.

RECOMMENDATION 3: The Council recommends the titles "EMA" and "Paramedic" be reserved for registrants who are licensed by the Board.

The joint submission contained extensive information about the six categories of EMAs defined under the HEA. All persons licensed by the Board must meet certain prescribed educational criteria and standards of practice based upon the level of EMA practice for which they are licensed or employed. In the Council's view, all persons who are licensed by the Board would fall within either the category "EMA" or the category "paramedic". The Council considers that these two titles and variations of them, which describe the specific level of training achieved, are in the public interest.

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IV. RECOMMENDATIONS

1. The practice of emergency medical assistance is the performance of prehospital emergency procedures necessary for the preservation of life and health for which training and medical direction or supervision are provided.
2. The Council does not recommend any reserved acts be granted to emergency medical assistants.
3. The Council recommends the titles "emergency medical assistant" and "paramedic" be reserved for registrants who are licensed by the Board.

Last Revised: March 08, 2002

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Health Professions Council POST-HEARING UPDATE OF PRELIMINARY REPORT: EMERGENCY MEDICAL ASSISTANTS

Irvine E. Epstein, Q.C., Chair
Arminée Kazanjian, Member
David MacAulay, Member

March 2001

This Post-Hearing Update should be read
in conjunction with the [Preliminary Report](#) for the profession.

The Council issued its *Emergency Medical Assistants Scope of Practice (Preliminary Report)* in March 1999. There was no public hearing. There have been no changes to the *Preliminary Report*.

Last Revised: March 08, 2002

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Health Professions Council Massage Therapists Scope of Practice Preliminary Report

Irvine E. Epstein, Q.C., Chair
Arminée Kazanjian, Member
David MacAulay, Member

February, 1999

This Preliminary Report should be read in conjunction with the [Post-Hearing Update](#) for the profession.

FOREWORD

This report is the result of the Health Professions Council's review of the scope of practice of massage therapy pursuant to the [Terms of Reference](#) from the Minister of Health and Minister Responsible for Seniors. Under the [Health Professions Act](#), the Health Professions Council is a six person advisory body appointed by the Government of British Columbia to make recommendations to the Minister of Health and Minister Responsible for Seniors about the regulation of health professions.

In this report the Health Professions Council examines how the existing scope of practice of Massage Therapy should be legislatively defined in order to reflect fairly and accurately the current state of practice and the public interest in the practice of massage therapy.

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EXECUTIVE SUMMARY

The Health Professions Council has conducted a review of the scope of practice of massage therapy.

The purpose of the review is to provide recommendations to the Minister of Health and Minister Responsible for Seniors regarding four matters: scope of practice statements, reserved acts, supervised acts, and reserved titles.

The Health Professions Council has conducted a detailed consultation process and its conclusions and recommendations regarding the four elements of the scope review are as follows:

1. The Council recommends the following scope of practice statement for members of the College of Massage Therapists:

The practice of massage therapy is the assessment of the soft tissues and joints of the body and the treatment and prevention 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.

2. The Council recommends that massage therapists not be granted any reserved acts.
3. The Council recommends the title "Registered Massage Therapist" be reserved for members of the College of Massage Therapists.

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I. INTRODUCTION

A. THE NATURE OF THE REVIEW

This is the preliminary report of the review of the scope of practice of massage therapy by the Health Professions Council (the Council).

The review was conducted pursuant to [Terms of Reference](#) issued by the Minister of Health and Minister Responsible for Seniors in accordance with section 25 [24] of the [Health Professions Act](#) (the HPA). The [Terms of Reference](#) direct the Council to review the scopes of practice of the recognized health professions, of which massage therapy is one.

The Terms of Reference, which are included as [Appendix A](#) to this report, indicate that there are four main elements to the scope of practice review:

- I. scope of practice statements which describe what the profession does, the methods it uses and the purpose for which it does it;
- II. reserved acts which are those acts that present such a significant risk of harm that they should be performed only by professionals who are qualified to perform them;
- III. supervised acts which are reserved acts, or aspects of reserved acts, which may be performed by persons supervised by health professionals; and
- IV. reserved titles which are titles that describe a profession's services and which are reserved exclusively for the health profession.

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B. THE PROCESS FOR THE REVIEW

The general process for the review provides for an initial meeting with the profession(s), submission of briefs by the regulatory body and professional association for each profession, a consultation process involving all health professions and interested parties regarding each professions' submission, drafting of a preliminary report, public hearings and a final report.

This report will be circulated to all health professions and other interested parties who participated in the Council's consultation process.

The HPC met with representatives of the British Columbia College of Massage Therapists (the "College") in December 1994. The B.C. Association of Massage Therapists (BCAMT) was not in attendance. In September 1995 a second meeting was held with representatives of the College who, at that time, presented the HPC with a copy of their scope of practice submission. Only the College submitted a scope of practice brief on behalf of the profession of massage therapy. In January 1996, the brief was summarized and distributed to interested groups and individuals including other regulated and unregulated health professions, teaching facilities and other provinces. After discussion with the Council, the College subsequently amended its original brief by letters in July and September 1996.

Respondents to this consultation process focussed on a number of issues which the Council felt warranted further investigation. In July 1996, members of the Council made a site visit to the West Coast College of Massage Therapy to clarify concerns regarding the education and training of massage therapists which had arisen as a result of the consultation process. Following this visit, the Council requested that the College clarify issues which were unresolved by the Council's own investigation. In August 1996, members of the Council again met with representatives of the College for discussions about issues raised during the consultation process. In July 1998, the College submitted a second scope of practice brief in response to the [Council's Shared Scope of Practice Model Working Paper](#) (the *Working Paper*) which was issued in January 1998. This July 1998 submission replaces the September 1995 submission which was withdrawn in response to the [Working Paper](#).

This report is written to reflect both the 1998 submission and relevant parts of the original 1995 submission. Those parts of the 1995 submission which the Council considers relevant are those which were reiterated in the

1998 submission. The 1995 submission was the subject of the initial consultation process in 1996 and comments made about relevant parts of that submission by respondents will be included in this preliminary report. The Council will conduct public hearings in 1999 and interested parties who wish to comment about the BCCMT 1998 submission and this preliminary report should submit their comments in writing to the Council prior to that hearing. Both documents are available on the HPC website. Only those who have responded in writing to the 1998 submission and/or this preliminary report will be invited to make an oral presentation at the hearing.

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C. THE REGULATION OF MASSAGE THERAPY IN BRITISH COLUMBIA

Massage therapists were initially governed under one act with physiotherapists. The first provincial enactment was the Physiotherapists and Massage Practitioners Act, S.B.C. 1946, c. 59. It created the Association of Physiotherapists and Massage Practitioners of British Columbia, the regulatory body, as well as the Board of Physiotherapists and Massage Practitioners. The first enactment defined massage and physiotherapy and restricted the use of the following reserved titles: chartered physiotherapists, physiotherapists, massage practitioner, and masseur.

In 1954, the Physiotherapists and Massage Practitioners Amendment Act, 1954, c.32, provided for several amendments. The Board of Physiotherapists and Massage Practitioners was renamed the Council of Physiotherapists and Massage Practitioners, and was given the power to make regulations respecting applications, cancellations, suspensions, and reinstatement of members. Educational qualifications were revised while the requirements of a school to be able to teach massage were defined. Registered physiotherapists and masseurs were given the exclusive right to practise their respective fields and the Council was given authority to approve all schools teaching physiotherapy and massage. The Physiotherapists and Massage Practitioners Amendment Act, 1957, c.48 made it illegal for a hospital employee, other than a registered physiotherapist or massage practitioner, to provide massage of any kind for patients. An amendment was made to exempt from the prohibition certain hospitals, particularly those which were too small to employ a physiotherapist or massage practitioner.

In 1972, the Physiotherapists and Massage Practitioners Act, 1972, c. 42, eliminated the reference to the Trade-School Regulation Act and the teaching of physiotherapy as well as the requirement that standards of education of the Canadian Physiotherapy Association apply under the Act. In 1979, the statute was renamed the Physiotherapists Act, R.S.B.C. 1979, c.327. The Health Statutes Amendment Act, 1984, c. 19, removed the specific reference to the minimum academic requirements for registration as a massage therapist and allowed the Minister and the Council to determine the requirements.

In 1987, the Health Statutes Amendment Act, 1987, c. 55, revised educational and training qualifications for registration as a physiotherapist to include training as a remedial gymnast. The educational qualifications for registration as a masseur were likewise revised. While the act repealed the power of the Lieutenant Governor in Council to make regulations prescribing educational qualifications and requirements for temporary registration, it permitted the Minister to request an amendment to a rule. Subsequently, the Health Professions Statutes Amendment Act, 1993, c. 50, set out the duties and objects for the regulatory body and Association of Physiotherapists and Massage Practitioners. It mandated for the requirement of public representation in the association while enhancing the association's investigatory and suspension powers.

Finally, the Health Professions Statutes Amendment Act, 1994, c. 42, repealed the Physiotherapists Act, R.S.B.C. 1979, c. 327, as the professions of Physiotherapists and Massage Practitioners were designated under the HPA in December, 1994. The designation was pursuant to the Lieutenant Governor in Council's power to designate a health profession under section 12 [12] of the HPA without directing the Council to conduct an investigation. Under the HPA two separate colleges were established: the College of Physical Therapists of British Columbia and the College of Massage Therapists of British Columbia.

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D. THE REGULATION OF MASSAGE THERAPY IN OTHER PROVINCES

In Ontario, massage therapy is regulated under the *Massage Therapy Act*. The title "massage therapist" is reserved to members of the College of Massage Therapy, however massage therapists have been granted no controlled acts under the *Regulated Health Professions Act*.

In Quebec, the Office des professions du Québec conducted an extensive consultation process to determine whether massage therapy should be regulated under the Code des professions. Their report was issued in 1992 and determined that massage therapy did not meet the criteria required for this type of professional regulation. In particular "the gravity of the prejudice or damage which might be sustained by those who have recourse to the services of such persons because their competence or integrity was not supervised by the order" did not meet the level required. The report found at page 10 that "In general, the techniques utilized in massage do not present acute risk" to the public and would therefore not be regulated under the Code des professions.

No other provinces have granted massage therapy self-regulating status or title protection.

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II. THE POLICY BACKGROUND

The main impetus for a scope of practice review was the Report of the British Columbia Royal Commission on Health Care and Costs (the Seaton Commission). The Seaton Commission stated that the existing legislation governing the health professions creates persistent jurisdictional disputes and a distinct lack of cooperation among the health professions, despite the fact that all health professional colleges have the same mandate - to protect the public from preventable harm.

The Seaton Commission stated that the primary reason for the jurisdictional disputes was the present regulatory system's reliance on exclusive scopes of practice. Under the exclusive scope of practice model, the various health professions have been granted an exclusive right to practice within a legislatively defined scope of practice. No one, other than a member in good standing of that profession, can perform acts within the profession's scope of practice unless they are granted an exemption.

The Commission concluded:

...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.

(*Closer to Home, The Report of the Royal Commission on Health Care and Costs in British Columbia*, Volume 2, 1991, p. D-33)

This recommendation is also consistent with legislative initiatives underway in Alberta. The Seaton Commission was not the first review body to suggest that the present legislative model of exclusive scopes of practice was inappropriate. Restricting professional monopolies (exclusive scopes of practice) was also recommended in an earlier study commissioned by the British Columbia Minister of Health. In discussing the conflicts which may arise between the professional college and the public interest, the issue of exclusive scopes of practice was raised:

It must be emphasized that any professional legislation which unduly restricts the scope of practice of skilled personnel may be contrary to the public interest in greater supply and accessibility of service through the development of team practice. Therefore, it is urged that: Professional legislation should not contain narrow restrictions or rigid definitions of scope of practice which are excessively exclusive; that measures should be taken (as indicated below) to reduce the area of interprofessional strain and conflict; and that no prosecutions for violations of scope of practice legislation should be undertaken without the prior consent of the appropriate public authority.

Insofar as may be possible with due regard for public safety, professional law should not place rigid restrictions on the scope of practice of allied health personnel, and greater flexibility should be encouraged in the allocation of roles between the health disciplines.

(Professor J.T. McLeod, *Public Regulation of the Professions in Health Security for British Columbians, Special Report: Consumer Participation, Regulation of the Professions, and Decentralization* (1974), the report of Richard D. Foulkes, B.A., M.D., F.A.P.H.A. to the Minister of Health, Province of British Columbia, Tome Three, p. 145)

Thus, the trend in regulatory policy for the health professions has been towards reducing exclusivity in order to enhance interdisciplinary practice, improve accessibility to health care services and increase consumer choice, while at the same time maintaining the fundamental objective of protecting the public.

These policy trends are clearly reflected in the [Terms of Reference](#) for the scope of practice review which provide the basis for a new regulatory framework for health professions in British Columbia. The core elements of the new framework are scope of practice statements and reserved acts.

Under the present system, scope of practice statements are exclusive. In the new system, scope statements will not be exclusive but professions may be granted reserved acts.

Reserved acts are those elements of a profession's scope of practice which present such a significant risk of harm that they should be reserved to a particular profession, or shared amongst particular professions. Thus, unlike the present system in which each profession is granted exclusivity within its entire defined scope of practice (subject to specified exceptions), only those acts which present a significant risk of harm will be reserved.

In short, the government has assigned the Council the task of creating a regulatory model based on broad, non-

exclusive scope of practice statements and narrowly defined reserved acts.

The government has the responsibility to ensure that those services which are accessible are safe and that the regulatory framework for the practice of health professions protects the public from incompetent, impaired, or unethical practitioners. At the same time, the regulatory framework should not entrench a paternalistic function for professions or reserve exclusive areas of practice simply to enhance professional status and control.

The new system of overlapping scopes of practice and narrow reserved acts removes barriers to interdisciplinary practice and offers greater choice and accessibility to the public. In the Council's view, the public interest is served by professional legislation which promotes quality in the delivery of health care services within safe parameters. Indeed, the Council's primary policy objective in conducting its review is achieving the optimum balance between safe practice and consumer choice.

With this in mind, the Council proposes to consider the practice of Massage Therapy having regard to the four elements of the scope review.

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III. DISCUSSION OF ISSUES

The main issues raised by this review are the following four elements: scope of practice, reserved acts, supervised acts and reserved titles.

A. SCOPE OF PRACTICE STATEMENT

In the Council's view the scope statement should describe what the profession does, the methods it uses, and the purpose for which it does it. Unlike the present legislative scheme, the statement itself does not grant an exclusive scope of practice. Nonetheless, the statement is important because: 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; and it informs the public about the services practitioners are qualified to perform. It is expected that the Council's recommendations will increase overlapping scopes of practice.

The Council believes that it is not necessary or useful to itemize every facet of a profession's scope of practice. Rather, a scope of practice definition should be sufficiently descriptive so that other health professions and members of the public alike can understand what the particular health professional does.

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1. Current Scope of Practice

The College of Massage Therapy was formed in 1994 when the Minister of Health separated the governance of physical therapy from that of massage therapy and created a separate college for each under the existing

system for regulation of health professions. The Massage Therapists Regulation (the "Regulation") under the HPA continued verbatim the definition of massage therapy as it was worded in the Physiotherapists Act, R.S.B.C. 1979, c. 327. In 1995, the Council was directed by its [Terms of Reference](#) to review the scope of practice of thirteen health professions, including massage therapy.

The current scope of practice of massage therapy is set out in the Regulation under the HPA:

"massage therapy" means the kneading, rubbing or massaging of the human body, whether with or without steam baths, vapour baths, fume baths, electric light baths or other appliances, and hydrotherapy or any similar method taught in schools of massage approved under the former Physiotherapists Act, but does not include any form of medical electricity.

Section 5(1) of the Regulation reads:

Subject to section 14 of the Act, no person other than a registrant may practise massage therapy.

Section 14 of the HPA states:

Despite section 13, nothing in this Act, the regulations or the bylaws prohibits a person from

- *practising a profession, discipline or other occupation in accordance with this or another Act, or*
- *providing or giving first aid or temporary assistance to another person in case of emergency if that aid or assistance is given without gain or reward.*

The combined effect of s.5(1) of the Regulation and s.14 of the HPA essentially reserves the entire scope of massage therapy practice exclusively to massage therapists or other regulated health professionals whose scope of practice encompasses such activities without regard to whether these activities present a significant risk of harm and should be reserved acts or not. The Regulation under the HPA, as currently worded, makes the entire existing scope of practice exclusive for members of the College. In contrast, the [Terms of Reference](#) clearly state that the rationale underlying the granting of reserved acts is to protect the public by restricting only those acts which present a significant risk of harm. Such acts are to be restricted to members of specific professions who are qualified to perform them. The entire thrust of the scope review process, as set out in the *Working Paper*, is to restrict only those activities which carry a significant risk of harm.

The Council has received numerous responses including letters, petitions and telephone calls during the consultation process indicating that the current reservation of "massage therapy" exclusively to members of the College has caused confusion, concern and alarm among members of the public and alternative practitioners. The Regulation has given rise to numerous investigations of alternative practitioners by the College and has been the subject of litigation to clarify its meaning. Such exclusivity which is contrary to the *Terms of Reference* represents an unwarranted barrier which may prevent the practice of massage by individuals who are not members of the College.

The College recognizes in its brief that the Regulation which currently reserves the entire scope of practice is too broadly stated and cites the British Columbia Royal Commission on Health Care and Costs which identified this sort of legislative shortcoming as one of its major reasons in recommending a wholesale change in the

legislative system used to regulate British Columbia's health care professionals. The Commission felt that the reserved acts granted to professions should be narrowly focussed on preventing harm. The Council's [Terms of Reference](#) for the scope of practice review have reflected this view.

The Council wishes to emphasize that under the new regulatory model envisaged by the Council's [Terms of Reference](#), the scope statement is not exclusive, only descriptive. Further, it is expected that the scope of practice review process will result in more overlapping scopes of practice. To the extent that a broad scope of practice statement might encompass acts which carry a significant risk of harm, the reserved acts system will address such acts.

The College submits that the current scope statement is poorly worded and insufficient for several reasons. The submission states the current scope statement inadequately describes massage therapy by using a list of techniques which is limited and incomplete. The submission also states that the current scope statement contains no reference to therapeutic intent which is fundamental to current training and practice of massage therapy.

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2. Proposed Scope of Practice by the College of Massage Therapists of B.C.

The College proposed the following options for a revised scope of practice statement in its 1995 submission:

Option 1: The practice of massage therapy is the assessment of the soft tissues and joints of the body and the treatment and prevention of physical disorders, dysfunction, injury and pain of the soft tissues and joints to develop, maintain, rehabilitate or augment physical function to relieve pain, and to promote health.

Option 2: The practice of massage therapy is the assessment, treatment and prevention of soft tissue and joint disorders, dysfunction or injury using treatment methods which include but are not limited to manual techniques, hydrotherapy, light therapy, electrical modalities, therapeutic exercise and patient education to rehabilitate, relieve pain and promote health.

In 1996, after reviewing the responses to the consultation process the Council requested a meeting with the College. At an August 1996 meeting with the Council the College discussed the proposed Options for the scope of practice statement.

On September 3, 1996 the College sent a letter to the Council in which the College requested the following changes to Option 2 Scope of Practice Statement (emphasis added by the Council to indicate changes from Option 2). For ease of reference, the Council will refer to this as Option 3:

Option 3: The practice of massage therapy is the assessment, treatment and prevention of soft tissue and joint disorders, dysfunction or injury using treatment methods which include but are not limited to manual techniques, hydrotherapy, light therapy, electrical modalities, therapeutic exercise and patient education to rehabilitate, relieve pain, facilitate relaxation, reduce stress and promote health.

The College requested the changes "to reflect the broadest possible description of the massage profession's activities".

In July 1998, the College proposed a fourth scope of practice definition, after having withdrawn its previous submissions (emphasis added by the Council to indicate changes from Option 2). For ease of reference, the Council will refer to this as Option 4:

Option 4: The practice of massage therapy is the assessment and diagnosis of soft tissue and joint disorders and the treatment and prevention of physical disorders, dysfunction, injury and pain of the soft tissues and joints using treatment methods which include but are not limited to manual techniques, hydrotherapy, light therapy, electrical modalities, therapeutic exercise and patient education to rehabilitate, augment physical function, relieve pain, facilitate relaxation, reduce stress and promote health.

In Option 4, the College has added "diagnosis" to their previous submissions, based on their rationale that diagnosis is an essential first step in providing any form of therapy. The issue of diagnosis will be dealt with in the Reserved Acts section of this report.

The College provided the following rationale for changes to its scope of practice statement:

- *specific examples of the more common massage treatment techniques in order to provide greater specificity than the Ontario definition*
- *the therapeutic objectives of "to facilitate relaxation" and "to reduce stress" as these are important features of massage therapy generally, and indicate that massage therapists are capable of providing both therapeutic and simple relaxation massage*
- *electrical modalities. Currently, massage therapists are prohibited from using any form of electrical medical therapies. The College is proposing that this prohibition be eliminated - in light of the Council's approach to defining reserved acts British Columbia set out in its Working Paper, it is legislatively redundant. (See Part 6, Prohibited Acts, for further discussion on this point).*

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3. Responses from Consultation Process to Proposed Scope of Practice Statements (Options 1 and 2)

Because the proposed scope of practice statements available at the time of the consultation process were Options 1 and 2, the following comments reflect the views expressed on those two Options. These are still relevant however because they represent opinions regarding elements which are components of revised option 4.

A number of respondents commented that the scope of practice statement overlapped with their scope of practice. These included the Registered Nurses Association of B.C. (RNABC), the B.C. Naturopathic Association (BCNA), and the College of Licensed Practical Nurses of B.C. (CLPNBC). Under the [Terms of Reference](#) scope of practice statements are descriptive, not exclusive, and regulated health professions may share areas of scopes of practice.

The British Columbia Medical Association (BCMA) commented that the proposed scope "is quite an extension from the current scope...We have grave concerns that the assessment of soft tissue and joint injuries is well beyond the scope of massage therapy and should be reserved for those with medical training. We recommend that the scope of practice remain as currently defined."

The College of Physicians and Surgeons of B.C. (CPSBC) shares the concerns of the BCMA: "the proposed new definition...conveys the impression of diagnostic abilities going well beyond what can be confidently expected, and fails to define the quite narrow field of therapeutic modalities that should be permitted with respect to the qualifications and training of massage therapists and which the public should be able to easily identify."

The British Columbia College of Chiropractors (BCCC) commented that the College has serious concerns about the second half of the scope definition "the treatment and prevention of physical disorders, dysfunction, injury and pain of the soft tissues and joints to develop, maintain, rehabilitate or injury and pain of the soft tissues and joints to develop, maintain, rehabilitate or augment physical function". The College states that it is unaware of any physical disorders that are treated by massage therapists and comments that their proposal represents a significant expansion of the scope of practice that does not appear, from their submission, to be based on any mandatory core educational training.

New Brunswick Health commented that the scope of practice which has been proposed "is broader than the current practice...particularly so in the case of the massage therapy proposal which describes what is the current scope of practice for physiotherapy." The submission goes on to say:

At present, in New Brunswick, massage therapy is considered a specific modality, not a process of assessment, treatment and prevention of a broad description of physical dysfunction. We presume that the training the members of the professions would receive, would support the enhanced scopes of practice which are being proposed.

The Canadian Athletic Therapists Association (CATA) commented that its main concern was with the proposed increased scope of practice and pointed out that the College had not provided any curriculum or standards on which to base the increased scope of practice.

The Tripartite Committee of the College of Massage Therapists of Ontario, the Ontario Massage Therapists Association, and the five Ontario massage therapy schools support the increased scope of practice and they commented on the specifics of the proposed reserved acts which will be discussed later in this report.

The College of Physical Therapists of B.C. (CPTBC) commented that the proposed scope is a significant expansion of the existing scope. "The actual risk of physical harm for massage therapy, as currently defined, is minimal. We are concerned that expanding the scope of practice as proposed may place the public at greater risk."

The CPTBC also made a lengthy submission discussing the relationship between education of practitioners, educational institutions and processes, and the professional regulatory body's role in accreditation of educational organizations. This latter submission will be forwarded to the Minister of Health as it is germane to the regulation of health professions but is not within the Council's Terms of Reference for the scope of practice review.

In summary, massage therapists' education and training for the scope of practice proposed has been

questioned by the BCMA, the BCCC, the CATA, New Brunswick Health, and the CPTBC. All of these groups question whether the massage therapy curriculum is currently adequate for training in assessment. The BCCC also questions whether massage therapists are trained in "treatment of physical disorders".

The Council considered the comments made during the consultation process, in particular those regarding the educational preparation of massage therapists as it relates to the increased scope of practice proposed particularly with regard to education and training in assessment and diagnosis. In a letter of July 3, 1996, the Council requested more specific information from the College regarding education and training of massage therapists. The College responded by providing the Curriculum Standard of the College of Massage Therapists of B.C.. The Council has reviewed this document along with the College's revised brief and other information provided in letter form by the College to assess the scope of practice of massage therapists.

In the [Working Paper](#), the Council describes "assessment" as a process of observation and evaluation of the physical status or progress of a patient, which may involve observation of symptoms, but does not include naming or identifying a disease, disorder, or condition as the cause of these symptoms. The Council has determined that the materials submitted support massage therapists' training in the use of assessment. The issue of diagnosis will be dealt with in the Reserved Act section of this report.

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4. Conclusion

The Council has reworded the proposed scope of practice statement (Option 4) to more closely conform to its [Terms of Reference](#). The Council has described general categories of techniques, not specific techniques. By making a broad statement regarding techniques, the public and the other health professions will have sufficient information to define massage therapy and the scope will not be limited to narrowly stated techniques which would constrain growth and development of the profession. In the Council's view, the reworded scope statement represents a concise definition which fairly and accurately reflects the current state of massage therapy practice. It describes what the profession does, the methods the profession uses, and the purpose for which the profession performs its functions.

The College's proposed additional references to "...*pain of soft tissues and joints ... facilitate relaxation, reduce stress ...*" are encompassed in "*treatment and prevention of soft tissue and joint disorders*" and in "*relieve pain and promote health*". The Council has added "*by manipulation*" which gives a general description of massage therapy techniques and is part of the Ontario scope of practice definition.

The Council recommends the following scope of practice statement for members of the College of Massage Therapists:

The practice of massage therapy is the assessment of the soft tissues and joints of the body and the treatment and prevention 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.

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B. RESERVED ACTS

The rationale underlying the granting of reserved acts is to protect the public by limiting provision of those particularly dangerous acts to members of specific professions who are qualified to perform them. Only those acts which present a significant risk of harm will be reserved. The Council has developed a list of reserved acts ([Appendix B](#)) which is set out in its the [Working Paper](#)". The [Working Paper](#) was, in large part, a result of the Council's review of information provided by the various professions during the scope of practice consultation process.

The Council wishes to emphasize that its recommendations will likely provide for the sharing of many of the reserved acts. Thus, in conducting its review of any of the reserved acts of a profession, the Council is not necessarily deciding which acts would be reserved exclusively to that profession. It is possible and indeed likely that acts reserved to a profession will also be reserved to other professions. However, each profession may perform the reserved acts granted to it only within the context of its defined scope of practice. Each profession is being given the opportunity to describe which of the reserved acts its members are qualified to perform and therefore should be reserved to members of that profession.

The current definition of the scope of practice of massage therapy is contained in the Regulation. Section 5(1) of the Regulation reserves the entire scope of massage practice exclusively to members of the College, with the s.14(1) exceptions at page10, supra.

In response to the [Working Paper](#), the College withdrew its earlier submissions to the Council and in a revised submission of July 30, 1998, proposed the following reserved acts for members of the College:

1. *Making a soft tissue diagnosis by identifying a disease, disorder or condition of the soft tissue as the cause of signs or symptoms of an individual.*
2. *Manipulation of soft tissues with sufficient biomechanical pressure to cause tissue damage, including microtearing, bruising or inflammation.*
3. *Moving body joints beyond the individual's current physiological range.*
4. *Putting a finger beyond the labia majora or the anal verge.*
5. *Using massage therapy techniques on a patient when a contraindication for that patient exists that would necessitate avoidance or modification of the technique, and the technique to be given*
 - A. *would significantly increase the blood or lymph circulation of that patient,*
 - B. *requires deep pressure or stretch to be applied to the soft tissues of the patient's body, or*
 - C. *would passively mobilize the patient's joint (excluding high velocity manipulation).*

6. *Using massage therapy techniques on a patient when a contraindication exists that would necessitate avoidance or modification of the technique, including but not limited to*
 - A. *an acute or chronic injury, structural abnormality or disease of a joint, muscle, ligament, tendon, connective tissue, bone or organ of the body,*
 - B. *a circulatory or lymphatic condition that compromises either system, and*
 - C. *a neurological injury or disease.*

The Council will discuss each of these in turn using the reserved acts outlined in the [Working Paper](#) as its focus. The Council wishes to point out that proposed reserved acts #1, 2, and 3 have not been the subject of a broad consultation process, since they were part of the College's July 1998 submission. The Council invites written comments to these proposed reserved acts and to this preliminary report prior to the public hearings. Reserved acts #4, 5, and 6 were part of the College's original 1995 submission and, as such, were subject to review and comment during the consultation process.

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1. Diagnosis

The College's first proposed reserved act is: "making a soft tissue diagnosis by identifying a disease, disorder, or condition of the soft tissue as the cause of signs or symptoms of an individual". The College submitted the following rationale for the risk of harm associated with this act:

In this context, "soft tissue" means muscle, fascia, tendon, ligament, bursae, joint capsules, and other associated connective tissue components.

Soft tissue diagnosis is an essential component of the services normally provided by massage therapists. If this service is not provided, or is provided by someone who is not sufficiently trained and skilled, there is a risk that musculoskeletal injuries and disorders may be exacerbated through treatment that is not of an appropriate type or intensity. There is a risk that injury may occur due to a failure to recognize contraindications to treatment or that systemic disease or other medical conditions that contribute to the presenting signs and symptoms may go unrecognized and untreated.

Differential diagnosis is also required to rule out systemic disease or other causes that may mimic musculoskeletal disorders but are not treatable through massage therapy. A review of the patient's past and present symptoms and medical history may indicate that an unidentified medical condition is causing the patient's symptoms and a visit to a physician is required instead of massage therapy. For example, a patient with chest pain should be asked specifically about both musculoskeletal and systemic origins of present pain and symptoms. Similarly, a patient with a history of kidney infection may experience back pain that is not treatable by massage therapy.

The College further described the process utilized by massage therapists before initiating treatment:

Identifying causative factors or etiology by the massage therapist is limited primarily to neuromusculoskeletal abnormalities that result in pain and pathokinetic problems (disorders affecting movement) and massage therapists may often be able to make a more accurate diagnosis of such conditions than most general practice physicians. Physicians, unless they have specialized in such fields such as orthopedics or sports medicine, do not receive the lengthy and detailed training in soft tissue/musculoskeletal assessment procedures that massage therapists receive, nor are they called on to perform related procedures on a daily basis. (This may explain why general practice physicians in particular seem to consider spending the time required to perform detailed diagnostic procedures not necessary once their preliminary evaluation has indicated that referral to a massage therapist or physiotherapist is indicated.)

In all cases it is a skilled physical assessment, palpative examination and accurate and complete history taking and diagnostic assessment performed by the massage therapist that identifies the location, etiology, and other relevant characteristics of the condition to be treated. The therapist differentiates between neuromusculoskeletal problems and systemic disease or other medical condition as the source of signs and symptoms, and identifies the presence of contraindications to certain types of treatment.

In regard to training in "diagnostic assessment", the College submitted their curriculum standards and provided the following description:

A minimum of 150 hours of training is provided to massage therapy students attending British Columbia's two accredited educational programs in history taking, interviewing and physical assessment. However, the education director of the West Coast College of Massage Therapy estimates that, when all academic and clinical subjects and courses dealing specifically with diagnostic assessment are combined with approximately 38 hours spent practicing these methods in the student clinic, massage therapists receive more than 400 hours of training in history taking, physical assessment and diagnostic skills. This is comparable to the number of hours of training that students in similar health professions, such as physical therapy and chiropractic, receive. (Appendix "I" provides examples of the basic case history and assessment forms that are used by the West Coast College of Massage Therapy.)

In its [Working Paper](#), the Council distinguished between diagnosis and assessment, describing diagnosis as "the identification of the cause of signs and symptoms" and assessment as "a process of observation and evaluation of the physical status or progress of a patient, which may involve observation of symptoms, but does not include naming or identifying a disease, disorder or condition as the cause of these symptoms."

The Council reflected on this distinction in its review of the scope of physical therapy:

Assessment must be an integral and fundamental part of every health professional's practice. Assessment refers to the first step in how physical therapists practice their profession. Evaluation includes history taking and assessment (not diagnosis) for the purpose of initiation and modification of treatment. Use of the term "diagnosis" can become problematic if used interchangeably with "assessment".

The diagnostic process requires education and training to interpret the data collected in determining the full range of pathological conditions which may be present. This may require the use of a range of diagnostic tools, including laboratory data, x-rays and other imaging procedures where necessary.

The College indicated in its submission that massage therapists generally practice on referral from a medical doctor when treating injuries or chronic conditions and that a medical doctor was actively involved with the majority of patients who seek treatment for an injury or previously diagnosed condition.

In Ontario, the only other province to grant self-regulatory status to massage therapy, diagnosis which is a controlled [reserved] act, is not part of the scope of massage therapy. Relevant to the issue of diagnosis, the Council has been provided with the College of Dental Hygienists of Ontario (CDHO) April 1995 submission to the Health Professions Regulatory Advisory Council. In distinguishing between assessment and diagnosis the CDHO states:

We wish to confront the issue as to whether absence of the RHPA's controlled act of "communicating a diagnosis" inhibits dental hygienists' abilities to take and interpret a medical history to the extent required by the . . . proposed regulations and standards of practice. We firmly believe that the ability to "assess" teeth and adjacent tissues is sufficient. In letter to the Royal College of Dental Surgeons (RCDS) in 1987, Alan Schwartz, who headed the Health Professions Legislation Review, wrote:

What the Review does not intend to restrict through the licensure of "diagnosis" is the ability of others to assess their patients or clients, as they do now. We recognize that undertaking treatment of any sort in the absence of an assessment would be improper practice, and would fall below the standards of care of any profession.

In recognition of this fact the proposed general scope statements of many professions include the word "assessment". The Review believes that the proposed system will not in any way impede practitioners not licensed to diagnose from assessing their patients or clients to determine the applicability of a particular range of treatments and from undertaking a course of treatment in appropriate situations. As is the case today, if the treatment has no beneficial effect, or if the patient continues to deteriorate, further investigation is undertaken or, where appropriate, a referral to another profession is made.

In our view, a diagnosis is rarely necessary or in fact done. We believe . . that an assessment, rather than a diagnosis is precisely what a physician or dentist does in most cases.

The Council considered the information provided by the College, the comments by the respondents in the consultation process, and the curriculum and training. The Council finds that the processes are more accurately described as assessment and that the education and training are more appropriate for soft tissue and joint assessment than for differential diagnosis. Assessment is an integral component of the proposed scope of practice of massage therapists but is not a reserved act. Assessment is discussed further at page 26 of this report.

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2. Physically Invasive or Physically Manipulative Acts

The College's second proposed reserved act is: "manipulation of soft tissues with sufficient biomechanical pressure to cause tissue damage, including, microtearing, bruising or inflammation". The College's rationale for risk of harm is as follows:

Therapeutic massage often involves working on soft tissues to a greater depth and with the application of more force than recreational massage or massage performed for the purpose of relaxation. Treatment may also focus on isolated structures such as tendons, musculotendinous or tenoperiosteal junctions, ligaments, or joint capsules. This creates the possibility of tissue damage in the form of microtears, and can result in bruising and inflammation, particularly where injury, disease, or other medical conditions are present.

Implicit within the therapeutic intent of massage is the expectation that the tissues being treated are not normal, healthy tissues, and that they are more easily injured. The manipulation of injured tissue through the application of pressure and stretching, becomes potentially more harmful in proportion to the amount of force used and the severity of the injury or other pathology that is present.

In fact, in the treatment of musculoskeletal injuries, where fibrosis, adhesions, and loss of normal tissue extensibility contribute to pain and reduced range of motion, some carefully controlled intentional tissue disruption does occur. However, bruising and inflammation are undesired side effects of such treatment, and often indicate that the force, duration, or frequency of treatment is in excess of tissue tolerances. The presence of inflammation in particular indicates that tissue damage has occurred to an extent that manipulation may make the presenting condition worse rather than better. Where such damage occurs, there exists a real risk that significant and lasting harm may be done: An otherwise treatable condition may become chronic or disabling.

The College does not believe that it is in the public interest to allow inadequately trained individuals to perform soft tissue manipulations with sufficient force to produce tissue damage, particularly in therapeutic situations. Where the treatment involves sufficient biomechanical force to alter tissue structure, inadequately trained individuals may do significant damage.

The College has classified this proposed reserved act as a "*non-invasive but physically manipulative procedure . . . on tissue below the dermis*".

In support of its contention that this proposed reserved act should be reserved to massage therapists, the College cites an anecdotal incident in which two patients were injured by the same unregulated practitioner.

Where a person is seriously harmed during treatment by an unregulated practitioner, the general harm clause, one of the elements of the reserved acts system described in the Council's [Working Paper](#), addresses this issue:

. . . there should be a general risk of harm clause, which provides:

No one, other than a qualified health professional acting within the scope of practice of his/her profession, shall deliver health services in circumstances in which it is reasonably foreseeable that serious harm may result from the delivery or omission of such services.

This clause protects patients from (a) regulated professionals who do something harmful that is outside their scope of practice, and (b) unregulated practitioners who cause patients serious harm in the course of providing health care services.

The College has stated that microtearing, bruising and inflammation often occur during normal physical exercise. There is little or no evidence that microtearing, bruising and inflammation are a widespread problem or a serious consequence of unregulated massage. The College has provided no literature or scientific studies to show objective evidence of significant risk of harm.

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3. Movement of the Joints of the Spine

The third reserved act proposed by the College is "moving joints beyond the individual's current physiological range". In a letter of October 5, 1998, the College requested that this wording be changed to: "moving body joints beyond the limits the body can voluntarily achieve but within the anatomical range of motion". The College's rationale for risk of harm is:

The College offers this change because massage therapists and physical therapists commonly use joint mobilization techniques which are applied to joints other than the spine, and which are performed at low velocity. The potential for harm to joints is not limited to those of the spine.

Low velocity joint manipulations involving progressively greater amplitude are technically known as grade I through IV joint mobilizations. High velocity, low amplitude thrust is a grade V mobilization. Mobilizations using lower velocity can be potentially as harmful as high velocity mobilizations, in particular if the range of motion of an individual's joint is currently limited due to soft tissue or joint disorders, dysfunction or injury.

A wide variety of musculoskeletal disorders, including trauma and certain chronic conditions, result in a reduction of the physiological range of motion to less than normal due to shortening and/or the formation of adhesions within the connective tissue structures associated with joints. Specific manipulations are used to assess restricted movement and to restore normal joint movement.

The College has proposed modifying the Council's Reserved Act 2(c) by removing the qualifying phrase "using a high velocity, low amplitude thrust" and changing "joints of the spine" to "body joints".

The College provides two separate anecdotal situations in which patients were injured by an "unlicensed" practitioner. The situation of an unlicensed practitioner causing harm while performing what would be considered a health care service would be covered by the general risk of harm clause previously discussed.

The College has not provided any studies or literature review to support this broadening of the Council's narrowly focussed reserved act 2(c) "movement of 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". This act carries a significant risk of harm, even when performed by a trained and regulated health professional. The most serious risk is cardio-vascular accident (CVA) or stroke, as it is commonly known.

To modify this reserved act by the wording suggested by the College would be contrary to the Council's mandate, unless it is clearly demonstrated that these other joint mobilization techniques carry a significant risk of harm. Amending the Council's reserved act 2(c) would result in the serious risks represented by reserved act 2(c) becoming only one aspect of a vaguely worded, overly broad reserved act. Massage therapists are not qualified for the reserved act as currently worded as acknowledged in their submission of September 1995. The Council has seen no evidence which supports expanding the scope of this reserved act.

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4. Putting a Finger(s) Beyond Various Parts of the Body

After consultation with the College in August 1996, the Council learned that the College's proposed reserved act "putting a finger beyond the labia majora or the anal verge" is not currently practiced nor taught in the curricula of colleges of massage therapy.

There are no massage therapists practicing in British Columbia utilizing these techniques, and no certification process exists, according to information provided by the College at the August 1996 meeting.

This was supported by the submission of the Tripartite Committee of the College of Massage Therapists of Ontario, the Ontario Massage Therapists Association and the five Ontario Massage Therapy schools whose comments expressed concern that inclusion of invasive techniques as reserved acts in a general scope of practice "*creates the need for training of all massage therapy students to a level of proficiency...[greater] than is currently considered entry to practice level.*" The Tripartite Committee explained that "*any significant change in B.C.'s massage therapy scope of practice will impact the profession nationally especially in light of the internal trade agreement. As well, Ontario graduates frequently sit the B.C. registration examinations, and we have an interest in the curriculum they are required to take.*"

The Council is not prepared to recommend a proposed reserved act which is not part of current massage therapy practice and for which there is no education or training process in place.

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5. Other Proposed Reserved Acts Not Included in the Council's Working Paper

The College's rationale for proposing that massage therapists be granted proposed reserved acts 5 and 6 is as follows:

The risk of harm associated with massage therapy treatment of certain medical conditions and musculoskeletal injuries has long been recognized by massage therapists, and is the reason contraindications are taught in massage therapy schools. The goal is to treat the patient in whom a contraindication exists such that a beneficial response may be obtained without producing unnecessary pain, causing further injury, or adversely affecting other medical conditions. Many contraindications are relative, meaning that certain techniques may be safe, while others are not. The contraindication may also mean that a particular technique may have to be modified in order

to be safe.

These proposed reserved acts numbers 5 and 6 were part of the College's original brief submitted in 1995.

A number of respondents to the consultation process questioned the training of massage therapists in the area of assessment, including the area of assessment of contraindications.

Under section 19 [18] of the HPA, the issue of competency to practice is the responsibility of the College. The minimum standards of good practice of any profession would require the individual practitioner to practice safely and within their scope of practice as educated and trained. This would include, for any health professional, an assessment of the patient to determine whether professional intervention would be beneficial, should be modified in a particular situation to avoid harm to the patient, or indeed whether referral to another health profession is indicated in lieu of undertaking any treatment. Since assessment is included in their scope of practice, all registrants of the College must be adequately trained in assessment, including recognition of contraindications to massage therapy.

6. Conclusion

Results of research commissioned by the College and discussed in its July 98 brief were also submitted to the Council by one of the respondents to the consultation process, the British Columbia Coalition of Allied Bodywork Practitioners. That research indicates that, while therapeutic massage forms part of health care systems in various parts of the world across a range of cultures, no jurisdiction grants exclusive rights to practice to massage therapists. The Council was not convinced by the arguments or anecdotal evidence presented, that any reserved acts should be granted to massage therapists.

The Council recommends that massage therapists not be granted any reserved acts.

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C. SUPERVISED ACTS

The issue of supervised or delegated acts arises only when a profession has been granted a reserved act(s). The Council is not currently recommending any reserved acts be granted to members of the College, consequently there is no need to discuss the submission of the College on this issue.

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D. RESERVED TITLES

Reserved titles are titles reserved exclusively to a health profession. Reserved titles afford a means for consumers to identify the different types of health care providers, to distinguish the qualified from the unqualified, and to differentiate those practitioners who are regulated from those who are not. Titles must adequately serve the public in describing the practitioner and the services being provided and must distinguish the practitioner from others performing services outside the jurisdiction of the college.

Currently, section 3 of the Regulation sets out four occupational titles that have been granted to members of the College:

No person other than a registrant may use the title "massage therapist", "registered massage therapist", "massage practitioner" or "registered massage practitioner".

The College proposes that the current four titles continue to be the exclusive occupational titles granted to the profession.

In addition, the College proposes a new title for members of the profession: "registered myofascial therapist" which would also be abbreviated as "RMT".

The College's rationale for use of and definition of the word "myofascial" to describe the therapists who are licensed to practice this form of therapy in British Columbia is as follows:

"myo-" word element (Gr.), "muscle" (Dorland's Pocket Medical Dictionary - 22nd Edition); "myo-" (from the Greek mys, muscle) "Combining form [pertaining] to muscle." (Taber's Cyclopedic Medical Dictionary - 16th Edition).

"Fascia" (L.) a sheet or band of fibrous tissue such as lies deep to the skin or invests muscles." (Dorland's Pocket Medical Dictionary - 22nd Edition); "Fascia" (L. a band). A fibrous membrane covering, supporting, and separating muscles. It also unites the skin with underlying tissue. Fascia may be superficial, a nearly subcutaneous covering permitting free movement of the skin, or it may be deep, enveloping and binding muscles. . "(Taber's Cyclopedic Medical Dictionary - 16th Edition).

The College believes that "myofascial" is a reasonable and useful alternative word to describe the therapists who are licensed to practice this form of therapy in B.C. .

When members of the public and the medical community see the title, Registered Massage Therapist, they often respond according to their past experience with "massage". Their experience may or may not have been acquired from a personal experience of therapy provided by a Registered Massage Therapist. The services

of a Registered Massage Therapist are medical or health care services, in the same way that the services provided by a Physical Therapist are medical services. On the other hand, there is evidence of public confusion regarding the services provided by Registered Massage Therapists and the non-therapeutic massage services provided by persons who include the word "massage" in their titles or advertising. The new title Registered Myofascial Therapist would further help to differentiate members of the College from those who include the word "massage" to describe themselves or their services, but who are not providing a medical or therapeutic service, and are not covered by public and private health care insurance plans.

The College distinguishes therapeutic from relaxation massage. Whether therapeutic or relaxation, all massage is in the public domain as not being included as part of a reserved act.

When members of the public receive massage services from a registrant of the College of Massage Therapy, they can rely on the fact that a regulatory body has established standards of practice, ethical and disciplinary processes. If they choose an unregulated practitioner, they do not have this assurance.

The Council believes the term "myofascial therapist" does not inform, and has the potential to confuse, the public. The word "myofascial" is technical, not commonly understood and is more narrow than the word "massage". When used in conjunction with "therapist" this title may describe a type of therapist whose scope is narrower than the general scope of practice of massage therapy. Therefore, the Council does not recommend the use of the term "myofascial".

The Council recommends that the title for massage therapists should include the word "therapist" to educate the public as is the case with "physical therapist" and "physiotherapist". The use of the term "practitioner" does not differentiate a member of the College from others performing similar services.

It has been the Council's practice to avoid use of the term "registered" where possible, as the system which is envisaged by the [Terms of Reference](#) is not a "registration" system, per se. However, in this instance, the Council believes that the term "registered" would be helpful to distinguish members of the College from unregulated practitioners.

The Council recommends the title "Registered Massage Therapist" be reserved for members of the College of Massage Therapists.

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IV. RECOMMENDATIONS

1. *The Council recommends the following scope of practice statement for members of the College of Massage Therapists:*

The practice of massage therapy is the assessment of the soft tissues and joints of the body and the treatment and prevention 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.

2. *The Council recommends that massage therapists not be granted any reserved acts.*
3. *The Council recommends the title "Registered Massage Therapist" be reserved for members of the College of Massage Therapists.*

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APPENDIX C

GLOSSARY

Throughout this report, the Council makes reference to the College submission and to the responses received during the consultation process. The Council has abbreviated its references to many of the responses received and for ease of reference, the Council has included the following glossary of terms and abbreviations used:

British Columbia College of Massage Therapists	College
Massage Therapists Regulation	Regulation
British Columbia Medical Association	BCMA
British Columbia College of Chiropractors	BCCC
Canadian Athletic Therapists Association	CATA
College of Physical Therapists of B.C.	CPTBC
College of Dental Hygents of Ontario	CDHO

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Health Professions Council POST-HEARING UPDATE OF PRELIMINARY REPORT: MASSAGE THERAPISTS

Irvine E. Epstein, Q.C., Chair
Arminée Kazanjian, Member
David MacAulay, Member

March 2001

This Post-Hearing Update should be read in conjunction with the [Preliminary Report](#) for the profession.

The Council issued its *Massage Therapists Scope of Practice (Preliminary Report)* in August 1998. The public hearing was held on 31 May 1999. The following are changes to the *Preliminary Report* which arose from the submissions made either at the public hearing or in subsequent written submissions.

I. SCOPE OF PRACTICE

The Council's *Preliminary Report* recommended the following scope of practice for massage therapists:

The practice of massage therapy is the assessment of the soft tissues and joints of the body and the treatment and prevention 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.

A. Methods of Practice

In its May 1999 response to the *Preliminary Report*, at the public hearing and in a subsequent submission in November 2000, the College of Massage Therapists of BC (College) objected to the use of the phrase "primarily by manipulation." The College suggests rather the phrase "by manual and physical methods." The College provided its reasons for supporting this phrase:

It avoids having to quantify...the proportion of time that massage therapists provide a particular form of massage therapy...the term "manual methods" encompasses actual massage of the body and includes techniques such as deep friction massage, stretch, manual lymph drainage, connective tissue mobilisation, position release therapy, and other osteopathic techniques. This term also incorporates joint mobilisation techniques, traction, and strain reduction and muscle balancing techniques...the term "physical methods" covers methods and techniques that are not

manual...do not involve direct touching...(i.e., therapeutic exercise, hydrotherapy, and the use of physical agents such as heat, infrared and ultraviolet, and cryotherapy.)

B. Patient Education

The College had also requested the phrase "and patient education" be added. However, the Council believes that patient education is a component of every health profession's practice and need not be included in scope statements.

The Council agrees with these proposed changes and recommends the following scope of practice statement:

The Health Professions Council recommends the following scope of practice statement for massage therapists:

The practice of massage therapy is the assessment of the soft tissues and joints of the body and the treatment and prevention of dysfunction, injury, pain and physical disorders of the soft tissues and joints by manual and physical methods to develop, maintain, rehabilitate or augment physical function, to relieve pain and promote health.

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II. RESERVED ACTS

In its *Preliminary Report*, the Council did not recommend that massage therapists be granted any reserved acts.

At the public hearing on 31 May 1999 and subsequently in November 1999 and in July 2000, the College submitted revised proposals for reserved acts. Those revised requests were:

1. *Making a soft tissue diagnosis by identifying a disorder or condition of the soft tissue as the cause of signs or symptoms of an individual;*
2. *Using massage techniques for the treatment of an acute or chronic injury, structural abnormality or disease of the musculoskeletal system, or for the treatment of a circulatory or lymphatic condition that compromises either system;*
3. *Manipulation of soft tissues with sufficient biomechanical pressure to cause tissue damage, including microtearing, bruising or inflammation;*
4. *Moving body joints beyond the individual's current physiological range of motion;*
5. *Putting a finger beyond the labia majora or the anal verge: accessing the muscles of the pelvic floor.*

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A. Soft Tissue Diagnosis, Massage Techniques for Treatment of Acute or Chronic Injury and Manipulation of Soft Tissues

In its rationale for the first three reserved acts, the College made a distinction between forms of therapeutic massage. The first form is where the primary intent of the treatment is the production of specific therapeutic effects. The second form is massage treatment in which the primary intent is the production of therapeutic benefits of a more general nature. The College asserted that the type of massage associated with specific therapeutic intent often involves working on soft tissues to a greater depth and with the application of more force as compared to massage performed with general therapeutic intent. The College asserted that the first type of massage has "significant implications for the potential risk of harm associated with massage treatment." The College outlines the risks as:

- *Failure to recognize the presence of a condition for which the effects of massage may be harmful;*
- *Failure to avoid or modify treatment appropriately to prevent injury where an abnormal or pathological condition is known to exist;*
- *Inappropriate application of therapeutic massage techniques that are potentially harmful in and of themselves.*

The College presented written submissions about massage therapists' training in differential diagnosis, asserting that the medical diagnoses which are provided from referring physicians are often incomplete. The College asserted that without a reserved act of diagnosis, its members would be subject to prosecutions under the *Health Professions Act* for breaches of the diagnosis reserved acts that will be granted to other health professions.

The College has not requested this reserved act nor implied that its members are trained in laboratory diagnostic testing or medical imaging to aid its members in diagnosis of any kind. In fact, the College submits that massage therapists treat most of their patients (approximately 70 per cent) on referral from medical practitioners. The College also submits that:

reports in the medical literature of injury resulting from massage have been rare in the past. (However,) several reports of injury resulting from massage have recently appeared in the medical literature and we may expect this to occur with increasing frequency.

The College asserts that there are three reasons for the potential increase:

- *The standards of training for massage therapy remain very low. The majority of regulatory jurisdictions within the United States require 500 hours or less of training, and these are based almost solely on hours of instruction and practice with no real definition of content;*
- *The increased public interest in traditional and alternative therapies increases the likelihood of minimally trained massage practitioners treating clients who are seeking therapy for pre-existing medical conditions; and*
- *An increased tendency on the part of minimally trained massage practitioners to view their role as*

providers of specific rather than general therapeutic benefits results in an increased willingness to treat clients for medical conditions, and to use potentially harmful methods and techniques without adequate training to support this practice.

The College's request for the addition to the Reserved Acts List of soft tissue diagnosis and the proposed reserved acts associated with soft tissue massage have not been substantiated by evidence of risk of harm. It appears that a substantial majority of patients who are treated for injury are referred by a medical practitioner who makes a differential diagnosis prior to referral. The medical practitioner referral is a requirement for MSP payment. The College acknowledges that there are few reported cases of harm from massage therapy but asks for this reserved act in anticipation of harm which may increase in the future.

In the Council's view, the College's request for these proposed new reserved acts is an attempt to reserve the entire scope of massage practice. If the College's rationale were adopted and if the proposed reserved acts were added to the Reserved Acts List and granted to massage therapists, the practice of unregulated massage practitioners would be inhibited. Every act of massage could be subject to investigation and evaluation of the intent of the massage practitioner. To accede to the College's request would result in an unwarranted infringement of the public's right to choose a massage practitioner.

The Council has seen no evidence that massage therapy carries with it such a sufficient risk of harm to warrant making any portion of its practice a reserved act.

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B. Moving Body Joints

The College submitted an excerpt from a revised *Physician's Guide* by John Yates, Ph.D, in further support of its position that this form of therapy be made a reserved act.

Dr. Yates has been a faculty member of the West Coast College of Massage Therapy in Vancouver and has written texts which are used in the West Coast College of Massage Therapy, as well as guides for medical practitioners to assist in referrals to massage therapists.

The Council notes the College submission that there are very few cases of documented harm resulting from massage therapy. There has not been sufficient evidence presented which supports this proposed reserved act and the Council again declines to recommend it be reserved.

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C. Putting a Finger(s) Beyond the Labia Majora or the Anal Verge

Representatives of the College made submissions at the public hearing indicating that there were a small number of massage therapists who were trained by a physiotherapist to perform this type of massage therapy for pelvic floor dysfunction. The College made post-hearing submissions which indicated that it has proposed an amendment to its bylaws to "license pelvic floor work." The College also provided a letter from Dr. Wolfgang Schamberger, FRCPC, Musculoskeletal and Sports Medicine, Division of Rehabilitation Medicine, University of British Columbia, that supports therapists continuing to treat problems related to pelvic floor dysfunction by accessing the muscles of the pelvic floor via the labia majora or the anal verge. Dr. Schamberger made

suggestions about the kind of training program that would be necessary for advanced practitioners in this specialized therapy. The College indicated that they are developing criteria for inclusion in an advanced competency examination for members of the College.

Subsequently, the Council received letters from the College of Physicians and Surgeons of British Columbia. The first letter indicated that it was "unable to support" the College's request for inclusion of this reserved act in the massage therapy scope of practice. The second letter indicated that the College of Physicians and Surgeons of British Columbia had requested the B.C. Medical Association, Section of Physical Medicine and Rehabilitation, review the subject and respond with regard to evidence of current knowledge and practice in this area. To date the Council has not had any further information about the B.C. Medical Association or College of Physicians and Surgeons of British Columbia position with regard to use of this reserved act for this purpose by massage therapists or others.

The College has acknowledged that this type of therapy is a newly emerging treatment for pelvic floor dysfunction and that there are very few massage therapists trained in its use. This is consistent with information provided by the College of Physical Therapists of British Columbia in its scope of practice review, during which physical therapists also requested this reserved act.

Without commenting on the efficacy of this type of treatment, the Council notes the lack of a recognized training program or advanced competency assessment or credentialing program in both the College of Massage Therapists of British Columbia and the College of Physical Therapists of British Columbia. Without a College approved program for post-graduate training and in the absence of clinical undergraduate training, this service can continue to be provided only as a delegated reserved act following the Council's delegation protocols outlined in the Council's *Final Report on the Scope of Practice Review*. This would allow for the services to continue uninterrupted, but only when a physician refers the patient to a massage therapist who the physician is confident can provide this service in a safe manner.

III. RESERVED TITLES

The Council's *Preliminary Report* recommended the following reserved title for massage therapists:

- "Registered Massage Therapist"

In its November 1999 response to the Council's *Preliminary Report* and at the public hearing, the College expressed its concerns with the single title "Registered Massage Therapist." The College reasons can be summarized as: inconsistency with title protection recommended for other health professions and loss of the title "Massage Practitioner." A third concern was that requiring the term "Registered Massage Therapist" might permit non-registrants to call themselves "Massage Therapist" which would be confusing to the public.

The Council has carefully considered the submissions of the College and the numerous responses by its registrants. The Council agrees that in the interest of consistency and in support of the public's freedom of choice among massage practitioners, recommendation of the title "registered" is potentially confusing and unnecessary. The title "Practitioner" has not been recommended for any other health profession and its reservation for the exclusive use of registrants of the College might impede others who are practising massage.

Therefore, the Council recommends a single title for registrants of the College.

The Health Professions Council recommends the following reserved titles for massage therapists:

- "Massage Therapist" and
- any abbreviation this title.

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Health Professions Council Naturopathic Physicians Scope of Practice Preliminary Report

Irvine E. Epstein, Q.C., Chair
Arminée Kazanjian, Member
David MacAulay, Member

December 1998

This Preliminary Report should be read
in conjunction with the [Post-Hearing Update](#) for the profession.

FOREWORD

This report is the result of the Health Professions Council's review of the scope of practice of naturopathy pursuant to the [Terms of Reference](#) from the Minister of Health and Minister Responsible for Seniors. Under the [Health Professions Act](#), the Health Professions Council is a six-person advisory body appointed by the Government of British Columbia to make recommendations to the Minister of Health and Minister Responsible for Seniors about the regulation of the health professions.

In this report the Health Professions Council examined how the existing scope of practice of naturopathy should be legislatively defined in order to reflect fairly and accurately the current state of practice and the public interest in the practice of naturopathy.

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EXECUTIVE SUMMARY

The Health Professions Council has conducted a review of the scope of practice of naturopathy.

The purpose of the review is to provide recommendations to the Minister of Health and Minister Responsible for Seniors regarding four matters: scope of practice statements, reserved acts, supervised acts, and reserved titles.

The Health Professions Council has conducted a detailed consultation process and its conclusions and recommendations regarding the four elements of the scope review are as follows:

1. The Council recommends the following scope of practice statement for members of the Association of Naturopathic Physicians of B.C. (ANPBC).

The practice of naturopathy is the prevention, diagnosis and treatment of diseases, disorders or conditions of an individual through the use of education and natural therapies or therapeutics to support and stimulate inherent self-healing processes.

2. The Council recommends the following reserved acts be granted to members of the ANPBC:

A. Making a diagnosis using naturopathic methods.

- B. Performing procedures below the dermis but only for the purposes of venipuncture and skin pricking for the collection of blood samples, needle insertion acupuncture, removal of foreign bodies from superficial structures, and first aid treatment of minor cuts, abrasions and contusions. Procedures on tissue below the surface of mucous membrane, the cornea, or the surface of teeth, including the scaling of teeth, or any other surgical procedures are not included within this reserved act.
 - C. 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. Administering a substance by injection or inhalation, but not including anaesthetics.
 - E. Putting an instrument, hand or finger(s),
 - I. beyond the point in the nasal passages, where they normally narrow,
 - II. beyond the opening of the urethra,
 - III. beyond the labia majora,
 - IV. beyond the anal verge.
 - F. Allergy challenge testing in which a positive result of the test is a significant allergic response or allergy desensitizing treatment in which there is a risk of significant allergic response.
3. The Council recommends that a provision be enacted which sets out the duties of a health professional and his or her regulatory college when delegating a reserved act. The provision should require the following:
- The assigning health professional's governing body must provide assent to the proposed reserved act being performed by someone else;
 - The reserved act to be assigned as well as the level of supervision must be clearly defined and circumscribed by the assigning health professional's governing body;
 - Where the person to whom the act will be assigned is a member of a self-regulating health profession, his or her governing body must approve of the assigning of the reserved act;
 - The instruction to perform the act must be made in writing either by way of a general written protocol or through a case-specific instruction;
 - The assigning health professional must be satisfied that the individual who will be performing the act has the necessary skills and training to perform the act safely;
 - The assigning health professional must ensure that the person who will be performing the act accepts the assignment.
4. The Council recommends

- that the titles "naturopathic doctor", "naturopathic physician" and "naturopath" and any affix of those titles be reserved; and
- that members of the ANPBC be granted the use of those reserved titles.

5. The Council recommends that members of the ANPBC be granted a limited range of laboratory testing, based upon satisfying the following criteria:

- the range of laboratory testing granted is based upon the scope of practice of members of the ANPBC;
- the ANPBC demonstrates a relationship between the laboratory testing requested and naturopathic diagnosis; and
- the ANPBC provides further information concerning the experience, education and training in use of laboratory testing which members of the ANPBC currently possess.

6. The Council recommends that any barriers to members of the ANPBC providing treatment services within a hospital be reviewed with a view to removal of such barriers.

7. The Council recommends that any barriers which prevent referrals to medical specialists by members of the ANPBC be removed.

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I. INTRODUCTION

This is the preliminary report of the review of the scope of practice of naturopathy by the Health Professions Council (the Council).

The review was conducted pursuant to [Terms of Reference](#) issued by the Minister of Health and Minister Responsible for Seniors in accordance with section 24 now section 25 of the [Health Professions Act](#) (the HPA). [During the early drafting of this Report statute references were based on RSBC 1979 and Amendments. For ease of reference, the older provisions of the revised statutes 1979 are indicated in brackets next to the current citations. The current versions refer to the [Health Professions Act](#), RSBC 1996, Chapter 183, and the [Naturopaths Act](#), RSBC 1996, Chapter 332.] The [Terms of Reference](#) direct the Council to review the scopes of practice of the recognized health professions, of which naturopathy is one.

The [Terms of Reference](#), which are included as [Appendix A](#) to this report, indicate that there are four main elements to the scope of practice review:

- I. scope of practice statements which describe what the profession does, the methods it uses and the purpose for which it does it;

- II. reserved acts which are those acts that present such a significant risk of harm that they should be performed only by professionals who are qualified to perform them;
- III. supervised acts which are reserved acts, or aspects of reserved acts, which may be performed by persons supervised by health professionals; and
- IV. reserved titles which are titles that describe a profession's services and which are reserved exclusively for the health profession.

The general process for the review provides for an initial meeting with the profession, submission of briefs by the regulatory body and professional association for each profession, a consultation process involving all health professions and interested parties regarding each professions' submission, drafting of a preliminary report, public hearings and a final report.

The Council met with representatives of the regulatory body for naturopathy, the Association of Naturopathic Physicians of B.C. (the ANPBC) and the professional association, the British Columbia Naturopathic Association (the BCNA) in November, 1994. The BCNA submitted two written briefs, the first in June, 1995 and the second in September, 1995 while the ANPBC submitted a single brief in September, 1995. The submissions were then summarized and distributed to interested groups and individuals including other regulated and unregulated health professions, teaching facilities and other provinces. Many responses were received, and the Council has carefully considered them in drafting this preliminary report. The Council also requested and received follow up information from the ANPBC and the BCNA in early 1998.

This report will be circulated to all health professions and other interested parties who participated in the Council's consultation process.

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OVERVIEW OF NATUROPATHY

The Council believes a brief overview of the nature of naturopathy is important to an understanding of the issues in this review.

As part of its submission, the ANPBC included a document setting out generally, the nature of naturopathy:

Naturopathic Medicine views the individual as an integral whole, and symptoms of disease are seen as indicators of improper functioning and unfavourable habits of lifestyle. As a result, a primary goal of treatment is to address the underlying cause of illness and to avoid treatments that might cause new illness and complicate the existing disease process.

*Naturopathic Medicine is founded on the most time-tested medical principle: **vis medicatrix naturae**, the healing power of nature. Under this system, the goal of the naturopathic physician is to restore the normal functioning of the body through the use of natural substances and treatments that enhance the body's own healing abilities.*

The ANPBC also included a description of the modalities used in naturopathy:

Treatment Modalities

The treatment modalities provided by naturopathic doctors are based on the second principle of naturopathic medicine - vis medicatrix naturae, the healing power of nature. Therapies which assist, support or stimulate the body's inherent healing processes are the foundation of naturopathic practice. Naturopathic services are unique because each registrant is trained not only in each treatment modality described below, but also in their integrated use to achieve greater synergy than any single modality alone. The training and education that underlies treatment modalities used in modern naturopathic medicine incorporates both traditional knowledge and the latest advances in science.

The most commonly used naturopathic treatment modalities are listed below:

- botanical medicine
- clinical nutrition
- counselling
- homeopathic medicine
- mechanotherapy including manipulation of the spine and extremities
- naturopathic hygienic principles and lifestyle modification
- oriental medicine and acupuncture
- physical therapeutic procedures

Thus, naturopathic medicine is a system of natural healing which incorporates a wide variety of treatment modalities.

As part of its submission the ANPBC also outlines the basic training of naturopathic physicians:

The prerequisites for entry into the colleges are three years of university studies with required courses in general biology, chemistry and organic chemistry. The four year full time naturopathic program of academic, clinical studies and supervised clinical training total approximately 4500 hours.

...

The first two years of training provide foundation knowledge in the basic medical and clinical sciences necessary to assess and diagnosis a patient's condition (anatomy, physiology, biochemistry, microbiology, pathology, physical and clinical diagnosis, differential diagnosis, and clinical biochemistry) as well as allied medical sciences (pharmacology, toxicology and immunology). Within the first two years, students are also introduced to naturopathic therapies. Naturopathic therapies introduced in year two and subsequent years, are expanded in advanced compulsory courses (botanical medicine, clinical nutrition, counselling, homeopathic medicine, hydrotherapy, manual and mechanotherapy, naturopathic hygienic principles and lifestyle modification, Oriental medicine and acupuncture, and physical therapeutic procedures).

The academic portion of the third and fourth years deepens the student's knowledge in the specific application of naturopathic therapies through a variety of clinical courses - endocrinology, cardiology, gastroenterology, proctology, dermatology, gynaecology, obstetrics, pediatrics, orthopaedics, radiology, and laboratory diagnosis.

Clinical training, under the supervision of registered naturopathic doctors, begins, to a limited extent, during the second year, increases during the third year, and is major component of the fourth year. In total, students spend 5 semesters (1500 hours) integrating their examination, diagnostic and naturopathic treatment skills in a supervised clinical setting before graduation. Clinical entrance exams precede admittance to clinic and clinic exit exams must be completed before graduation.

The ANPBC notes that it currently accepts graduates of three institutions, two American and one Canadian. The institutions are vetted by a standing accreditation process that is government regulated. The ANPBC states:

The accreditation process is overseen by official agencies, authorized and subject to the accreditation process itself, all being subject to the supervision of the US Department of Education.

The ANPBC states that new graduates entering into practice in British Columbia are required to write the "NPLEX" board examinations, an international licensing standard, and oral and practical examinations.

Both the BCNA and the ANPBC emphasize the distinction between naturopathic medicine and "allopathic" or "conventional treatment". For example, the ANPBC states that "the public is increasingly aware of and dissatisfied with the limitations that the conventional methods of drugs and surgery provide for many of their health complaints". Elsewhere, the ANPBC refers to naturopathic medicine as being based on "natural therapies" and the growing interest in the use of safe, effective natural remedies and treatments.

However, both the BCNA and the ANPBC state that naturopathic physicians are primary care givers because of their training, education and scope of practice, all of which are very similar to that of medical practitioners.

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II. THE POLICY BACKGROUND

The main impetus for a scope of practice review was the Report of the British Columbia Royal Commission on Health Care and Costs (the Seaton Commission). The Seaton Commission stated that the existing legislation governing the health professions creates persistent jurisdictional disputes and a distinct lack of cooperation among the health professions, despite the fact that all health professional colleges have the same mandate - to protect the public from preventable harm.

The Seaton Commission stated that the primary reason for the jurisdictional disputes was the present regulatory system's reliance on exclusive scopes of practice. Under the exclusive scope of practice model, the various health professions have been granted an exclusive right to practice within a legislatively defined scope of practice. No one, other than a member in good standing of that profession, can perform acts within the profession's scope of practice unless they are granted an exemption.

The Commission concluded:

...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.

(*Closer to Home, The Report of the Royal Commission on Health Care and Costs in British Columbia*, Volume 2, 1991, p. D-33)

This recommendation is also consistent with legislative initiatives underway in Alberta. The Seaton Commission was not the first review body to suggest that the present legislative model of exclusive scopes of practice was inappropriate. Restricting professional monopolies (exclusive scopes of practice) was also recommended in an earlier study commissioned by the British Columbia Minister of Health. In discussing the conflicts which may arise between the professional college and the public interest, the issue of exclusive scopes of practice was raised:

It must be emphasized that any professional legislation which unduly restricts the scope of practice of skilled personnel may be contrary to the public interest in greater supply and accessibility of service through the development of team practice. Therefore, it is urged that: Professional legislation should not contain narrow restrictions or rigid definitions of scope of practice which are excessively exclusive; that measures should be taken (as indicated below) to reduce the area of interprofessional strain and conflict; and that no prosecutions for violations of scope of practice legislation should be undertaken without the prior consent of the appropriate public authority.

Insofar as may be possible with due regard for public safety, professional law should not place rigid restrictions on the scope of practice of allied health personnel, and greater flexibility should be encouraged in the allocation of roles between the health disciplines. (Professor J.T. McLeod, "Public Regulation of the Professions" in *Health Security for British Columbians, Special Report: Consumer Participation, Regulation of the Professions, and Decentralization* (1974), the report of Richard D. Foulkes, B.A., M.D., F.A.P.H.A. to the Minister of Health, Province of British Columbia, Tome Three, p. 145)

Thus, the trend in regulatory policy for the health professions has been towards reducing exclusivity in order to enhance interdisciplinary practice, improve accessibility to health care services and increase consumer choice, while at the same time maintaining the fundamental objective of protecting the public.

These policy trends are clearly reflected in the *Terms of Reference* for the scope of practice review which provide the basis for a new regulatory framework for health professions in British Columbia. The core elements of the new framework are scope of practice statements and reserved acts.

Under the present system, scope of practice statements are exclusive. In the new system, scope statements will not be exclusive but professions may be granted reserved acts.

Reserved acts are those elements of a profession's scope of practice which present such a significant risk of harm that they should be reserved to a particular profession, or shared amongst particular professions. Thus, unlike the present system in which each profession is granted exclusivity within its entire defined scope of practice (subject to specified exceptions), only those acts which present a significant risk of harm will be reserved.

In short, the government has assigned the Council the task of creating a regulatory model based on broad, non-exclusive scope of practice statements and narrowly defined reserved acts.

The government has the responsibility to ensure that those services which are accessible are safe and that the regulatory framework for the practice of health professions protects the public from incompetent, impaired, or unethical practitioners. At the same time, the regulatory framework should not entrench a paternalistic function for professions or reserve exclusive areas of practice simply to enhance professional status and control.

The new system of overlapping scopes of practice and narrow reserved acts removes barriers to interdisciplinary practice and offers greater choice and accessibility to the public. In the Council's view, the public interest is served by professional legislation which promotes quality in the delivery of health care services within safe parameters. Indeed, the Council's primary policy objective in conducting its review is achieving the optimum balance between safe practice and consumer choice.

With this in mind, the Council proposes to consider the practice of naturopathy having regard to the four elements of the scope review.

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III. DISCUSSION OF ISSUES

The main issues raised by this review are the four elements listed above: scope of practice statements, reserved acts, supervised acts and reserved titles.

A. SCOPE OF PRACTICE STATEMENT

The scope statement describes what the profession does, the methods it uses, and the purpose for which it does it. Unlike the present legislative scheme, the statement itself does not grant an exclusive scope of practice. Nonetheless, the statement is important because: 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; and it informs the public about the services practitioners are qualified to perform. It is expected that the Council's recommendations will increase overlapping scopes of practice.

The Council believes that it is not necessary or useful to itemize every facet of a profession's scope of practice. Rather, a scope of practice definition should be sufficiently descriptive so that other health professions and members of the public alike can understand what the particular health professional does.

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1. The Current Scope of Practice

The current scope of practice is set out in section 1 [1] of the [Naturopaths Act](#).

"naturopathy" means the art of healing by natural methods or therapeutics and, without limiting

this definition includes the first aid treatment of minor cuts, abrasions and contusions, bandaging and the taking of blood samples.

Section 13 [10] of the [*Naturopaths Act*](#) provides:

Nothing in this Act authorizes a person

- (a) to prescribe or administer drugs for internal or external use other than the drugs specified in regulations made by the board and approved by the Lieutenant Governor in Council,*
- (b) or to use or administer anaesthetics for any purpose, or*
- (c) to practise surgery.*

Section 14 [11] of the [*Naturopaths Act*](#) provides :

... a person who practises naturopathy for remuneration or the expectation of remuneration, without being registered as a naturopathic physician under this Act, commits an offence.

Section 24 [14] provides:

Nothing in this Act applies or affects any of the following:

- (a) the practice of a profession or calling under another Act;*
- (b) a nurse acting in the absence of or under the prescription or direction of a medical practitioner;*
- (c) the furnishing of first aid or temporary assistance in cases of emergency;*
- (d) persons doctoring human ailments by prayer or spiritual means as an enjoyment or exercise of religious freedom.*

In summary, the current scope of practice of naturopathy is healing by natural methods, and includes first aid treatment of minor cuts, abrasions and contusions, bandaging and the taking of blood samples. The scope of practice expressly excludes surgery or the use of anaesthetics.

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2. Scope of Practice in other Jurisdictions

The current scope of practice of naturopathy in British Columbia is similar to that of several Canadian jurisdictions. The following are excerpts from various Canadian statutes governing naturopathy:

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a) Manitoba (the Naturopathic Act, R.S.M. 1987, CCSM c. N80)

1 *In this Act,*

...

"naturopathy" means a drugless system of therapy that treats human injuries, ailments, or diseases, by natural methods, including any one or more of the physical, mechanical, or material, forces or agencies of nature, and employs as auxiliaries for such purposes the use of electro-therapy, hydro-therapy, body manipulations, or dietetics; . . .

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b) Saskatchewan (the Naturopathy Act, c. N-4)

2 *In this Act:*

...

(e) "naturopathy" means the art of healing by natural methods as taught in recognized schools of naturopathy.

10 *Nothing in this Act or the bylaws shall authorize any person to prescribe or administer drugs for use internally or externally, or to use or direct or prescribe the use of anaesthetics for any purpose whatsoever, or to treat venereal disease or a communicable disease as defined in The Public Health Act, or to practise medicine, surgery or midwifery, or to use any method of treatment other than naturopathy.*

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c) Ontario (the Drugless Practitioners Act, R.S.O. 1990, c. D.18)

Ontario does not have a separate act regarding naturopathy but the practice of naturopathy in that jurisdiction falls within the *Drugless Practitioners Act*. That Act states, in part:

1. *In this Act,*

...

"drugless practitioner" means a person who practises the treatment of any ailment, disease, defect or disability of the human body by manipulation, adjustment, manual or electro-therapy or by any similar method;

7. Nothing in this Act or the regulations authorizes a person, not being so expressly authorized under a general or special Act of the Legislature, to prescribe or administer drugs for use internally or externally or to use or direct or prescribe the use of anaesthetics for any purpose whatsoever or to practise surgery or midwifery.

At the time of the health professions legislation review in the 1980s, it was recommended in Ontario that naturopathy would not continue to be regulated. The reasons for the recommendation included the minimal risk of harm and the notion that the philosophy of natural healing on which naturopathy is based makes it virtually impossible to define standards of practice by which members of the profession will consider themselves bound. Notwithstanding this recommendation, naturopathy continues to be regulated in Ontario under the Drugless Practitioners Act. Recently, the Health Professions Regulatory Advisory Council of Ontario considered an application by the naturopathic physicians for recognition under the new system but, as yet, no decision has been made.

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d) American Jurisdictions

The Council has also reviewed legislation from several American jurisdictions. Typical of the provisions governing naturopathy are the following excerpts from the most recent Washington and Oregon legislation available to the Council.

(1) Washington (The Law Relating to Naturopathy, 18.36A RCW)

The scope of practice in Washington is defined as follows:

RCW 18.36A.040 Scope of Practice. (Effective until June 30, 1995.) Naturopathic medicine or naturopathy is the practice by naturopaths of the art and science of the diagnosis, prevention, and treatment of disorders of the body by stimulation or support, or both, of the natural processes of the human body. A naturopath is responsible and accountable to the consumer for the quality of naturopathic care rendered.

The practice of naturopathy includes manual manipulation (mechanotherapy), the prescription, administration, dispensing, and use, except for the treatment of malignancies or neoplastic disease, of nutrition and food science, physical modalities, homeopathy, certain medicines of mineral, animal, and botanical origin, hygiene and immunization, common diagnostic procedures, and suggestion; however, nothing in this chapter shall prohibit consultation and treatment of a patient in concert with a practitioner licensed under chapter 18.57 or 18.71 RCW. No person licensed under this chapter may employ the term "chiropractic" to describe any services provided by a naturopath under this chapter.

In terms of invasive procedures naturopathic physicians in Washington appear to be limited to "minor office procedures" which are defined as follows:

RCW 18.36.020 Definitions. (Effective until June 30, 1995.) Unless the context clearly requires otherwise, the definitions in this section apply throughout this chapter.

...

(12) "Minor office procedures" means care incident thereto of superficial lacerations and abrasions, and the removal of foreign bodies located in superficial structures, not to include the eye; and the use of antiseptics and topical local anaesthetics in connection therewith.

(2) Oregon (Naturopaths, 1993 edition, c.685)

In Oregon, the scope of practice is defined as follows:

685.010 Definitions. As used in this chapter:

...

(5) "Naturopathic medicine" means the discipline that includes physiotherapy, natural healing processes and minor surgery and has as its objective the maintaining of the body in, or of restoring it to, a state of normal health.

"Minor surgery" is defined as follows:

(4) "Minor surgery" means the use of electrical or other methods for the surgical repair and care incident thereto of superficial lacerations and abrasions, benign superficial lesions, and the removal of foreign bodies located in the superficial structures; and the use of antiseptics and local anaesthetics in connection therewith.

The terms "superficial" and "lesions" are further defined in chapter 850, division 10 of the Oregon Administrative Rules, as follows:

Definitions

(9) "Superficial" refers to lacerations, abrasions, benign lesions, foreign bodies and wounds which involve the skin, mucosa, and subcutaneous tissue to a depth of the deep superficial fascia, and which do not involve vital deep structure such as major nerves, major tendons, major blood vessels and bone or viscera.

(10) "Lesions" refers to any pathological or traumatic change to human tissue or impairment of a bodily function.

3. The Scope of Practice Proposal by the BC Naturopathic Association and the Association of Naturopathic Physicians of BC

It is clear from the submissions of the ANPBC and the BCNA that naturopathic physicians are seeking a wide expansion of their current scope of practice. In their submissions both the BCNA and the ANPBC submit that the current legislative definition does not accurately reflect the current practice of the profession. The ANPBC states that the current definition of scope of practice is antiquated. Both groups have provided proposals for a new definition. For example, the ANPBC states:

Currently, the Naturopaths Act prohibits naturopathic physicians in British Columbia from performing certain procedures such as minor surgery or the use of anaesthetics. Yet, these procedures are within the naturopathic scope of practice defined by our training and licensure in other jurisdictions. In a number of U.S. jurisdictions, naturopathic physicians have access to limited prescription rights of certain drugs. These inclusions are necessary for the safe practice of such procedures as obstetrics and midwifery which has long been part of the scope of practice of naturopathic medicine.

...

To state that naturopathic physicians in British Columbia do not share the competency of naturopathic physicians in other licensed jurisdictions allowing a broader scope of practice than is currently allowed in B.C. is ludicrous. All jurisdictions that reflect fairly and accurately the current state of naturopathic practice allow these procedures; two of these, Washington and Oregon, are home to Bastyr University and National College, respectively where these procedures form part of the profession's core curriculum. In the U.S. the State government regulates the practice of naturopathic medicine in the public interest. It has deemed that naturopathic physicians are trained and competent in the use of minor surgery, obstetrics and midwifery, and are able to prescribe a limited schedule of restricted drugs.

In its submission, the ANPBC proposes the following definition of scope of practice:

Naturopathic medicine or naturopathy means a distinct system of primary health care practised by naturopathic physicians for the prevention, diagnosis, and treatment of human health conditions, injury and disease. Its purpose is to promote or restore health by the support and stimulation of the individual's inherent self-healing processes. This is accomplished through education and treatment of the patient by a naturopathic physician and through the use of natural therapies and therapeutic substances.

Public health duties of naturopathic physicians. Naturopathic physicians have the same authority and responsibility as other licensed physicians with regard to public health laws, reportable diseases and conditions, communicable disease control and prevention, recording of vital statistics, health and physical examinations, and local boards of health, except that the authority and responsibility are limited to activities consistent with the scope of practice described in this chapter.

In its submission, the BCNA proposes the following scope of practice statement:

Naturopathy means natural healing based on science and without limiting the generality of the foregoing, for the purposes of this Act, shall be deemed to include the treatment of the whole person, prevention of disease, promotion of wellness, support of the person's inherent healing ability and teaching individual responsibility for health and well-being.

Although not specifically listed in the proposed scope statements, it is important to note that both the BCNA and the ANPBC have indicated that their proposals would allow naturopathic physicians to:

- I. make referrals to specialists in all health fields;
- II. have hospital privileges;
- III. have unfettered access to diagnostic laboratory facilities;
- IV. practice midwifery, subject to the completion of courses additional to those offered in basic naturopathic training;
- V. perform "minor surgery";
- VI. apply anaesthesia; and
- VII. have access to more billing codes (that is, obtain reimbursement for a greater number of procedures).

Some of these services appear on the Council's Reserved Acts List which is attached as Appendix B to this report. In this section of its report the Council is simply dealing with how the scope of practice of naturopathy should be defined. The scope statement is a general statement of what the profession does, and generally, it is not appropriate to include specific acts within such a statement. The issue of whether the profession is entitled to perform such specific acts will be dealt with in the "Reserved Acts" section of this report, to the extent that they are included on the Council's Reserved Acts List. If the specific act is not on the Council's Reserved Acts List, there is no restriction, and it may be performed without a reference to it in the scope of practice definition.

Under the current *Naturopaths Act*, the scope of practice of naturopathy is restricted to healing by natural methods and expressly excludes surgery or the use of anaesthetics. Both the BCNA and the ANPBC are seeking a wide expansion in this current scope and in particular are requesting that naturopathic physicians be entitled to perform minor surgery, use anaesthetics, and practise obstetrics and midwifery. One of the key factors relied upon by both the ANPBC and the BCNA to support their request for an expanded scope of practice is the fact that in several American jurisdictions, the scope of practice of naturopathy includes such procedures. Indeed, as noted above, the ANPBC states that it is "ludicrous" not to allow naturopathic physicians in BC to perform the broader scope of practice. The Council emphasizes that the focus of its review is to determine the nature of services that naturopathic physicians in BC are currently trained and educated to perform. Scopes of practice from other jurisdictions are a factor that the Council considers, but they are not determinative for granting expanded scopes of practice in B.C.

The Council circulated the proposals from the BCNA for consultation, and the comments received are summarized below.

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4. Summary of Submissions

The British Columbia Society of Medical Laboratory Technologists is concerned that the statements do not describe the resources naturopathic physicians would use to diagnose. It questions whether naturopathic physicians have the training and education necessary to interpret the results of testing, thus raising the possibility of misdiagnosis. It also questions whether naturopathic physicians have the training necessary to treat patients who react adversely to anaesthetic.

The Acupuncture Association of British Columbia states that the current scope is reasonable but that naturopathic physicians should not do minor surgery or apply anesthetics, nor should they practice midwifery.

The British Columbia Medical Association (the BCMA) states that the current scope of practice of naturopathy should remain. It believes that the proposal amounts to a request that naturopathic physicians be entitled to practice medicine. The BCMA believes this is completely inappropriate, and creates the potential for harm to the public.

The College of Midwives of British Columbia (the CMBC) believes that it is not appropriate for naturopathic physicians to be doing midwifery, and that those naturopathic physicians who want to practice midwifery should register with the midwives college. The CMBC submits:

The practice of midwifery has the potential to cause harm to the public if practitioners are not regulated. The College of Midwives has developed mechanisms and policies specific to midwifery practice in order to address public safety issues. A health care profession whose primary mandate is not the provision of midwifery care might not have as its primary concern the development of specific mechanisms for the regulation of its members who are engaged in the practice of midwifery.

The College of Midwives submits that the BCNA interpretation of their proposed scope of practice is too broad and in the interests of avoiding confusion, ensuring consistency of midwifery practice and to protect the safety of the public, all persons practicing midwifery should be regulated by a single regulatory body.

The College of Massage Therapists states that the two proposals seem reasonable but that the second part of the ANPBC's submission regarding public health duties seems more like a statement of fact than a description of services and is not the sort of thing that should be embodied in a scope of practice statement.

The College of Physical Therapists of British Columbia states that the current definition is appropriate.

The British Columbia Association of Podiatrists is concerned about the proposal that naturopathic physicians apply anaesthesia. It notes that the Bastyr College of Naturopathy offers only a one semester course in surgery and no specific course in anaesthesia. It believes there is no indication that naturopathic training equips naturopathic physicians to apply anaesthesia or to perform any surgery other than the minor surgery referred to in the current Act.

The College of Dental Surgeons of British Columbia makes a very general submission that a profession must

base its therapies on scientific studies, and it has a concern that this is not the case with naturopathic physicians.

The British Columbia College of Chiropractors states that the naturopathic physicians have failed to provide evidence of their training and education to support their request for expanded scope of practice in the area of spinal manipulation.

The College of Physicians and Surgeons of British Columbia (the CPSBC) made a lengthy submission. On scope of practice the CPSBC states that it is unable to propose a scope of practice because naturopathic practice relies on theories that are fundamentally inconsistent with the CPSBC's standards. In other words, it appears to question whether naturopathy should have any scope of practice. The CPSBC also states:

The ANPBC general description of naturopathy reveals nothing unique or which would distinguish it from orthodox medical practice, except for the suggestion that their treatments are to be distinguished by being "natural". The problem of defining what is natural has already been discussed. The point at which a particular method of diagnosis or treatment switches from natural (naturopathic) to unnatural (medical/surgical) seems to shift conveniently, e.g. some synthetic drugs and minor surgery (limits not defined) should now be approved parts of naturopathy, according to the latest proposals.

Several of the preceding submissions simply made unsupported, conclusory statements and were not particularly useful to the Council.

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5. Conclusions

The Council has reviewed the ANPBC's and BCNA's submissions, and the responses to the consultation, and has reached the following conclusions.

The current definition of naturopathy does not accurately reflect the current practice of the profession. However, the proposals by both the BCNA and the ANPBC are not appropriate replacements, for various reasons.

First, a scope of practice statement should not include reference to "a distinct system of primary health care" or to the "public health duties of naturopathic physicians". As noted above, the *Terms of Reference* indicate that the scope statement is intended as a description of the services performed by a health profession.

Second, neither proposed statement includes reference, as does the present , *Naturopaths Act*, to the nature of invasive procedures performed by naturopathic physicians. As noted, the present *Naturopaths Act* prohibits naturopathic physicians from performing surgery or applying anaesthetics. Based on its review the Council is not prepared to recommend that the scope of practice of naturopathy be expanded in this manner. This issue will be discussed in detail in the section on reserved acts.

In summary, the Council has reviewed the proposed scope statements in light of the submissions received and the *Terms of Reference*, and has developed a scope of practice statement.

The Council recommends the following scope of practice statement for members of the ANPBC.

The practice of naturopathy is the prevention, diagnosis and treatment of diseases, disorders or conditions of an individual through the use of education and natural therapies or therapeutics to support and stimulate inherent self-healing processes.

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B. RESERVED ACTS

The rationale underlying the granting of reserved acts is to protect the public by limiting provision of those particularly dangerous acts to members of specific professions who are qualified to perform them. Only those acts which present a significant risk of harm will be reserved. It is also important to note that a profession may only perform reserved acts within its defined scope of practice.

In conducting its review of the scope of practice of naturopathy, the Council is not deciding which acts should be reserved exclusively to naturopathic physicians. Thus, the Council is not making a decision on the ANPBC's proposal that prescription and dispensing of botanical medicines and homeopathic medicines be reserved exclusively to registered naturopathic physicians. It is possible and indeed likely that if any reserved acts are granted to naturopathic physicians they may also be granted to other professions. This concept of shared reserved acts underscores one of the main purposes underlying the [Terms of Reference](#) which is to maximize consumer choice within safe parameters.

The Council has developed a list of reserved acts (Appendix B) which is included in its [Shared Scope of Practice Model Working Paper](#) (the *Working Paper*). The list was largely a result of the Council's review of the information provided by the professions during the scope of practice review process. The professions' initial submissions in the scope of practice review process were composed without the benefit of the Council's Reserved Acts List. As a result, the Council conducted a separate consultation process on the [Working Paper](#), and in many cases, such as naturopathy, sought clarification from the profession as to which reserved acts it was seeking.

A review of the submissions of the BCNA and the ANPBC indicates that they are seeking virtually all of the reserved acts on the Council's list. The Council has reviewed each of the BCNA's and the ANPBCs' proposed reserved acts in turn with reference to the Council's list.

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1. Diagnosis

The Council's reserved act regarding diagnosis is as follows:

Making a diagnosis identifying a disease, disorder or condition as the cause of signs or symptoms of the individual.

Both the ANPBC and the BCNA request a form of diagnosis as a reserved act. The ANPBC submits as follows:

Naturopathic doctors are trained and regulated to provide diagnoses consistent with naturopathic education, body of knowledge and scope of practice. Diagnoses are communicated to the patient and in turn they rely on the diagnoses in making decisions about their health care. The skills required for the diagnostic procedures are taught in all naturopathic colleges and are examined for in all regulated jurisdictions.

Diagnosis is an essential and integral part of naturopathic practice. Standards for naturopathic practice require that diagnosis be made prior to initiating naturopathic treatment to ensure that the correct treatment is applied to the patient for the specific diagnosed condition. Naturopathic doctors diagnose patients using standard Western medical diagnostic tools, procedures and language.

...

"Diagnosis by Naturopathic physicians is the same as MD's. Naturopathic diagnosis, as with allopathic diagnosis, means to determine the type and cause of a health condition based on the signs and symptoms of the patient, data obtained from laboratory analysis of fluid, tissue specimens, and other tests, and family and occupational background information such as recent injuries or exposure to toxic substances.

It is the philosophy which is different and therefore the application of medical knowledge is different. While allopathic doctors may diagnose purely at the biomedical level, naturopathic doctors attempt to correlate disease at the biomedical level with respect to an individual's overall health.

The biggest difference between diagnostic protocol between MD's and ND's is in the evaluation of functional health problems. Whereas MD's and ND's diagnose disease using the same instruments and analytical techniques, ND's also evaluate/diagnose health problems by drawing upon their additional training in such thing as; traditional Chinese medicine, Homeopathy, spinal manipulation and clinical nutrition.

Both the BCNA and the ANPBC indicate that training in physical and clinical diagnosis is equivalent to that at allopathic medical schools and is part of the core curriculum for naturopathic physicians. A review of the curricula provided by the ANPBC indicates that naturopathic colleges have several courses in diagnosis. The ANPBC also notes that diagnosis has been part of the naturopathic scope of practice in BC since its inception.

The Council has considered the submissions received and the information provided by the ANPBC and the BCNA, and is satisfied that diagnosis falls within the scope of practice of naturopathic medicine. However, as both the BCNA and the ANPBC state, although the diagnostic process is somewhat similar to that of MDs, it is based on a different philosophy which includes a consideration of a patient's functional health.

The Council recommends that members of the ANPBC be granted the reserved act of making a diagnosis using naturopathic methods.

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2. Physically Invasive Acts

The second reserved act on the Council's list states as follows:

2. Performing the following physically invasive or physically manipulative acts:

- A. *procedures on tissue below the dermis, below the surface of a mucous membrane, in or below the surface of the cornea, in or below the surfaces of the teeth, including the scaling of teeth;*
- B. *setting or casting a fracture of a bone or reducing a dislocation of a joint;*
- C. *movement of 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, hand or finger(s),*
 - I. *beyond the external ear canal,*
 - II. *beyond the point in the nasal passages, where they normally narrow,*
 - III. *beyond the pharynx,*
 - 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.*

Both the BCNA and ANPBC state that they are requesting virtually this entire act. The Council proposes to review each element of this act in turn.

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a) Procedures Below the Dermis

The current [Naturopaths Act](#) prohibits naturopathic physicians from performing surgery or applying anaesthetics. Both the BCNA and the ANPBC submit that naturopathic physicians are trained and educated and are performing such acts in British Columbia except for procedures in or below the surface of the cornea, and procedures in or below the surfaces of the teeth, including the scaling of teeth. In its initial submission, the ANPBC stated that:

Limited portions of this controlled act are part of the traditional scope of naturopathic medicine. These include venipuncture and skin pricking for the collection of blood samples, needle insertion acupuncture, removal of foreign bodies from superficial structures, and treatment of minor cuts, abrasions and contusions. Traditional naturopathic practice does not include the practice of procedures below the surface of the cornea or below the surface of the teeth, or the scaling of teeth. It does include minor surgical procedures and the use of anaesthetic.

In subsequent submissions both the BCNA and the ANPBC set out what was intended by the use of the term "minor surgery":

You also ask about the term "minor surgery" and what it entails. In short, minor surgery is everything that is not major surgery -- major surgery being surgery which entails general anaesthetics and/or spinal, etc. (e.g., major body cavity surgeries and sensitive tissues such as the eyes, hands, etc.). We should restate, drawing from previous submissions and correspondence, that all naturopathic physicians have training in minor surgery; it is not a speciality but a core part of naturopathic education. As NDs are primarily health care professionals, minor surgery includes items that are essential to the daily routines of primary health care and which don't require general anaesthetic. This includes but is not limited to the removal of warts, moles, ganglion cysts; obtaining sampling tissues for skin cancer, lipoma, and skin tag; cautery; the application and removal of sutures.

The ANPBC made an almost identical submission pertaining to minor surgery.

As far as education in surgical procedures, the Council reviewed the curriculum of Bastyr College, a naturopathic college in the state of Washington from which many naturopathic physicians in British Columbia have graduated. The only reference to minor surgery is the description of the following course:

Minor Surgery

This is a lecture/laboratory course in common surgical office procedures. Topics include suturing techniques; wound, infection and burn management; local anaesthetics; bandaging techniques; bone fracture casting; and the recognition of conditions requiring medical surgical intervention.

This is a three credit, three-hour lecture course to be taken on the fifth year of the five-year program for naturopathic medicine.

A review of the curriculum of the Canadian College of Naturopathic Medicine indicates that the following course is offered:

Minor Surgery (26 hours, 1 semester)

An introductory course in the use of minor surgical procedures in naturopathic practice. Basic surgical principles such as suturing, lancing of wounds, the use of topical anaesthetics and basic surgical instrumentation are reviewed. This course prepares the student for more advanced training in minor surgery in those jurisdictions where such licensing applies.(Emphasis added)

Neither the BCNA nor the ANPBC provided information regarding clinical training in such procedures, or advanced training.

If invasive procedures of any degree are to be included in their scope of practice, it is essential that the scope of practice statement indicate what limits, if any, there are to be on that scope of practice.

In all of the jurisdictions canvassed by the Council, at pages 10 to 14 above, the legislation regarding naturopathy contained some form of specific limitation on the invasive procedures performed by naturopathic physicians. Currently, in British Columbia, naturopathic physicians may only perform "first aid treatment of minor cuts, abrasions and contusions, bandaging and the taking of blood samples". Although both the BCNA and the ANPBC seek the right to perform "minor surgery", which they submit is part of traditional naturopathic practice, their description of what is included in that term is inadequate. On the basis of the submissions from the ANPBC and the BCNA, the Council is not prepared to remove the current limitations, set out in section 13 [10] of the *Naturopaths Act*, on the practice of the profession.

Nonetheless, the Council is satisfied that limited portions of this reserved act should be granted to naturopathic physicians.

The Council recommends that members of the ANPBC be granted the reserved act of performing procedures below the dermis but only for the purposes of venipuncture and skin pricking for the collection of blood samples, needle insertion acupuncture, removal of foreign bodies from superficial structures, and first aid treatment of minor cuts, abrasions and contusions. Procedures on tissue below the surface of mucous membrane, the cornea, or the surface of teeth, including the scaling of teeth, or any other surgical procedures are not included within this reserved act.

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b) Setting or Casting a Fracture of a Bone or Reducing a Dislocation of a Joint

The ANPBC states that although naturopathic physicians are trained and educated to perform such acts, they are not currently performing such acts in British Columbia. In reviewing the curriculum provided by the ANPBC as part of its submission, the Council notes that the only reference to training in this type of surgery is as part of the course of minor surgery at Bastyr College, excerpted above, at page 24. Neither the BCNA nor the ANPBC provided additional information about clinical training or advanced training in this area. Based on its review of the information provided regarding their training and education in this area, the Council is not prepared to grant this reserved act to naturopathic physicians

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c) Movement of 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

The Council's intention regarding this reserved act was not to reserve all manipulation but only that part of manipulative therapy which presents a significant risk of harm. The current wording of this act was arrived at after extensive consultation by the Council done in the course of preparing its *Working Paper*.

The BCNA and the ANPBC submitted that naturopathic physicians should be granted this reserved act. In its initial submission the ANPBC stated that naturopathic physicians perform and should continue to perform high velocity, low amplitude adjustments or manipulations. The Council requested clarification regarding the nature of manipulative therapy performed by naturopathic physicians and received the following response:

The form of manipulation practiced by Naturopathic Physicians does fall within the reserved act of manipulation as defined by the HPC. You also ask whether it is necessary that a ND hold a degree as a DC in order to perform manipulation as per the proposed reserved act. The answer is no. Training for Naturopathic Doctors (Naturopathic Physicians) encompasses chiropractic philosophy. The current scope of practice for Naturopathic Physicians in this province encompasses manipulation. Naturopathic Physicians perform both mobilization and high velocity adjustments according to their education and training; while techniques vary between chiropodists, osteopaths, and physiotherapists, the philosophy and training are similar. We restate that naturopathic manipulation is a core element of our training with a minimum 200 hours training to understand manipulation.

The B.C. College of Chiropractors objected to this act being included within the scope of practice of naturopathy:

Naturopathic training does not include core courses in adjustment. Similarly, adjustment is not included in the additional post-graduate educational training programs offered to naturopaths, as outlined in the Naturopathic Medicine Program at Bastyr College.

The Naturopathic Medicine Program at Bastyr College requires 322.5 credits for completion. Of the 322.5 credits, only 11 credits are required "Naturopathic Manipulation". This reinforces that "manipulation" as defined by chiropractors, is in the public domain and only requires basic training by other health professionals to ensure competency.

The naturopathic curriculum makes no reference to training in "chiropractic adjustment or manipulation", but instead explicitly recognizes that the training of naturopaths is in "physiotherapy", "mechanotherapy" and "naturopathic corrections and manipulation"... All of these therapies are distinct from chiropractic.

The 11 credit requirement of naturopathic manipulation does not approximate the level of training required to safely perform adjustments, as included in the two years of mandatory core chiropractic study. On an hourly basis, the chiropractic education and training is at least 5 times greater.

Accordingly, we disagree with the contention in Dr. Pontius' letter of April 3, 1996 to the Council that "... body mechanics and adjustment/manipulation, being part of the naturopathic curriculum

... is an integral part of naturopathic medicine". Instruction in "body mechanics" and "manipulation" does not include adjustment.

The BCNA responded directly to the B.C. College of Chiropractor's objection as follows:

In your brief ... [you] state that the naturopathic medicine programme at Bastyr University makes no reference to training in chiropractic adjustment or manipulation. True, the word 'chiropractic' is not used, but the training for naturopathic doctors (NDs) encompasses chiropractic philosophy. The naturopathic manipulation courses at Bastyr University and other accredited naturopathic colleges, emphasize structure and gait analysis, evaluation of musculoskeletal conditions, differential diagnosis, assessment and treatment, various forms of soft tissue therapy and craniosacral manipulation as well as osseous manipulation and, in the advanced courses, indications for the use of diagnostic testing, such as radiography, CT, MRI, and extremity manipulation. We feel this training, while not explicitly 'chiropractic' is, contrary to your statements , an integral part of naturopathic medicine and does include adjustment.

The chiropractic brief ... details a number of other concerns regarding the training of NDs. The current scope of practice for NDs in this province encompasses manipulation. NDs perform both mobilization and high velocity adjustments according to their education and training; while techniques vary between chiropodists [sic], osteopaths, and physiotherapists, the philosophy and training are similar. We restate that naturopathic manipulation is a core element of our training with a minimum 200 hours training to understand manipulation.

Having reviewed the information provided, the Council is satisfied that manipulation, including high velocity, low amplitude adjustments form part of the scope of practice of naturopathic medicine, and that this reserved act ought to be granted to naturopathic physicians. The BCNA states that naturopathic physicians perform this act "according to their education and training". The Council emphasizes that like all regulatory colleges the ANPBC is charged with the duty of ensuring that its members practice within the level of their competency.

The Council recommends that members of the ANPBC be granted the reserved act 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.

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d) Administering a Substance by Injection or Inhalation

The ANPBC states that naturopathic physicians are trained and educated to perform this act and are currently performing this act in British Columbia. In reviewing the submissions of both the BCNA and the ANPBC the Council notes that this act appears to be an important part of naturopathic practice. The ANPBC states that current examples of substances injected include vitamins, minerals and homeopathic preparations and certain botanical and homeopathic medicines which can be administered by inhalation. The issue of which specific substances may be used by naturopathic physicians is dealt with in the reserved act of prescribing, compounding or dispensing a drug restricted under provincial or federal legislation, discussed below.

The curriculum for naturopathic medicine includes training and education in this service. The following course

description is from the curriculum of Bastyr College:

NM8418 Medical Procedures 3 credits

Provide students with training in a variety of medical procedures including immunization, prescription writing, intravenous and intramuscular injections. In addition, lecture and demonstration on pharmacology and use of drugs which, although not part of the usual naturopathic practice, are occasionally needed in life-threatening conditions and rural practices.

This reserved act forms a key part of naturopathic practice.

The Council recommends that members of the ANPBC be granted the reserved act of administering a substance by injection or inhalation, but not including anaesthetics.

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e) Putting an Instrument, Hand or Finger(s) Beyond Various Parts of the Body

In its initial submission, the ANPBC states that naturopathic physicians are trained and educated to perform most aspects of this act and provided the following examples:

The scope of naturopathic practice includes putting an instrument, hand or finger

- I. *beyond the external ear canal for examination, instrumentation, and lavage*
- II. *beyond the point in the nasal passages where they normally narrow for examination, therapy and lavage*
- III. *beyond the opening of the urethra to obtain a sample for culture*
- IV. *beyond the labia majora for gynecological examination, diagnostic instruments and therapeutic substances*
- V. *beyond the anal verge for examination (rectal and prostatic), colon therapy and injection of therapeutic substances.*

In a recent letter the ANPBC submits:

(e) putting an instrument, hands or finger(s),

- I. *beyond the external ear canal,*
- Naturopathic Doctors are NOT currently trained and educated to perform these
- and Naturopathic Doctors are NOT performing such acts in practice in British Columbia

- II. beyond the point in the nasal passages, where they normally narrow,
 - **Naturopathic Doctors are currently trained and educated to perform these**
 - **and Naturopathic Doctors are performing such acts in practice in British Columbia**

- III. beyond the pharynx,
 - **Naturopathic Doctors are currently trained and educated to perform these**
 - **and Naturopathic Doctors are performing such acts in practice in British Columbia**

- IV. beyond the opening of the urethra,
 - **Naturopathic Doctors are currently trained and educated to perform these**
 - **and Naturopathic Doctors are performing such acts in practice in British Columbia**

- V. beyond the labia majora,
 - **Naturopathic Doctors are currently trained and educated to perform these**
 - **and Naturopathic Doctors are performing such acts in practice in British Columbia**

- VI. beyond the anal verge, or
 - **Naturopathic Doctors are currently trained and educated to perform these**
 - **and Naturopathic Doctors are performing such acts in practice in British Columbia**

- VII. into an artificial opening into the body
 - **Naturopathic Doctors are currently trained and educated to perform these**
 - **and Naturopathic Doctors are performing such acts in practice in British Columbia**

Very little comment was made by the respondents to the consultation process in regard to this report of the ANPBC's proposals.

The Council has concluded that much of the physically invasive acts form part of the scope of practice of naturopathic medicine. However, the two submissions from the ANPBC conflict in terms of the acts performed by naturopathic physicians. For example, the Council notes:

- While the initial submission includes procedures "beyond the external ear canal", the second submission states that naturopathic physicians are not trained and educated to perform, nor are they currently performing this reserved act.

- While the initial submission makes no reference to procedures beyond the larynx (new version of the reserved act states "pharynx"), the second submission states that they are trained and educated to perform, and are performing this act. The ANPBC provided no examples of the types of acts which fall within this category which naturopathic physicians are currently performing.

- While the initial submission made no mention of procedures regarding artificial openings into the body, the second submission states that naturopathic physicians currently perform such acts in B.C. Again, no details have been provided regarding the nature of such acts.

In light of these conflicting submissions, the Council is not prepared to grant this entire reserved act to members of the ANPBC.

The Council recommends that members of the ANPBC be granted the reserved act of putting an instrument, hand or finger(s),

1. **beyond the point in the nasal passages, where they normally narrow ,**
2. **beyond the opening of the urethra,**
3. **beyond the labia majora,**
4. **beyond the anal verge.**

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3. Managing Labour or Delivery of a Baby

Both the BCNA and ANPBC state they are seeking this reserved act, though both acknowledge that it does not currently fall within their scope of practice and naturopathic physicians are not currently performing this reserved act in British Columbia. The BCNA states:

First, all NDs have core training in gynaecology and obstetrics. Prenatal and postpartum care is currently part of the scope of practice for this profession, and many NDs offering primary care are performing such care. There is a difference, however, between this core training and the management and delivery of births. Training in naturopathic obstetrics over and above the core curriculum is required for the management and delivery of births in jurisdictions where such care is regulated (i.e., the US). This accreditation is offered at naturopathic college; for your information I have attached the Midwifery/Natural Childbirth Program curriculum available at Bastyr University. While NDs may graduate having completed this additional program, in BC the current scope for NDs does not explicitly include or exclude natural childbirth -- even if a ND is qualified to perform midwifery in another jurisdiction.

The ANPBC made a similar submission.

The College of Midwives opposed the granting of this reserved act to naturopathic physicians:

The BCNA proposes a general statement regarding the practice of naturopathic medicine and then claims that this definition will allow naturopathic physicians to practice midwifery, subject to the completion of courses additional to those offered in basic naturopathic training. The College of Midwives submits that this interpretation is too broad and there is significant potential for public confusion.

... If the scope of practice proposed by the BCNA is adopted, a woman seeking midwifery services will be able to choose whether a naturopathic physician with midwifery training or a registrant of the College of Midwives. The woman seeking care may find comparisons between

the two groups confusing if the model of practice and regulatory mechanisms of the two "colleges" differ. The practice of midwifery has the potential to cause harm to the public if practitioners are not regulated. The College of Midwives has developed mechanisms and policies specific to midwifery practice in order to address public safety issues. A health care profession whose primary mandate is not the provision of midwifery care might not have as its primary concern the development of specific mechanisms for the regulation of its members who are engaged in the practice of midwifery.

The College of Midwives submits that the BCNA interpretation of their proposed scope of practice is too broad and in the interest of avoiding confusion, ensuring consistency of midwifery practice and to protect the safety of the public, all persons practicing midwifery should be regulated by a single regulatory body.

The Acupuncture Association of British Columbia and the CPSBC also opposed the granting of this reserved act to naturopathic physicians though neither submission was particularly useful as no details were provided.

While it may be the case that certain American jurisdictions permit naturopathic physicians to manage labour and deliver babies, the Council is not satisfied, based on the information provided, that naturopathic physicians in BC are trained and educated to perform this reserved act. The Council was not provided with any information about advanced training in BC, nor did the ANPBC indicate that it has any system in place to regulate advanced competency in this area.

The Council is not prepared to recommend that the reserved act of "managing labour or delivery of a baby" be granted to members of the ANPBC.

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4. Applying or Ordering the Application of a Hazardous Form of Energy

Both the BCNA and the ANPBC state that energy is used throughout the practice of naturopathy. For example the ANPBC states:

Energy is used in all aspects of this profession and, indeed, has a long history of usage amongst naturopathic physicians. All licensed Naturopathic Physicians in BC have had between one and three courses in physical modalities ... Standard clinical therapies which employ energy are commonly used in physiotherapy and rehabilitation settings, these include but are not limited to, low volt and high volt galvanic current; diathermy; inferential current; TENS units; non-surgical laser or soft laser; magnetic current therapy; sine wave; hyperthermia; and virtually all the forms of energy.

Energy is currently used in a Naturopathic Doctors practice also as a functional method for diagnosis and treatment of a patient. Examples of this include EKG or EEG, thermograms, electro-dermal screening, Doppler, diagnostic ultra-sound and x-ray. Of course, despite this being a part of primary care, and despite education and training in diagnostic imaging, radiographic interpretation, etc., laboratory access in BC is currently limited by the CPSBC. Therefore, in order to use energy in a therapeutic fashion Naturopathic Physicians must either personally invest in diagnostic equipment, refer patients to MDs, or refer to private laboratories in

Alberta or the US. Ideally, of course, x-rays are best if sent through a medical laboratory, and with lab access Naturopathic Physicians would refer to medical laboratories. Again, Naturopathic Physicians would prefer to use British Columbia labs.

The BCNA made a similar submission.

The Council wishes to emphasize that its intention in reserving this act was not to reserve all forms of energy but only those that present a significant risk of harm. In its [Working Paper](#), the Council indicated that the reserved act of "applying or ordering a hazardous form of energy" would be left non-exhaustive for the present and that once the review process is complete this act should be more clearly defined to set out the types of energy that fall within it. The [Working Paper](#) did, however, include examples of the types of energy the Council felt fell within the act, and also stated the Council's preliminary view that therapeutic, as opposed to diagnostic ultrasound did not fall within this act.

The Council appreciates that it is difficult for professions to describe the types of "hazardous energy" that fall within their scope of practice without a clearer definition of the term. The Council recently considered this issue and recommended to the Ministry that it convene a group to determine a list of hazardous forms of energy requiring regulation. The recommendations are listed in the Council's [Interim Report](#). More detailed recommendations regarding the use of hazardous energy by the naturopathic profession should await the conclusion of that process.

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5. Prescribing, Compounding or Dispensing a Drug Restricted under Provincial or Federal Legislation

The purpose of this reserved act is to reserve only those substances which present a significant risk of harm. The effect of the proposal, as currently worded, is that only substances which require a prescription and substances which are non-prescription but must be sold from restricted area of pharmacy would be reserved. The use of substances not falling within this act, for example herbal remedies which do not appear on the relevant schedules, would not be restricted.

Both the BCNA and the ANPBC were advised of the wording of this reserved act. Both submit that naturopathic physicians should be granted not only the right to use several substances which fall within this reserved act, but that the Council should also approve a comprehensive list of substances for use by naturopathic physicians in the form of a Naturopathic Pharmacopoeia. Both have included submissions about what should be included on the list such as for example the naturopathic pharmacopoeias from the states of Oregon and Washington.

Some discussion of the background of a naturopathic pharmacopoeia is necessary to understanding this reserved act request.

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a) The Naturopathic Pharmacopoeia

Section 7(1)(o) [5(1)(o)] of the [Naturopaths Act](#) states that the Board of Naturopathic Physicians...

...with the approval of the Lieutenant Governor in Council and subject to this Act, ... may make rules...

(o) providing for a schedule of preparations and medicines to be authorized for use by naturopathic physicians.

Section 13 [10] of the NA identifies certain practices which are prohibited under the NA:

Nothing in this Act authorizes a person

- a) to prescribe or administer drugs for internal or external use other than the drugs specified in regulations made by the board and approved by the Lieutenant Governor in Council,*
- (b) or to use or administer anaesthetics for any purpose, or*
- (c) to practise surgery.*

Drugs are not defined under the [Naturopaths Act](#), however, the definition used in the Pharmacists Act clearly includes both substances which require a prescription and those which do not.

The combined effect of these provisions is that naturopathic physicians are prohibited from prescribing or administering any preparations or medicines other than those defined under section 7(1)(o) [5(1)(o)] and approved by the Lieutenant Governor in Council. Despite repeated requests from the naturopathic physicians, no schedule of preparations and medicines has ever been approved. Thus, it would appear that under current legislation naturopathic physicians may not prescribe or administer any preparations or medicines.

This lack of approval has frustrated naturopathic physicians for many years. In its scope of practice submission, the BCNA stated:

Naturopathic physicians have called for the application of this statutory directive for countless years.

...

Successive provincial governments have declined to regulate a schedule of preparations and medicines. At the same time, such governments have not repealed the provision under the [Naturopaths Act](#) regarding the schedule of preparations and medicines provision.

...

Naturopathic physicians and their patients are prejudiced by the failure of successive provincial governments to provide a schedule of preparations and medicines under the [Naturopaths Act](#)

In 1992, the Ministry established [Terms of Reference](#) for a review committee to examine the approval of a pharmacopoeia for use by naturopathic physicians. The review committee achieved substantial agreement on most substances for inclusion in a schedule of preparations and medicines. However the Committee ran into problems as a result of internal disagreements, and no final conclusions were reached.

Thus, the situation remains unchanged and it would appear that naturopathic physicians are severely limited in the substances they may employ in practice.

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b) The Reserved Acts Model

An understanding of the reserved acts model, reflected in the Council's [Terms of Reference](#), is important to addressing this reserved act.

Under the existing regulatory system, naturopathic physicians are prohibited from using any substances unless they are specifically permitted to do so, and as yet no list has been developed. In practice, naturopathic physicians are currently using many substances in their practices. Under the new reserved acts model, a profession may perform any act within their scope of practice as long as either the act is not reserved or the profession is granted the specific reserved act. In the case of substances falling within this reserved act, this means that naturopathic physicians will be entitled to use any substances not restricted under federal or provincial legislation since this reserved act refers only to such drugs. Therefore, it is not necessary to develop a list of all substances naturopathic physicians propose to use in their practice. Rather, all that is required is a listing of substances which fall within the reserved act. This position will require modifications to the current legislation governing naturopathy, and specifically modifications to section 7(1)(o) [5(1)(o)] and 13 [10] of the current [Naturopaths Act](#). This specific issue of amendments to legislation will be dealt with in the Council's legislative review process.

Both the BCNA and ANPBC were advised of the nature of the reserved acts model, the wording of this reserved act and its implications for the practice of naturopathy. The BCNA submits that the Council must still approve of a Naturopathic Pharmacopoeia listing all substances used in the practice of naturopathy in order to protect the profession from the effects of the federal regulatory system:

Access to high-quality specialized products, which NDs are trained to use, but which may no longer exist in Canada due to some manufacturers refusing to meet complex bureaucratic requirements is a concern to NDs and a threat to the delivery of health care in this profession. It is essential to us that a Naturopathic Pharmacopoeia for the profession contain not only certain Schedule F items, but all the OTC items as per the reference sources cited in our application for a Limited and Interim Schedule of Preparations in June, 1995.

In short, the BCNA believes that by including certain substances in the reserved acts for naturopathy these substances would remain within the scope of naturopathic practice despite federal regulatory efforts. However, the Council emphasizes that, as a matter of jurisdiction, the provincial government must follow the federal government's lead in this regard. While regulation of practitioners is within the provincial domain, regulation of drug products is within the federal domain and the province cannot determine which substances will be available for use in Canada. In short, it is not within the jurisdiction of the Council to approve of naturopathic physicians' use of substances which have not been approved by the Health Protection Branch for use in

Canada.

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c) Schedule of Substances

In its March 31, 1993 interim report, the Naturopathic Pharmacopoeia Review Committee noted that the naturopathic physicians on the Committee had prioritized their request for Schedule F items to nine substances. The Committee noted that no consensus was achieved because the College of Physicians and Surgeons refused to endorse any schedule of preparations and medicines for use by naturopathic physicians that included substances included or proposed to be included in Schedule "F" of the Regulations under the federal Food and Drug Act. The Committee went on to recommend that:

A review should proceed of the nine Schedule F items identified by naturopaths as having priority in their request for authorization of a naturopathic pharmacopoeia. These substances are:

- *Vitamin A in daily dosages up to 25,000 IU*
- *Vitamin B12 with intrinsic factor*
- *Vitamin D in daily dosages up to 50,000 IU*
- *Vitamin K for emergency use, in single dose form*
- *Thyroid extract dessicated (i.e. with thyroxin)*
- *Rauwolfia serpentina, in plant form only, not synthetic*
- *Nicotiana tabacum, in nicotine patch form*
- *Lidocaine, or another local anaesthetic, for use in minor surgery*
- *Dimethylsulfoxide (DMSO), for external use only, as a carrier*

The committee's recommendations were never implemented.

The ANPBC has included with its submission to the Council a list of substances for use by naturopathic physicians which would fall within the reserved act. It is included as Appendix 1-A to a recent letter from the ANPBC. The list comprises approximately 31 substances.

It is very difficult to assess whether naturopathic physicians should be granted this reserved act without further information regarding how the substance(s) fit within their scope of practice and the nature of their training and education to use such substances. The former point is particularly important as an initial review of the Schedule F substances proposed for use by naturopathic physicians indicates that several of them appear to be linked to the profession's request for an expanded scope of practice. For example, lidocaine is likely tied in to the request to do minor surgery, and vitamin K is likely tied into the request to perform midwifery services. Further, an initial review of the proposed substances indicates that several, such as lidocaine, rauwolfia and vitamin B12 and thyroid extract can be extremely dangerous.

The Council was not satisfied at the time this report was drafted that either the BCNA or the ANPBC had provided sufficient information to justify the granting of this reserved act. However, just before the report was released both the BCNA and the ANPBC made detailed submissions on this issue. The Council did not have time to review this material before the release of this preliminary report.

For the purposes of consultation, the Council has attached, as Appendix C, a comprehensive list of Schedule F

substances which the ANPBC is proposing for use by its members. In addition, the ANPBC has prepared a detailed item by item monograph for each of the substances. That monograph is available at the [Health Professions Council](#) website.

If anyone cannot access the Council's webpage, please contact the Council's office by phone, at (604) 775-3582, or by fax, at (604) 687-8551.

Another issue with respect to this reserved act is the issue of exclusivity. Several respondents to the consultation, such as the British Columbia Society of Medical Technologists, the Traditional Chinese Medicine Association of B.C., the College of Midwives of British Columbia, the College of Pharmacists of British Columbia, the Dominion Herbal College, the Vancouver Centre for Homeopathy, and the Canadian Herbalist's Association of British Columbia, all noted that the prescribing and dispensing of botanical and homeopathic medicines should not be reserved to naturopathic physicians alone. The Acupuncture Association of British Columbia contends that it also uses substances and is opposed to any exclusivity for naturopathic physicians. It states:

- (i) *Prescription and dispensing of botanical medicine (herbs) have been a part of acupuncturists' practice and T.C.M. and therefore should not be reserved exclusively to naturopaths.*

The Council again emphasizes that at this point it is simply dealing with which reserved acts should be granted to naturopathic physicians, and is making no determination about whether any other profession should be granted any rights to use such substances.

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8. Allergy Challenge Testing of a Kind in which a Positive Result of the Test is a Significant Allergic Response or Allergy Desensitizing Treatment in which there is a Risk of Significant Allergic Response

The ANPBC submits that this act forms an integral part of naturopathic practice:

The traditional practice of naturopathic medicine includes allergy/sensitivity challenge testing, allergen removal from the diet with reintroduction challenge testing, and provocative testing with sublingual drops, homeopathic dilutions and food substances. The appropriate parts of this controlled act have been used safely by naturopathic doctors since the start of regulation.

Bastyr College contains the following course requirement for naturopathic medicine:

NM7305 Clinical Ecology 2 credits

The diagnosis, prevention and treatment of allergy in its many forms: food, environment, hydrocarbon, autogenous, and other types are presented. Considered are such topics as masked allergies, allergic adaptation, challenge testing, rotation diets, environmental wards, fasting, and various laboratory tests for allergies (i.e., skin sublingual, intradermal, and blood).

The curricula of the various naturopathic colleges include several courses in diet and nutrition.

None of the responses to consultations contained any specific objections to this reserved act being granted to naturopathic physicians. The Council is satisfied that this reserved act forms a central part of naturopathic training, education and practice.

The Council recommends that members of the ANPBC be granted the reserved act of allergy challenge testing in which a positive result of the test is a significant allergic response or allergy desensitizing treatment in which there is a risk of significant allergic response.

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C. SUPERVISED ACTS

The [Terms of Reference](#) indicate that the Council will, for each reserved act granted to each profession, determine the circumstances in which the act may be performed by someone other than a member of that profession.

The ANPBC makes a brief submission on supervised acts:

Currently, nurses or assistants while acting under the direction or prescription of a person registered as a naturopathic physician under the [Naturopaths Act](#) are able to use, apply or administer any procedure within the scope of the Act.

The ANPBC recognizes that valuable role that nurses and assistants play in a private practice and submit that the standards that apply to nurses and assistants in other health disciplines also apply to nurses and assistants in naturopathic practices.

Section 27 [17] of the [Naturopaths Act](#) deals with the issue of delegation:

Nothing in this Act or in any other Act, law or regulation of British Columbia prohibits a nurse or assistant, while acting under the direction or prescription of a person registered as a naturopathic physician under this Act, from using, applying or administering a procedure that is within the scope of this Act.

The wording of this section is ambiguous, and does not provide a proper framework for safe delegation of reserved acts. It is potentially very broad in terms of what acts may be delegated, and there is no indication of what an "assistant's" qualifications or training may be.

The Council considered this issue in detail in its recent preliminary report regarding the [scope of practice of medicine](#). The Council first noted the submissions of the College of Physicians and Surgeons:

In its submission, the College makes a compelling argument that legislation is a blunt instrument to deal with this issue. The College states that the issue of delegation and supervision is a question of individual competence and the circumstances of each case, and that supervision of certain acts can be addressed only

after a careful review of all the circumstances surrounding a particular act and by imposing, where necessary, clear guidelines, restrictions or conditions on such supervision.

The College further submits that compiling a list of acts which may be delegated or performed under supervision would not adequately address the complexities of medical situations which present to physicians nor would it protect the public. The College notes that there will be situations where, because of the individuals involved, the site or location, or the specific nature of the presenting problem, it may not be appropriate to delegate an act which might otherwise be capable of delegation.

The Council accepted this submission and stated as follows:

The Council ... believes that it would be better to take a general approach to the issue of supervision. The general thrust of the approach is that the decision as to whether an act can be performed under supervision should be left up to the health professions, and that a set of principles embodying the duties of the delegating professional and his or her regulatory college be established and enacted into legislation when the shared scope of practice model takes effect. The principles are derived largely from the CMA's Guidelines for the Delegation of a Medical Act which the College enclosed with its submission.

As a result, the Council stated that supervised acts would not be dealt with individually for each profession, and made the following general recommendation regarding this issue:

The Council recommends that a provision be enacted which sets out the duties of a health professional and his or her regulatory college when delegating a reserved act. The provision should require the following:

- The assigning health professional's governing body must provide assent to the proposed reserved act being performed by someone else;
- The reserved act to be assigned as well as the level of supervision must be clearly defined and circumscribed by the assigning health professional's governing body;
- Where the person to whom the act will be assigned is a member of a self-regulating health profession, his or her governing body must approve of the assigning of the reserved act;
- The instruction to perform the act must be made in writing either by way of a general written protocol or through a case-specific instruction;
- The assigning health professional must be satisfied that the individual who will be performing the act has the necessary skills and training to perform the act safely;
- The assigning health professional must ensure that the person who will be performing the act accepts the assignment.

The Council believes this general approach to supervised acts more accurately reflects the reality that procedures to be delegated vary from profession to profession and may include subsets and variations of reserved acts and further, may be performed under a myriad of circumstances and conditions.

In its preliminary report on the scope of practice of medicine the Council also noted the following:

- *although this term of reference refers to "supervised" acts, it is intended to encompass any situation where someone other than the person to whom the reserved act has been granted performs that act. In other words, this term of reference refers to both delegation and supervision.*
- *This proposal is not intended to apply on a case-by-case basis. The requirement for approval of the*

governing body is meant to apply generally and not to individual cases, and would be satisfied by, for example, a general protocol in respect of delegation of reserved acts.

In the Council's view, this general position should be applied to all professions. It is largely a recognition that the regulatory body is best placed to determine when other health care providers can perform services under supervision, and thus a regulatory body should be charged with determining when delegation is appropriate in accordance with the principles set out above.

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D. RESERVED TITLES

Reserved titles are titles reserved exclusively to a health profession. Reserved titles afford a means for consumers to identify the different types of health care providers, to distinguish the qualified from the unqualified, and to differentiate those practitioners who are regulated from those who are not. Titles must adequately serve the public in describing the practitioner and the services being provided and must distinguish the practitioner from others performing services outside the jurisdiction of the college.

Section 11 [8.1] of the [*Naturopaths Act*](#) reserves the use of the titles "doctor" and "Dr." but only as "Doctor of Naturopathic Medicine", "Dr. of Naturopathic Medicine", "Naturopathic Doctor" or "Naturopathic Dr.".

Section 12 [9] of the [*Naturopaths Act*](#) states:

Use of "naturopathic physician" and other titles

12. A person must not, unless registered under this Act,

(a) practise as a naturopathic physician, drugless physician, sanipractic physician or drugless healer, or

(b) use a designation or in any manner seek to convey that the person is entitled to practise as a naturopathic physician, drugless physician, sanipractic physician or drugless healer in British Columbia.

The ANPBC proposes that the following titles be reserved:

naturopathic doctor,
naturopathic physician,
naturopath, and
N.D. or ND.

The BCNA proposes that the title, "naturopathic physician" be reserved although it appears to take the position that the present [*Naturopaths Act*](#) already reserves this title.

The Council believes that the titles "naturopathic doctor", "naturopathic physician" and "naturopath" adequately

serve the public in describing naturopathic physicians and the services they provide. The Council does not believe there is a public interest in reserving educational titles.

The Council recommends:

- **that the titles, "naturopathic doctor", "naturopathic physician" and "naturopath" and any affix of those titles be reserved; and**
- **that members of the ANPBC be granted the use of those reserved titles.**

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E. OTHER ISSUES

In this portion of the report the Council will consider various issues raised by the naturopathic physicians which do not fall neatly within the scope review including laboratory privileges, hospital privileges, specialist referrals and the Medical Services Plan.

1. Laboratory Privileges

In discussing the issue of diagnosis, both the BCNA and the ANPBC have indicated that they are seeking test ordering privileges. For example, the BCNA states:

In regard to laboratory testing, NDs require full laboratory testing for the performance of primary health care, nothing less. Indeed, this issue was raised so prominently in our Scope submission, and in later correspondence, not because it is a scope issue, but rather because of the limited access currently allowed in BC. Naturopathic physicians are currently using laboratory testing in the same fashion MDs are - but they are forced to use US laboratories at a cost to their patients.

At the risk of sounding redundant, lab testing relates to the practice of naturopathic medicine because:

- *NDs are trained in laboratory diagnosis*
- *NDs perform primary health care and primary health care includes laboratory diagnosis*
- *NDs are currently using laboratory diagnosis*

If you are asking, practically, how lab testing would be used on a daily basis, there is no end of examples. If a naturopathic physician is seeing a patient and needs to test their blood sugar to see whether they are diabetic, or whether they need to test a urine sample for a urinary tract infection, or whether they need to test cholesterol levels for heart problems, or whether they need to get a serology work-up for potentially infectious patients (e.g., HIV, hepatitis, etc.) - in short, when performing primary health care, when performing the duties of a naturopathic physician as per the current Act and scope, laboratory diagnosis is an essential element of naturopathic health care. The deliberate barring of access to privately owned and publicly funded medical laboratories in BC by the CPSBC has resulted in

a myriad of problems which: compromise the provision of health care; can result in patient harm; and at the very least result in additional costs to the patient and the medical system (MSP in BC).

The British Columbia Society of Medical Technologists questioned whether naturopathic physicians have the necessary education and training to interpret the results of examinations or testing. The BCNA indicated as follows:

It is worth noting that naturopathic physicians receive a full-year of lab diagnosis, and interspersed in the four-years of graduate training at naturopathic college receive signs, symptoms and diagnostic courses as well as sub-speciality courses (i.e., cardiology, gynaecology, neurology, etc.); there is also laboratory diagnosis in that course content (using the course curriculum material from Bastyr University, attached, you can see the exact lecture and lab portions, per hour, per course). Furthermore, courses such as diagnostic imagining [sic] and radiographic interpretation deal directly with x-rays and lab diagnosis, providing more than sufficient training for correct and timely patient assessment and diagnosis.

The Council's [Working Paper](#) at this time does not list ordering or using laboratory testing as a reserved act. The Council has recommended that naturopathic physicians be granted the reserved act of "making a diagnosis using naturopathic methods". Therefore, it may be in the public interest for naturopathic physicians to use certain laboratory testing if there is a relationship to their diagnostic process.

While the Council is prepared to consider the ANPBC's request for use of laboratory tests in the context of their reserved act of diagnosis, as previously described, the Council does not find that the ANPBC's submissions have set out the relationship between the laboratory testing requested and diagnosis as performed by a naturopathic physician. This is particularly the case as naturopathic physicians have distinguished the form of diagnosis they perform as "philosophically" different from that of other professions. In short, based on the information provided, the ANPBC has failed to provide sufficient evidence of how specific laboratory tests are related to their scope of practice.

Another issue related to laboratory privileges is access to laboratory facilities.

The general policy embodied in the [Terms of Reference](#), is to encourage interdisciplinary practice and freedom of choice among safe options in health care. With this policy in mind, any health practitioner trained to diagnose and treat his or her patients, should be allowed access to all available diagnostic tools if that professional is adequately trained to interpret such testing and if such tests are relevant and necessary for the professional to carry out the diagnostic process he or she is entitled to perform, i.e., the tests are relevant to the nature of diagnosis the profession is granted. These will be discussed in detail as each profession's preliminary scope report is issued.

Historically, the Ministry of Health has relied on the CPSBC to ensure the quality of laboratory services through its Diagnostic Accreditation Program. Because the CPSBC views the operation of a laboratory as part of the practice of medicine, the [Medical Practitioners Act](#) (the MPA) and Rules are currently applied to the practice of laboratory medicine. The MPA, specifically s. 93 [84], has been interpreted by the CPSBC as prohibiting laboratory physicians from accepting referrals from non-physicians. This section would presumably operate the same way for a situation where a chiropractor or other non-physician wanted to order an x-ray since the persons who are charged with the administration and operation of these testing facilities and the interpretation of the test results are also physicians.

This issue will be addressed in more detail in the Council's legislative review. However, from a scope of practice

perspective, the Council sees no need to restrict access by professions who can demonstrate that testing is relevant to their scope of practice and they are trained and educated to use and interpret such tests.

The Council is well aware that there are cost implications of broadening access to laboratory facilities, but cost implications are beyond its mandate.

The Council recommends that members of the ANPBC be granted a limited range of laboratory testing, based upon satisfying the following criteria:

- **the range of laboratory testing granted is based upon the scope of practice of members of the ANPBC;**
- **the ANPBC demonstrates a relationship between the laboratory testing requested and naturopathic diagnosis; and**
- **the ANPBC provides further information concerning the experience, education and training in use of laboratory testing which members of the ANPBC currently possess.**

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2. Hospital Privileges

In its submission the BCNA requests that naturopathic physicians be granted hospital privileges:

In relation to having access to specialists, naturopathic physicians also require hospital privileges. Although they currently act as primary care physicians, they are limited to offering ambulatory care. Limiting hospital care to medical doctors is also a conflict of interest. patients are denied choice, and the publicly-funded hospitals are monopolized by a single health profession. In addition to choice, the health care system would benefit, cost-wise, from the preventative medicine by naturopathic physicians.

A regulation under the Hospital Act, B.C. Reg. 121/97, deals with the issue of hospital privileges. It distinguishes between "attending or treating patients in a hospital" and "patient admitting and discharging privileges". The former are restricted to physicians and surgeons, dentists, and midwives, while the latter are restricted to physicians and surgeons and midwives.

The Council's investigation indicated no need for granting naturopathic physicians hospital admitting privileges to carry out their scope of practice. But that is not to say that, from a scope of practice perspective, there is no place for naturopathic treatment for patients admitted to hospitals under the care of other health care providers. The *Terms of Reference* indicate that any barriers to such treatment that exist, such as for example the provisions of the Hospital Act Regulation, ought to be reviewed with a view to removal of such barriers. In fashioning this recommendation the Council has not considered other factors such as insurance, internal hospital protocols regarding hospital patients and costs, all of which are beyond its mandate.

The Council recommends that any barriers to members of the ANPBC providing treatment services within a hospital be reviewed with a view to removal of such barriers.

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3. Referrals to Specialists

The BCNA also requests that the Council recommend that naturopathic physicians be granted access to medical specialists:

Additionally, the current definition does not qualify five major components of naturopathic care. First, as naturopathic physicians are primary care providers, they require access to specialists in all health fields. While any health professional can refer to an ophthalmologist, other specialists such as gynecologists, urologists and orthopaedists, require referrals from a medical doctor. Not having access to specialists creates two problems. First, the patient is compromised, forced to have a second consultation before receiving appropriate care and second, the health care system is burdened by additional doctor visits and therefore additional costs.

The CPSBC takes the position that only licensed medical practitioners have the training and qualifications necessary to make such referrals. The CPSBC also states that direct referrals from individuals other than licensed medical practitioners also pose problems for the medical specialist consulted, though the CPSBC provided no explanation for this comment.

The Council has no objection in principle to naturopathic physicians making referrals to specialists. However, the Council appreciates that specialists cannot be forced to accept such referrals. On the other hand, the Council does not believe that an outright ban on accepting referrals is appropriate or in the public interest. If individual specialists feel confident accepting such referrals they should feel free to do so without restriction. The CPSBC has not clearly indicated that such an outright ban does exist though one may infer from its submission that there is some form of prohibition.

The Council recommends that any barriers which prevent referrals to medical specialists by members of the ANPBC be removed.

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4. Medical Services Plan

The BCNA also requested an increase in the number of billing codes it has been allocated:

Finally, even though naturopathic physicians provide primary care, they are not awarded fees for services by the government Medical Services Plan. Naturopathic doctors currently have fewer

than five billing codes, whereas 30 - 40 would be a more realistic measure of naturopathic care. Routine procedures such as office lab work, urinalysis, injection or venipuncture fees and institutional visits such as those long-term care facilities are all presently not covered by the government. Increasing billing codes would more accurately represent the current services offered by naturopathic physicians, as well as offer patients greater access to health care of their choice.

The Council again emphasizes that the issue of Medical Services Plan reimbursement is not within its mandate, and the Council makes no recommendation on this issue.

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IV. RECOMMENDATIONS

1. The Council recommends the following scope of practice statement for members of the Association of Naturopathic Physicians of B.C. (ANPBC).

The practice of naturopathy is the prevention, diagnosis and treatment of diseases, disorders or conditions of an individual through the use of education and natural therapies or therapeutics to support and stimulate inherent self-healing processes.

2. The Council recommends the following reserved acts be granted to members of the ANPBC:

A. Making a diagnosis using naturopathic methods.

B. Performing procedures below the dermis but only for the purposes of venipuncture and skin pricking for the collection of blood samples, needle insertion acupuncture, removal of foreign bodies from superficial structures, and first aid treatment of minor cuts, abrasions and contusions. Procedures on tissue below the surface of mucous membrane, the cornea, or the surface of teeth, including the scaling of teeth, or any other surgical procedures are not included within this reserved act.

C. 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. Administering a substance by injection or inhalation, but not including anaesthetics.

E. Putting an instrument, hand or finger(s),

 I. beyond the point in the nasal passages, where they normally narrow,

 II. beyond the opening of the urethra,

 III. beyond the labia majora,

 IV. beyond the anal verge.

F. Allergy challenge testing in which a positive result of the test is a significant allergic response or allergy desensitizing treatment in which there is a risk of significant allergic response.

3. The Council recommends that a provision be enacted which sets out the duties of a health professional and his or her regulatory college when delegating a reserved act. The provision should require the following:

- The assigning health professional's governing body must provide assent to the proposed reserved act being performed by someone else;
- The reserved act to be assigned as well as the level of supervision must be clearly defined and circumscribed by the assigning health professional's governing body;
- Where the person to whom the act will be assigned is a member of a self-regulating health profession, his or her governing body must approve of the assigning of the reserved act;
- The instruction to perform the act must be made in writing either by way of a general written protocol or through a case-specific instruction;
- The assigning health professional must be satisfied that the individual who will be performing the act has the necessary skills and training to perform the act safely;
- The assigning health professional must ensure that the person who will be performing the act accepts the assignment.

4. The Council recommends

- that the titles "naturopathic doctor", "naturopathic physician" and "naturopath" and any affix of those titles be reserved; and
- that members of the ANPBC be granted the use of those reserved titles.

5. The Council recommends that members of the ANPBC be granted a limited range of laboratory testing, based upon satisfying the following criteria:

- the range of laboratory testing granted is based upon the scope of practice of members of the ANPBC;
- the ANPBC demonstrates a relationship between the laboratory testing requested and naturopathic diagnosis; and
- the ANPBC provides further information concerning the experience, education and training in use of laboratory testing which members of the ANPBC currently possess.

6. The Council recommends that any barriers to members of the ANPBC providing treatment services within a hospital be reviewed with a view to removal of such barriers.

7. The Council recommends that any barriers which prevent referrals to medical specialists by members of the ANPBC be removed.

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APPENDIX C - List of Schedule F substances proposed for use by ANPBC members

APPENDIX 1-A (REVISED OCT 6, 1998) HPC SUBMISSION

PROPOSED LIST OF SPECIFIC SUBSTANCES - NATUROPATHIC RESERVED SCHEDULE OF PREPARATIONS AND MEDICINES

All botanicals, including those listed below from Schedule A of the Pharmacy Act and Schedule F of the Federal Food and Drug Act: Preparations, alkaloids, salts, analogs, derivatives and synthetic preparations of:

- A. Centella Asiatica
- B. Colchicine
- C. Digitalis
- D. Nicotiana Tabacum
- E. Pilocarpin (pilocarpus)
- F. Podophyllum

- G. Rawolfia Serpentina
- H. Veratrum Viride
- I. Veratrum Album
- J. Yohimbe

All vitamins and nutrients, including those listed below from Schedule A of the Pharmacy Act and Schedule F of the Federal Food and Drug Act: USP, NF, PDR, CPS, package inserts. Preparations, salts, analogs and synthetic preparations of:

- K. Vitamin A, greater than 10,000 IU per dose
- L. Vitamin A acid
- M. Vitamin B12 with or without intrinsic factor
- N. Vitamin D, greater than 1,000 IU per dose
- O. Vitamin K
- P. Vitamin B-3, greater than 250 mg per dose

All naturally occurring hormones, enzymes, substances, lipids, proteins, glycosides, acids, including those listed below from Schedule A of the Pharmacy Act and Schedule F & G of the Federal Food and Drug Act: USP, NF, PDR, CPS, package inserts. Preparations, salts, analogs derivatives and synthetic preparations of:

- Q. Adrenocortical hormones
- R. Thyroid hormone
- S. Estrogen
- T. Progesterone

U. Androgens

All amino acids, including that listed below from Schedule A of the Pharmacy Act and Schedule F of the Federal Food and Drug Act: USP, NF, PDR, CPS, package inserts. Preparations, salts, analogs and derivatives of:

- A. L-Tryptophan

All minerals and salts including aspartates, orotates and picolinates, including that listed below from Schedule A of the Pharmacy Act and Schedule F of the Federal Food and Drug Act: USP, NF, PDR, CPS, package inserts. Preparations, salts, analogs and derivatives of:

- B. Lithium Carbonate

The local anesthetics listed below from Schedule A of the Pharmacy Act and Schedule F of the Federal Food and Drug Act: DOSAGE: USP, NF, PDR, CPS, package inserts. Preparations, alkaloids, salts, analogs and derivatives of:

- C. Lidocaine
- D. Procaine
- E. Topical sprays of lidocaine

The additional substances listed below from Schedule A of the Pharmacy Act and Schedule F & G of the Federal Food and Drug Act:

- F. DHEA (Prasterone), DHEA-S
- G. DMSO
- H. EDTA, DMPS, DMSA
- I. Melatonin

The additional substances listed below from Schedule A of the Pharmacy Act and Schedule F of the Federal Food and Drug Act: DOSAGE: USP, NF, PDR, CPS, package inserts. Preparations, alkaloids, salts, analogs and derivatives of:

- A. Penicillin V, Penicillin G, Dicloxacillin, Amoxicillin, Amoxicillin Clavulanate
- B. Tetracycline
- C. Erythromycin, Clarithromycin
- D. Cefaclor, Cephalexin, Cephradine
- E. Cromolyn sodium
- F. Gold compounds
- G. Pancreatic Enzymes
- H. Epinephrine (premeasured injection: for example, Epi-pen kit per emergency First Aid training in response to anaphylactic reaction)

Last Revised: March 08, 2002

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Health Professions Council POST-HEARING UPDATE OF PRELIMINARY REPORT: NATUROPATHIC PHYSICIANS

Irvine E. Epstein, Q.C., Chair
Arminée Kazanjian, Member
David MacAulay, Member

March 2001

This Post-Hearing Update should be read in conjunction with the [Preliminary Report](#) for the profession.

The Council issued its *Naturopathic Physicians Scope of Practice (Preliminary Report)* in December 1998. The public hearing was held on 23 November 1999. The following are changes to the *Preliminary Report* which arose from the submissions made either at the public hearing or in subsequent written submissions.

I. SCOPE OF PRACTICE

In its *Preliminary Report* the Council recommended the following scope of practice for naturopathic physicians:

The practice of naturopathy is the prevention, diagnosis and treatment of diseases, disorders or conditions of an individual through the use of educational and natural therapies or therapeutics to support and stimulate inherent self-healing processes.

In recommending this statement, the Council agreed that the current scope of practice provided in the *Naturopaths Act* did not reflect the current practice of the profession. However, the Council was not prepared to expand the scope to allow naturopathic physicians to perform surgery or use or administer anaesthetics.

At the hearing, the differences between the training and education of naturopathic physicians and medical practitioners was discussed at length. The Association of Naturopathic Physicians of British Columbia, now the College of Naturopaths of British Columbia (the College) maintained its position that medical practitioners and naturopathic physicians receive the same undergraduate pre-medical training, and both attend medical school for four years, except that medical students complete rounds after college while naturopathic students do so during college. The Council also received submissions on this issue from the College of Physicians and Surgeons of British Columbia, and reviewed and examined the training and education of each of these professions.

In the Council's view, the training of naturopathic physicians is considerably less than medical practitioners,

particularly in respect of clinical hours. The clinical training that naturopathic physicians receive in the four-year curriculum is insufficient for anyone to become competent in the great number of areas which the College wishes to have included in the scope of practice.

In order to perform the reserved acts safely, sufficient supervised clinical experience is necessary. The amount of time spent in supervised clinical activity at the end of four years at Bastyr College is less than the amount experienced by students graduating from North American medical schools. There is no post-graduate training required in order to obtain a license to practice naturopathy in B.C. Most clinical activity in naturopathy is confined to "natural" therapies: botanical medicine, homeopathy, clinical nutrition, naturopathic hygienic principles and lifestyle modifications.

Naturopathic students have less clinical experience than medical students who are still required, at the end of four years of schooling, to complete a minimum of another 5000 hours of supervised clinical experience before being eligible for licensure as a medical practitioner. The insufficient time assigned for both the academic and clinical aspects, plus the fact that the majority of clinical time for naturopathic students is spent on natural therapies, means that graduates of naturopathy schools are not competent to practise in the areas into which the profession wishes to expand, such as midwifery, invasive surgery, and use and application of anaesthesia.

The Council has also determined, as a general matter, that scope of practice statements should not contain or attempt to list the reserved acts granted to a profession. Accordingly, the Council has removed the term "diagnosis" from the scope of practice statement.

There is no doubt, however, that naturopathic physicians may perform diagnosis as that reserved act has been granted to them.

The Health Professions Council recommends the following scope of practice for naturopathic physicians:

The practice of naturopathy is the prevention and treatment of disease, disorder or condition of an individual through the use of education and natural therapies or therapeutics to support and stimulate inherent self-healing processes.

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II. RESERVED ACTS

In its *Preliminary Report*, the Council recommended the following reserved acts for naturopathic physicians:

1. *Making a diagnosis using naturopathic methods.*
2. *Performing procedures below the dermis but only for the purposes of venipuncture and skin pricking for the collection of blood samples; needle insertion acupuncture; removal of foreign bodies from superficial structures; and first aid treatment of minor cuts, abrasions and contusions. Procedures on tissue below the surface of mucous membrane, the cornea or the surface of teeth, including the scaling of teeth, or any other surgical procedures are not included within this reserved act.*

3. *Performing the following physically invasive or physically manipulative acts:*
 - a. *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;*
 - b. *Administering a substance by injection or inhalation but not including anaesthetic;*
 - c. *Putting an instrument, hand or finger(s)*
 - i. *beyond the point in the nasal passages where they normally narrow,*
 - ii. *beyond the opening of the urethra,*
 - iii. *beyond the labia majora,*
 - iv. *beyond the anal verge.*
4. *Allergy challenge testing in which a positive result of the test is a significant allergic response or allergy desensitizing treatment in which there is a risk of significant allergic response.*

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A. Procedures Below the Dermis [Reserved Act 2(a)]

In its *Preliminary Report*, the Council recommended reserved act 2(a) for naturopathic physicians as follows:

Performing procedures below the dermis but only for the purposes of venipuncture and skin pricking for the collection of blood samples; needle insertion acupuncture; removal of foreign bodies from superficial structures; and first aid treatment of minor cuts, abrasions and contusions. Procedures on tissue below the surface of mucous membrane, the cornea or the surface of teeth, including the scaling of teeth, or any other surgical procedures are not included within this reserved act.

The Council has changed the wording of this reserved act to make it easier to read.

B. Manipulation [Reserved Act 2(c)]

In its *Preliminary Report*, the Council recommended the following reserved act for naturopathic physicians:

Performing the following physically invasive or physically manipulative acts 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.

At the public hearing, the British Columbia College of Chiropractors (BCCC) opposed this recommendation. BCCC argued that information by naturopathic physicians given to the Council about their competence to perform this reserved act is inaccurate and may be misleading. Specifically, the BCCC contended that the last part of the reserved act, "using a high velocity, low amplitude thrust", has not been adequately addressed by naturopathic physicians, and that the alleged 200 hours of training to understand manipulation is actually spent on other courses aside from manipulation. The BCCC also suggested that cervical manipulation is the most

dangerous aspect of this act.

After reviewing this issue, the Council is satisfied that naturopathic physicians have the training and education and do perform some manipulation. However, the Council is concerned that naturopathic physicians are not adequately trained in the area of cervical manipulation which, the evidence indicates, is the most dangerous aspect of spinal manipulation.

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C. Administering a Substance [Reserved Act 2(d)]

This reserved act was modified after the *Preliminary Report* to add the words substance "other than a drug" and this necessitates a modification to this reserved act as granted to naturopathic physicians. Also, as this reserved act deals with the means of administration, not the substances administered, the reference to anaesthetics need not be included.

The Health Professions Council recommends the following reserved acts for naturopathic physicians:

2. Performing the following physically invasive or physically manipulative acts:

a. procedures below the dermis but only for the following purposes:

- **venipuncture and skin pricking for the collection of blood samples;**
- **needle insertion acupuncture;**
- **removal of foreign bodies from superficial structures; and**
- **first aid treatment of minor cuts, abrasions and contusions;**

b. moving the joints of the thoracic or lumbar spine beyond the limits the body can voluntarily achieve but within the anatomical range of motion using a high velocity, low amplitude thrust;

c. administering a substance, other than a drug, by injection or inhalation.

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D. Forms of Energy (Reserved Act 4)

In the *Preliminary Report*, the Council set out the submissions of the B.C. Naturopathic Association and the College which essentially indicated that "energy is used in all aspects" of naturopathic medicine, without including a comprehensive list of hazardous energies employed in the practice of the profession.

In October 1999, the Council asked the College and the B.C. Naturopathic Association to list the energies they use, the indications and contraindications for use of the listed energies, and the training and education of

naturopathic physicians in the use of energies. Neither group responded. This reserved act cannot be considered without information about the indications, contraindications and known hazards to the forms of energy as applied by naturopathic physicians. Therefore, the Council cannot recommend the granting of the reserved act 4, "applying or ordering the application of a hazardous form of energy."

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E. Prescribing Drugs [Reserved Act 5(a)]

The purpose of reserved act 5(a) is to reserve only substances which require a prescription (Schedule I) and substances which are non-prescription but must be sold from a restricted area of pharmacy (Schedule II). The use of substances not falling within this act is not restricted by reserved act 5(a). Therefore, it is not necessary to develop a list of all substances naturopathic physicians propose to use in their practice. Rather, all that is required is a listing of substances which naturopathic physicians use and which fall within the reserved act.

At the hearing, the College and B.C. Naturopathic Association provided a list of 28 Schedule I substances for use by naturopathic physicians that was approved by the College of Pharmacists of British Columbia (CPBC). The pharmacists supported some drug use by naturopathic physicians but conceded they had not considered whether such drugs were related to the scope of practice. The CPBC also stated that a certification process, perhaps including procedures to deal with emergencies, should be instituted.

The Council is not satisfied that naturopathic physicians are trained and educated to use the proposed Schedule I substances, nor is it satisfied that the use of these substances is related to the practice of naturopathic medicine. The limited amount of supervised clinical experience with drugs is of concern, particularly in light of the very serious side effects related to many of the substances. Therefore, the Council does not recommend the use of Schedule I substances by naturopathic physicians.

While the Council's review of scope of practice proceeded, the federal government undertook a project aimed at addressing the need for regulation of natural health products. The Office of Natural Health Products was created, and a consultation and investigation process was commenced. The Council is not aware of any final recommendations that have been made but understands that the thrust of the process was to create a new federally created category of "natural health products" in addition to food and drugs. It is important that the provincial government keep apprised of that process in order to ensure that provincially regulated health care practitioners, like naturopathic physicians, maintain access to natural health products which are essential to their practice.

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F. Allergy Testing (Reserved Act 7)

In its *Preliminary Report*, the Council recommended the following reserved act for naturopathic physicians:

Allergy challenge testing in which a positive result of the test is a significant allergic response or allergy desensitizing treatment in which there is a risk of significant allergic response.

Subsequently, the wording of reserved act 7 was modified so that the current reserved act states:

Allergy challenge testing or allergy desensitizing treatment involving injection, scratch tests or inhalation, and allergy challenge testing by any means with respect to a patient who has had a previous anaphylactic reaction.

At the public hearing the B.C. Dietitians' and Nutritionists' Association (BCDNA) opposed this recommendation. In its February 1999 submission to the Council, BCDNA stated:

[B]ased on the reasons detailed here, we submit that Naturopathic training does not provide the practitioner with skills to safely:

- *Administer skin tests*
- *Accurately interpret skin tests*
- *Accurately interpret RAST, ELISA and other immunological tests*
- *Administer challenge tests*
- *Administer invasive desensitization (e.g. injection) therapy*
- *Develop and supervise complex elimination diets*
- *Adequately provide for replacement of nutrients restricted in an elimination diet*
- *Supervise a reintroduction program to determine a client's limit of tolerance to foods*
- *Treat an anaphylactic reaction.*

In its November 1999 submission to the Council, BCDNA reiterated its arguments and stated that naturopathic physicians lack the medical training to safely administer allergy testing and manage either food or drug allergies.

Several submissions were made at the public hearing which questioned the ability of naturopathic physicians to perform this reserved act. The concerns focussed mainly on naturopathic physicians' ability to deal with anaphylactic reactions. The Council has similar concerns, mainly because this reserved act requires the ability to deal with anaphylactic reactions which in turn involves other reserved acts which have not been granted to naturopathic physicians. These reserved acts are administering a drug listed in Schedule I or II of the *Pharmacists, Pharmacy Operations and Drug Scheduling Act* [reserved act 5(a)], and performing prescribed procedures below the dermis [reserved act 2(a)]. These reserved acts are fundamental to the process of dealing with anaphylactic reactions.

The Council is not satisfied that naturopathic physicians have the necessary training and qualifications to administer these procedures.

It is important to note however that the reserved act does not restrict the performance of allergy challenges testing or allergy desensitizing treatment through oral means. This is because the Council concluded from its investigations that the immediate risk of anaphylactic reactions generally arises from injections rather than oral injuries. Therefore, naturopathic physicians may still perform activities in this area involving oral ingestion.

Accordingly, the Council has determined that it is not in the public interest to grant reserved act 7 to naturopathic physicians.

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III. OTHER ISSUES

Hospital privileges

In its preliminary report, the Council recommended that naturopathic physicians be granted hospital treating privileges. The Council has decided to change its recommendation on this issue. At the public hearing, the Dean of Bastyr College said that primary area of care is out patient, not hospital based. The B.C. Dietitians' and Nutritionists' Association opposed hospital treating privileges because of the possibility for harm from food diets prescribed by naturopathic physicians. In the Council's view, hospital treating privileges are not necessary for the practice of naturopathic medicine and also have the potential to create confusion and conflict within the context of hospital based practice. Therefore, the Council does not recommend that naturopathic physicians be granted hospital treating privileges.

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Health Professions Council Licensed Practical Nurses Scope of Practice Preliminary Report

Irvine E. Epstein, Q.C., Chair
Arminée Kazanjian, Member
David MacAulay, Member

April 2000

This Preliminary Report should be read in conjunction with the [Post-Hearing Update](#) for the profession.

FOREWORD

This report is the result of the Health Professions Council's review of the scope of practice of nursing by licensed practical nurses pursuant to the *Terms of Reference* from the Minister of Health and Minister Responsible for Seniors. Under the [Health Professions Act](#), the Health Professions Council is a six-person advisory body appointed by the Government of British Columbia to make recommendations to the Minister of Health and Minister Responsible for Seniors about the regulation of health professions.

In this report the Health Professions Council examines how the existing scope of practice of nursing by LPNs should be legislatively defined in order to reflect fairly and accurately the current state of practice and the public interest in the practice of nursing by licensed practical nurses.

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EXECUTIVE SUMMARY

The Health Professions Council has conducted a review of the scope of practice of nursing by licensed practical nurses (LPNs).

The purpose of the review is to provide recommendations to the Minister of Health and Minister Responsible for Seniors regarding four matters: scope of practice statements, reserved acts, supervised acts, and reserved titles.

The Health Professions Council has conducted a detailed consultation process and its recommendations regarding the four elements of the scope review are as follows:

1. The Council recommends the following scope of practice statement for licensed practical nurses:

The practice of nursing by licensed practical nurses is the provision of health care for the promotion, maintenance and restoration of health; and the treatment and prevention of illness and injury, including assessment of health status and implementation of interventions.

2. The Council recommends that the following reserved acts be granted to licensed practical nurses to perform only if the act is ordered by a health practitioner who is authorized by legislation to perform the act:

- a. Performing the following physically invasive or physically manipulative acts:

- i. procedures on tissue below the dermis, below the surface of a mucous membrane;

- ii. administering a substance by injection, inhalation, irrigation, or instillation;

- iii. putting an instrument, hand or finger(s)

- a. into the external ear canal, but excluding cerumen management,

- b. beyond the pharynx,

- c. beyond the opening of the urethra,

- d. beyond the labia majora, but excluding the insertion of intrauterine devices,

- e. beyond the anal verge, or

- f. into an artificial opening into the body.

- b. Administering by any means a drug listed in Schedule I or II of the Pharmacists, Pharmacy Operations and Drug Schedule Act.

3. The Council recommends that a provision be enacted which sets out the duties of a health professional and his or her regulatory college when delegating a reserved act. The provision should require the following:

- The assigning health professional's governing body must provide assent to the proposed reserved act being performed by someone else;
- The reserved act to be assigned as well as the level of supervision must be clearly defined and circumscribed by the assigning health professional's governing body;
- Where the person to whom the act will be assigned is a member of a self-regulating health profession, his or her governing body must approve of the assigning of the reserved act;
- The instruction to perform the act must be made in writing either by way of a general written protocol or through a case-specific instruction;
- The assigning health professional must be satisfied that the individual who will be performing the act has the necessary skills and training to perform the act safely;
- The assigning health professional must ensure that the person who will be performing the act accepts the assignment.

4. The Council recommends that the following titles be reserved for members of the profession:

- Licensed Practical Nurse;
- L.P.N.;
- Practical Nurse; and
- P.N.

5. The Council recommends that the title "nurse" be reserved for licensed practical nurses, registered nurses, registered psychiatric nurses, and Christian Science nurses.

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I. INTRODUCTION

A. THE NATURE OF THE REVIEW

This is the preliminary report of the review of the scope of practice of nursing by LPNs by the Health Professions Council (Council).

The review was conducted pursuant to [Terms of Reference](#) issued by the Minister of Health and Minister Responsible for Seniors in accordance with section 25 of the [Health Professions Act](#), RSBC 1996, c. 183 (HPA). The [Terms of Reference](#) direct the Council to review the scopes of practice of the recognized health professions, of which licensed practical nursing is one.

The Terms of Reference, which are included as [Appendix A](#) to this report, indicate that there are four main elements to the scope of practice review:

- i. scope of practice statements which describe what the profession does, the methods it uses and the purpose for which it does it;
- ii. reserved acts which are those acts that present such a significant risk of harm that they should be performed only by professionals who are qualified to perform them;
- iii. supervised acts which are reserved acts, or aspects of reserved acts, which may be performed by persons supervised by health professionals; and
- iv. reserved titles which are titles that describe a profession's services and which are reserved exclusively for the health profession.

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B. THE PROCESS FOR THE REVIEW

The general process for the review provides for an initial meeting with the profession, submission of briefs by the regulatory body and professional association, a consultation process involving the health profession and interested parties regarding the profession's submission, drafting of a preliminary report, public hearings and a final report.

The Council held an initial meeting with the Licensed Practical Nurses Association of BC (LPNABC) and the College of Licensed Practical Nurses of BC (CLPNBC, at that time known as the "BC Council of Licensed Practical Nurses") on April 19, 1995.

The LPNABC submitted its brief on June 29, 1995 and the CLPNBC submitted one on July 12, 1995. The Hospital Employees' Union (HEU), which represents most LPNs, also made a submission regarding the scope of practice for licensed practical nurses on June 29, 1995. The submissions were then summarized and distributed to interested groups and individuals including other regulated and unregulated health professions, teaching facilities and other provinces. Many responses were received.

In 1998, the Council issued the [Shared Scope of Practice Model Working Paper](#) (*Working Paper*) which discusses the Council's list of reserved acts. Health professions were invited to make a submission regarding the [Working Paper](#). The CLPNBC made two submissions in response to the [Working Paper](#), one in April 1998 and the other in July 1999. The HEU also made a submission on April 14, 1998.

Finally, in July 1999, the CLPNBC responded to a joint submission by the Registered Nurses Association of BC (RNABC) and the BC Nurses' Union (BCNU) on the scope of practice of nursing by registered nurses (RNs). The LPNABC responded to the joint submission in August 1999. These submissions contain material pertinent to this review.

The Council has carefully considered all of this information in drafting this preliminary report.

This report will be circulated to all health professions and other interested parties who participated in the

Council's consultation process. A public hearing is currently scheduled for May 15 and 16, 2000 after which a final report will be issued. Persons or organizations who have made written responses to either the original consultation letter or to this preliminary report will be invited to speak at the hearing.

Throughout this report, the Council makes reference to the submissions of the LPNABC and the CLPNBC and to the responses received during the consultation process. The Council has abbreviated its references to many of the respondents and for ease of reference, the Council has included as an Appendix C a glossary and abbreviations of names used in this report.

This review of nursing by LPNs is being conducted concurrently with the Council's review of nursing by registered nurses (RNs) and nursing by registered psychiatric nurses (RPNs).

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C. THE REGULATION OF LICENSED PRACTICAL NURSING

Professional organization of nursing in Canada began with the International Council of Nurses in 1899 and the Canadian Nurses Association which was established in 1908 as the Canadian National Association of Trained Nurses. By 1922, every Canadian province had enacted some form of legislation for nurse registration. In BC it was known as the *Registered Nurses Act*, SBC 1918, c.65.

In 1951, the first provincial legislation on licensed practical nurses was enacted with the *Practical Nurses Act*, SBC 1951, c.58, when the Council of Practical Nurses was established. In 1985, the Council of Practical Nurses was renamed the Council of Licensed Practical Nurses. Also in 1985, the title of the Act was changed to the *Nurses (Licensed Practical) Act*, to emphasize the licensing requirements.

The 1993 *Health Professions Statutes Amendment Act* set out the duties and objects of the Council of Licensed Practical Nurses, enhanced the Council's powers to investigate the practice of members of the profession, and permitted the Council to suspend or impose limits, in appropriate circumstances, on the practice of a member pending the completion of a hearing concerning the member's practice.

In 1994, the Licensed Practical Nurses Association of BC applied to the Ministry of Health for designation of licensed practical nursing under the *HPA*. In May, 1995, the *Nurses (Licensed Practical) Act* was repealed, and LPNs are now governed by the *HPA* and the *Nurses (Licensed Practical) Act Regulation*. The name of the regulatory body was changed to the College of Licensed Practical Nurses.

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II. THE POLICY BACKGROUND

The main impetus for a scope of practice review was the *Report of the British Columbia Royal Commission on Health Care and Costs* (Seaton Commission). The Seaton Commission stated that the existing legislation governing the health professions creates persistent jurisdictional disputes and a distinct lack of cooperation among the health professions, despite the fact that all health professional colleges have the same mandate - to

protect the public from preventable harm.

The Seaton Commission stated that the primary reason for the jurisdictional disputes was the present regulatory system's reliance on exclusive scopes of practice. Under the exclusive scope of practice model, the various health professions have been granted an exclusive right to practice within a legislatively defined scope of practice. No one, other than a member in good standing of that profession, can perform acts within the profession's scope of practice unless they are granted an exemption.

The Commission concluded:

...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.

(Closer to Home, The Report of the Royal Commission on Health Care and Costs in British Columbia, Volume 2, 1991, p. D-33)

This recommendation is also consistent with legislative initiatives underway in Alberta.

The Seaton Commission was not the first review body to suggest that the present legislative model of exclusive scopes of practice was inappropriate. Restricting professional monopolies (exclusive scopes of practice) was also recommended in an earlier study commissioned by the British Columbia Minister of Health. In discussing the conflicts which may arise between the professional college and the public interest, the issue of exclusive scopes of practice was raised:

It must be emphasized that any professional legislation which unduly restricts the scope of practice of skilled personnel may be contrary to the public interest in greater supply and accessibility of service through the development of team practice. Therefore, it is urged that: Professional legislation should not contain narrow restrictions or rigid definitions of scope of practice which are excessively exclusive; that measures should be taken (as indicated below) to reduce the area of interprofessional strain and conflict; and that no prosecutions for violations of scope of practice legislation should be undertaken without the prior consent of the appropriate public authority.

Insofar as may be possible with due regard for public safety, professional law should not place rigid restrictions on the scope of practice of allied health personnel, and greater flexibility should be encouraged in the allocation of roles between the health disciplines.

(Professor J.T. McLeod, Public Regulation of the Professions in Health Security for British Columbians, Special Report: Consumer Participation, Regulation of the Professions, and Decentralization (1974), the report of Richard D. Foulkes, B.A., M.D., F.A.P.H.A. to the Minister of Health, Province of British Columbia, Tome Three, p. 145)

Thus, the trend in regulatory policy for the health professions has been towards reducing exclusivity in order to enhance interdisciplinary practice, improve accessibility to health care services and increase consumer choice, while at the same time maintaining the fundamental objective of protecting the public.

These policy trends are clearly reflected in the [Terms of Reference](#) for the scope of practice review which

provide the basis for a new regulatory framework for health professions in British Columbia. The core elements of the new framework are scope of practice statements and reserved acts.

Under the present system, scope of practice statements are exclusive. In the new system, scope statements will not be exclusive but professions may be granted reserved acts.

Reserved acts are those elements of a profession's scope of practice which present such a significant risk of harm that they should be reserved to a particular profession, or shared amongst particular professions. Thus, unlike the present system in which each profession is granted exclusivity within its entire defined scope of practice (subject to specified exceptions), only those acts which present a significant risk of harm will be reserved.

In short, the government has assigned the Council the task of creating a regulatory model based on broad, non-exclusive scope of practice statements and narrowly defined reserved acts.

The government has the responsibility to ensure that those services which are accessible are safe and that the regulatory framework for the practice of health professions protects the public from incompetent, impaired, or unethical practitioners. At the same time, the regulatory framework should not entrench a paternalistic function for professions or reserve exclusive areas of practice simply to enhance professional status and control.

The new system of overlapping scopes of practice and narrow reserved acts removes barriers to interdisciplinary practice and offers greater choice and accessibility to the public. In the Council's view, the public interest is served by professional legislation which promotes quality in the delivery of health care services within safe parameters. Indeed, the Council's primary policy objective in conducting its review is achieving the optimum balance between safe practice and consumer choice.

With this in mind, the Council proposes to consider the practice of nursing by LPNs having regard to the four elements of the scope review.

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III. DISCUSSION OF ISSUES

The main issues raised by this review are the four elements listed above: scope of practice statement, reserved acts, supervised acts and reserved titles.

A. SCOPE OF PRACTICE

The scope statement describes what the profession does, the methods it uses, and the purpose for which it does it. Unlike the present legislative scheme, the statement itself does not grant an exclusive scope of practice. Nonetheless, the statement is important because: 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; and it informs the public about the services practitioners are qualified to perform. It is expected that the Council's recommendations will increase overlapping scopes of practice.

The Council believes that it is not necessary or useful to itemize every facet of a profession's scope of practice. Rather, a scope of practice definition should be sufficiently descriptive so that other health professions and members of the public alike can understand what the particular health professional does.

1. Current Scope of Practice of Nursing by Licensed Practical Nurses

The scope of practice for nursing by LPNs is set out in the *Nurses (Licensed Practical Act) Regulation* under the HPA:

Scope of practice

4.

A registrant may provide such nursing services related to the care of patients as are consistent with his or her training and ability.

Limitations on practice

5.(1)

Except in an emergency, all nursing services provided by a registrant must be carried out under the direction of a medical practitioner who is attending the patient or under the supervision of a registered nurse who is providing services to the patient.

(2) Subject to section 4, a registrant may provide a nursing service for a patient in a private home provided that the attending medical practitioner gives directions.

(3) A registrant may not give nursing service to patients except in accordance with this section and section 4.

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2. Proposed Scope of Practice

The CLPNBC and the LPNABC made separate proposals regarding scope of practice statements.

In its initial submission to the Council, the CLPNBC proposed the following scope of practice:

Fully Licensed practical nurses provide professional nursing care and promote health and healing, independently or in partnership with other health care professionals/providers to individuals, families, groups and communities, in a variety of care settings (acute care, home care, community, and long term care/extended care). Where the client has a well-defined health challenge with predictable outcomes the fully licensed practical nurse may function independently within their level of competence. As the acuity or complexity of care increases, and/or outcomes are not predictable and an advanced level of knowledge is required, the fully

licensed practical nurse must work in partnership with other health care professionals as an interdependent member of the team to meet the care needs of the client(s). The practice of the fully licensed practical nurse is based on knowledge derived from physical, biological, behavioral and nursing arts and sciences, common to all nurses and in accordance with the standards of practice and guidelines established by the College of Licensed Practical Nurses of B.C.

The LPNABC proposed the following scope of practice:

[T]he practice of nursing is the promotion and education of health and the assessment of, the provision of care for, and the treatment of health conditions by supportive, preventive, therapeutic, palliative and rehabilitative means in order to attain or maintain optimal function.

Both the LPNABC and the CLPNBC also proposed that there should be no provision in the scope of practice statement requiring supervision and direction of the fully licensed practical nurse by a registered nurse or physician.

The CLPNBC emphasizes that as professional practitioners, whose practice is monitored and regulated, its members should not be under the supervision or direction of another professional when they are providing care within their own level of competence.

In addition, the CLPNBC also proposed to include in its scope statement a provision for conditionally or partially licensed practical nurses (individuals grandfathered into licensure) as follows:

*Conditionally and partially licensed are individuals grandfathered into licensure and who may, within a facility, assist the fully licensed practical nurse, the registered nurse or the registered psychiatric nurse in the delivery of nursing care under the *direct supervision of those individuals. They function in accordance with the Standards of Practice and guidelines provided by the College of Licensed Practical Nurses.*

**The term "direct supervision" should be interpreted to indicate that another registered/licensed caregiver should be immediately available in the vicinity if required. It does not indicate that they must be in the specific room.*

However, after reviewing the RNABC's response to the proposal and in particular the criticism of the dual classes of licensure, the CLPNBC amended its proposal to remove the reference to conditionally or partially licensed individuals, indicating that the conditional and partial registrants met the requirements for registration when they joined the profession and thus should not be treated differently in the legislation. The CLPNBC also removed "confusing" language such as "stable", "unstable" and "predictable" because it felt the terms were not universally understood and placed artificial restrictions on LPN practice.

In its 1998 submission to the Council in response to the [Working Paper](#), the CLPNBC submitted the following revised scope of practice statement:

- *Licensed Practical Nurses provide professional nursing care and services to promote health and healing, independently and in partnership with other health professionals or providers to individuals, families and groups, in a variety of settings where nursing care and services are required or requested including acute care, continuing care, community and home care.*

- *The practice of Licensed Practical Nurses is based on knowledge derived from the physical, biological, behavioral and nursing arts and sciences common to all nurses and in accordance with the Standards of Practice and guidelines established by the College of Licensed Practical Nurses of B.C.*

The proposal was supported by the Health Employees' Union (HEU) which also submitted that the supervision requirement be removed.

The HEU also provided background for its support of the CLPNBC's proposal:

Since the early 1980s, HEU has raised two pressing LPN issues: the underutilization of LPNs and their displacement by registered nurses. As well, in recent years it has become increasingly apparent that the shift to community-based health care has implications for the nature of the work done by LPNs, and thus, scope of practice legislation must also address this issue. HEU expects that legislating scope of practice for LPNs will ensure an integral role for LPNs in the health care team and within the context of our evolving health care system.

Elsewhere in its submission, the HEU refers to the following recommendations of the Seaton Commission:

[that] the Ministry of Health require the use of licensed practical nurses and registered psychiatric nurses in hospitals, long term care facilitates, and elsewhere, where their employment is consistent with efficiency and quality care

and that

there be a continuum of education from nurses' aide to LPN to Baccalaureate RN, and that nurses licensed at each level of the continuum be employed at the highest level possible given their skills. Professional associations should not have the power to interfere with this policy.

The HEU also states:

HEU believes that LPNs should be free to do the work they are trained for without the supervision of RNs or physicians. This is especially important as health care moves out of large hospitals and into the home and smaller facilities. Where their work involves treatment of patients, LPNs are obliged like other health providers to record what they have done.

The CLPNBC also proposed that all reserved acts granted to the profession should be contained in the scope statement. However, as this Council has noted in previous reports, the scope of practice statement is intended to be a general statement, and does not include listings of specific reserved acts. Reserved acts will be dealt with in another section of this report.

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3. Regulation of Licensed Practical Nurses in Other Provinces

The Council also reviewed scope of practice definitions in other provinces.

In Ontario, nurses are governed by both the *Regulated Health Professions Act, 1991* and the *Nursing Act, 1991*. The *Nursing Act* outlines the nurses' scope of practice as follows:

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

The definition applies to both registered nurses and registered nursing assistants.

In New Brunswick, there are two regulated health professionals providing nursing services: the registered nurses and the registered nursing assistants. "Nursing assistant" is defined in the *Registered Nursing Assistants Act, 1977*, as follows:

"nursing assistant" means a graduate of an approved school of nursing assistants who, being neither a registered nurse nor a person in training to be a registered nurse, undertakes the care of patients under the direction of a registered nurse or a duly qualified medical practitioner, for custodial, convalescent, sub-acutely ill and chronically ill patients and who assists registered nurses in the care of acutely ill patients, rendering the services for which he or she has been trained.

In Alberta, licensed practical nurses are defined in the *Licensed Practical Nurses Regulation AR 97/103* as follows:

(1) A Licensed Practical Nurse, on being delegated under subsection (4) and within the guidelines approved by the Board, may provide the following services:

- i. collect health data from appropriate sources using established assessment format to contribute to the identification of a client's health care needs;*
- ii. organize the data in order to plan and implement appropriate care;*
- iii. participate in the plan of care by carrying out nursing treatments and interventions;*
- iv. prepare clients for tests, surgery and other procedures;*
- v. evaluate the effect of interventions;*
- vi. confer with appropriate regulated health professionals;*
- vii. document and communicate data for clients to provide continuity of care;*
- viii. implement an individualized teaching plan in order to promote, maintain and restore health.*

(2) A Licensed Practical Nurse, on being delegated under subsection (4) and within guidelines approved by the Board, may provide the following services:

- a. *prepare and administer percutaneous medications;*
- b. *prepare and administer oral and subcutaneous medications if the Licensed Practical Nurse has*
 - i. *graduated after 1995 from a program of studies referred to in section 2(1)(a), or*
 - ii. *completed advanced training approved by the Board;*
- c. *assess and maintain intravenous infusions if the Licensed Practical Nurse has*
 - i. *graduated after 1994 from a program of studies referred to in section 2(1)(a), or*
 - ii. *completed advanced training approved by the Board.*

(3) A Licensed Practical Nurse who has received advanced training approved by the Board may, on being delegated under subsection (4) and within guidelines approved by the Board, provide services in specialized areas, including but not limited to the following:

- a. *operating room;*
- b. *advanced orthopaedics;*
- c. *dialysis.*

(4) A regulated health professional who

- a. *has knowledge of the educational preparation of Licensed Practical Nurses and the nursing services they are qualified to provide, and*
- b. *has the authority for the appropriate delegation of client services may delegate practical nurse services to a Licensed Practical Nurse.*

(5) Notwithstanding subsections (1) to (4), the direction to provide clinical nursing services may only be given by

- a. *a registered nurse, a certified graduate nurse or a permit holder under the Nursing Profession Act,*
- b. *a registered member as defined in the Psychiatric Nurses Regulation (AR 509/87), or*
- c. *a physician.*

In Saskatchewan, licensed practical nurses are governed under the *Licensed Practical Nurses Act, SS 1993, c.L-14.1:*

"practice as a licensed practical nurse" means the performance of health care services under the direction of a:

- i. *duly qualified medical practitioner;*
- ii. *registered nurse; or*
- iii. *psychiatric nurse who is registered pursuant to The Psychiatric Nurses Act and whose registration is in good standing;*

where the performance of those services requires the knowledge and skill of a person who qualifies for registration pursuant to section 18, but does not include those services that are prescribed by the Lieutenant Governor in Council.

Finally, the Manitoba *Licensed Practical Nurses Act*, RSM 1987, c. P100, defines the scope of practice of LPNs as follows:

"practical nursing" and "the practice of licensed practical nursing" means representing oneself as a licensed practical nurse who

- a. *assists registered nurses in the care of acutely ill patients and rendering those services for which she has been trained,*
- b. *not being a registered nurse or a person in training to be a registered nurse, undertakes the care of patients under the direction of a medical practitioner or a registered nurse, and*
- c. *administers medication prescribed by a medical practitioner consistent with her training;*

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4. Responses to Consultation

Most of the responses are based on the scope of practice statement initially proposed by the LPNABC and the CLPNBC. Since there is some similarity between the initial submissions and the CLPNBC's revised scope statement, the responses are set out here.

Several respondents, including Douglas College, University of Victoria (School of Nursing) (UVIC), and Manitoba Health suggest that the proposed scope statement is too broad, and some, such as the Ministry of Advanced Education, Training and Technology (MAETT, formerly Ministry of Education, Skills and Training), suggest that there is much overlap with the RN scope of practice.

Many respondents, including the BC Society of Occupational Therapists (BCSOT), the BC Dietitians' and Nutritionists' Association (BCDNA), the Greater Victoria Hospital Society (GVHS) and the University of British Columbia School of Nursing (UBC), criticize that part of the College's proposal which states that LPNs can practice independently when clients have a "*well defined health challenge with predictable outcomes*" but must practice in partnership when a condition is more complex. Several respondents state that LPNs do not have the expertise to distinguish a complex from a non-complex condition.

For example, in response to the initial submission, the Registered Nurses Association of BC (RNABC) states:

RNABC has a concern about the concept of "independence" as it is currently presented in the context of practice component of the proposed scope. It is accurate to state that as a regulated group, LPNs are independently accountable for their practice. This does not mean, however, that their preparation allows them to practice independently in every health care situation. There are clearly situations where it would be inappropriate for the LPN to practise independently as noted below.

The interpretation of the "independent" practice of LPNs is important because as the College points out, their competencies prepare them to provide nursing care to "clients with well-defined health challenges with predictable outcomes". The LPN is not educationally prepared to make the determination about the nature of the health care challenge and whether or not the outcomes are predictable. This requires more advanced assessment skills which are part of the competency profile of a registered nurse. Thus it is important that the scope of practice statement clearly reflect that the LPN practices independently within his/her scope once the complexity of the client's care needs including possible outcomes have been established in partnership with others.

In response to the revised scope statement, the RNABC states:

The scope of practice proposed by CLPNBC can be viewed as having two components: a definition of practice and a context of practice statement. The definition states that LPNs "provide professional nursing care and services to promote health and healing..." The context of practice component states that LPNs practice "independently and in partnership...to individuals, families and groups, in a variety of settings..."

...

RNABC therefore has substantial concern with the proposal to delete the following from the scope statement "where the client has a well defined health challenge with predictable outcomes the LPN may function independently. As the acuity or complexity of care increases and/or outcomes are not predictable and an advanced level of knowledge is required, the LPN must work in partnership with other health care professionals as an interdependent member of the team to meet the care needs of the client(s)."

UBC states:

We have specific concern in regard to the vagueness of wording in the [CLPNBC]statement that alluded to "well-defined health challenges with predictable outcomes". Our questions included the following:

- *Who will assess clients for referral to an LPN caregiver?*
- *Who will monitor and evaluate that the assessments are accurate and made with the best interest of the client-rather than economic implications in mind?*

- *Will employers have adequate understanding of nursing education curricula to be able to deploy caregivers, based not on their relative cost, but on the necessary knowledge, skills and values to meet the client's needs, and with attention to provision of adequate decision support for the provision of safe and appropriate care?*

We suggest the addition of a clause addressing the issues of responsibility for defining "predictable outcomes" and "increasing complexity". The level of decision-making must not be driven entirely by economic factors, nor can it be left solely to the discretion of the employer or the LPN. Ambiguity in the current language leaves both the LPN and the client vulnerable.

In its submission the BC Nurses' Union (BCNU) contends that the twelve-month general education of LPNs does not equip them in the same way as RNs who complete a three-year comprehensive educational program.

Some respondents questioned whether LPNs should be providing care to families, groups and communities. For example, the HEABC stated that group care situations require much more advanced knowledge and training than LPNs possess.

The College of Massage Therapists of BC (CMTBC) states that the proposed scope of practice statement is too long and confusing.

Several of the respondents to the consultation make the general point that it is important that the scope of practice statements for the three professions be sufficiently different in order to indicate the unique characteristics of each profession.

Douglas College comments that there is little differentiation between the three nursing bodies' proposals. Similarly, the Ministry of Advanced Education, Training and Technology (MAETT) states that it is difficult to differentiate the three categories, and therefore difficult to assess what educational preparation is required.

Manitoba Health states that the scope statements for the three nursing professions should follow a similar format.

Responses to Proposal to Eliminate Supervision Requirement

The responses vary on the issue of whether the College's proposal to remove the supervision requirement is appropriate. The BC Society of Occupational Therapists (BCSOT), the Para-Med Health Services and Vancouver Community College (VCC) support removal, while the Health Employers Association of BC (HEABC), the BC Medical Association (BCMA), the College of Psychologists of BC (CPBC) and UBC do not.

For example, the BCMA states:

The current Act requires that LPNs carry out all duties under the direction of a physician. The new proposal from the [CLPNBC] recommends that LPN's work independently if they choose. This is of concern to us since the proposal suggests that such independence would be determined according to the ability of the LPN to work at an optimal level of competence vis-à-vis situations that may arise. Given this, any proposed change in the Act should continue to require that duties be carried out under the direction of a qualified physician.

The College of Psychologists of BC (CPBC) states:

In their proposals both groups have eliminated the requirement of 5 (1) of the proposed scope of practice of Licensed Practical Nurses under the Health Professions Act. This requirement "all nursing duties must, except in an emergency, be carried out under the direction of a medical practitioner who is attending the patient or under the supervision of a Registered Nurse who is rendering service to the patient," should be maintained. It is our understanding a practical nurse does not practice independently, but within the confines of a health care institution, such as a hospital or under the direction of a registered nurse or other health care professional. They may function without direct supervision.

In its April 30, 1998 submission, the CLPNBC states:

The term "supervision" is so poorly understood that it has been problematic in the practice setting and the professions would benefit from clear direction in that area. The situation often arises that a Registered Nurse who does not have a particular competency at the practice level, e.g. tracheostomy care, is supervising a Licensed Practical Nurse who not only has the competency for tach care but also has a post-basic specialty program in that area. This arises because the current legislated scope of practice of the LPN requires that supervision. Often it is assumed that a particular professional has a competency by virtue of their designation. The reserved acts model does not directly address that phenomenon which is common but will go a long way in identifying that when the Licensed Practical Nurse has the knowledge, skill, ability and judgement to carry out a reserved act the same baseline knowledge applied to the reserved act can be transferred to include similar components of care which are predicated on that same body of knowledge. It will assist in the appropriate utilization of nurses.

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5.The Council's Conclusions

The current scope of practice for licensed practical nursing requires that all services be performed under the direction of a medical practitioner or under the supervision of a registered nurse. Virtually all of the provinces reviewed by the Council impose similar requirements. However, in Ontario, where the "controlled" or reserved acts model is in place, registered nursing assistants are not subject to any supervision requirement.

The College's initial proposal stated that LPNs provide nursing care "*independently or in partnership with other health care professionals/providers*". While several respondents submitted that the supervision requirement ought to be maintained, others took a more flexible position. Though conceding that LPNs do practise independently in certain situations, others questioned whether LPNs had the training and education necessary to identify when independent practice is appropriate. The RNABC for example supports the removal of the supervision requirement but indicates that independent practice should be carefully circumscribed. Clearly, LPNs carry out some tasks independently and some under supervision but it is not easy to determine which tasks fall into which category.

Underlying the submissions favouring continuation of the supervision requirement is a concern that independent practice by LPNs would be unsafe. However, under the reserved acts model, only those acts which present a significant risk of harm are reserved to those professions which have the training and education necessary to perform them. The performance of non-reserved acts which fall within a profession's scope of practice is regulated by its College and the standards of practice. Therefore, there need not be a general supervision

requirement applying to a profession's entire scope of practice. To the extent that supervision is an issue in regard to the College's proposed reserved acts, that issue will be addressed in the reserved acts section of this report.

The Council's recommended scope of practice statement for LPNs is similar to that of RNs. However, that does not mean that LPNs and RNs have the same training and education or that they perform the same services. The College itself recognizes there is a distinction as it acknowledges that RNs have a higher level of knowledge and skill, and that RNs play a more "dominant" role in the treatment of patients. In its initial submission, the College stated that

As the acuity or complexity of care increases, and/or outcomes are not predictable and an advanced level of knowledge is required, the fully licensed practical nurse must work in partnership with other health care professionals as an interdependent member of the team to meet the care needs of the client(s).

In a July, 1999 letter to the Council, the College, in referring to the overlap amongst the nursing professions, states that the "actual differences lie in the levels and breadth of knowledge, skill and judgement as applied across the contexts of nursing practice for essentially the same professions."

The distinction between the two groups of nursing professionals is recognized in the scope statement and in the Council's recommendations on reserved acts, discussed below. Further, as the College states, "LPNs are responsible and accountable for the care and services they provide to clients through their Standards of Practice, the Code of Ethics and other practice guidelines." An important part of this role is ensuring that its members practice within their level of competency, and that LPNs are provided with guidance to determine when services must be carried out as part of an "interdependent team".

Therefore, the Council recommends the following scope of practice statement for licensed practical nurses:

The practice of nursing by licensed practical nurses is the provision of health care for the promotion, maintenance and restoration of health; and the treatment and prevention of illness and injury, including assessment of health status and implementation of interventions.

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B. RESERVED ACTS

The rationale underlying the granting of reserved acts is to protect the public by limiting provision of those particularly dangerous acts to members of specific professions who are qualified to perform them. Only those acts which present a significant risk of harm will be reserved. The Council developed a list of reserved acts, and included it in a 1998 report, the [Working Paper](#).

The list is the Council's working list of activities which present such a significant risk of harm that they should be

reserved to regulated health professionals. The list has been revised during the course of the Council's review process. The latest version is attached as Appendix B to this report.

As the Council has noted, the purpose of the profession-specific reviews is to determine which parts of the list each profession will be granted.

1. Proposed Reserved Acts

In its initial submission, the LPNs, like the Registered Nurses Association of BC (RNABC) and the Registered Psychiatric Nurses Association of BC (RPNABC), took the position that rather than proposing specific reserved acts, they should receive an exemption from the reserved acts of other professions. This proposal elicited the greatest response, most of it negative. Several respondents noted that the proposal amounted to a request that LPNs be granted a similar scope of practice to that of medicine.

The Central Vancouver Island Regional Health Board (CVIRHB) states that it likes the exemption proposal, which it feels offers the necessary flexibility. Similarly, the Greater Victoria Hospital Society (GVHS) states that it supports the nursing proposal as it believes members are able to practice within their level of competency through the supports and controls of the profession.

In its 1998 revised submission, the CLPNBC requested a specific list of reserved acts, as follows:

1. *Making a (nursing) diagnosis identifying a condition as the cause of signs or symptoms of the individual.*
2. *Performing the following physically invasive or physically manipulative acts:*
 - a. *procedures on tissue below the dermis*
 - b. *procedures below the surface of a mucous membrane*
 - c. *administering a substance by injection or inhalation*
 - d. *putting an instrument,*
 - i. *beyond the external ear canal*
 - ii. *beyond the point in the nasal passages where they normally narrow*
 - iii. *beyond the pharynx*
 - iv. *beyond the opening of the urethra*
 - v. *beyond the labia majora*
 - vi. *beyond the anal verge*
 - vii. *into an artificial opening into the body.*

In its revised proposal the College did not request the reserved act of prescribing, compounding, dispensing or administering by any means a listed drug (#5 on the Council's list). However, in a July, 1999 letter the College clarified that it had intended to request this act but had inadvertently omitted it from the proposal.

The CLPNBC submits that LPNs have graduated with the knowledge, skill, ability and judgment to carry out

these reserved acts independently.

The CLPNBC also proposes that the following three reserved acts be granted to LPNs acting under the direct supervision of a health professional caring for the client. They are:

1. Casting a fracture of a bone;
2. Applying or ordering the application of a hazardous form of energy including electricity, magnetic resonance imaging, lithotripsy, laser and x-ray; and
3. Allergy challenge testing of a kind in which a positive result of the test is a significant allergic response or allergy desensitizing treatment in which there is a significant allergic response.

The CLPNBC makes the following general statement regarding the reserved acts:

The determination of the reserved acts or portions of the reserved acts that a nurse should be competent to carry out depends on the level of their basic education and any post-basic work they have completed to give them additional knowledge and clinical competence. In nursing, it makes no difference whether the nurse is an LPN or an RN for the identified acts since the competence for a reserved act depends on the knowledge, skill, ability and judgement in a given context of practice. The context of practice, the Standards of Practice, the practice setting and any legal parameters will dictate who has the right to carry out a reserved act. There are LPNs who have had more experience, who have gained more knowledge and exhibit better judgement than a registered nurse in some aspects of care.

For each of its proposed reserved acts the CLPNBC gives examples of the types of procedures LPNs perform.

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2. Responses to Revised Reserved Acts Proposal

The Registered Nurses Association of BC (RNABC) does not support the CLPNBC's proposed reserved acts. It states:

It is our understanding the Health Professions Council intends that when a reserved act is assigned to a specific profession, members of the profession have the authority both to (1) make the decision that the act is required and (2) carry out the act. Further, granting a reserved act to a profession does not mean that all members of the profession would carry out the reserved act. The expectation is that professionals must always practice within their scope of competence.

Given the two criteria stated above in interpretation of reserved acts, RNABC does not support CLPNABC's request for LPNs to have authority for:

Performing the following physically invasive or physically manipulative acts:

- (a) procedures on tissue below the dermis, procedures below the surface of a mucous membrane
- (d) administering a substance by injection or inhalation

(e) putting an instrument beyond the ear canal; beyond the point in the nasal passages where they normally narrow; beyond the opening of the pharynx; beyond the opening of the urethra; beyond the labia majora; beyond the anal verge; and into an artificial opening into the body.

This does not mean that RNABC does not agree with LPNs carrying out some of the tasks and procedures associated with these reserved acts. In fact, preventing LPNs from doing so would create a significant barrier to meeting some patients' health care needs. What we are concerned with is that LPNs do not possess the necessary competencies to make independent decisions to initiate such procedures as inserting a urinary catheter, irrigating a wound and syringing an ear. RNABC takes this position because the LPN is not educationally prepared to make the determination about the nature of the health care challenge. Indeed, CLPNBC states that "further to the assessment, the status (stable, unstable) of the client will be established in consultation with other team members in order to develop the care plans and work toward optimum health of the client" and "complete care for the client would not be an independent function until after the status has been determined."

The RNs' comments are based on the principle that reserved acts are granted to professions that have the training and education to both initiate and perform the act independently. Several other respondents made the similar point that LPNs do not practice independently (see pages 18 to 21, above). One can infer from these submissions that these respondents do not support granting any reserved acts to LPNs.

The Council proposes to deal with each of the proposed reserved acts in turn.

a. Making a Diagnosis

The CLPNBC states that LPNs gather data (assessment) and reach a clear and concise statement of the patient's health status (nursing diagnosis). Further, it states:

Development of the nursing diagnosis is the responsibility of the entire team of nursing care providers and is not a static but rather a dynamic activity. Assessment of the patient is a continual process in which everyone caring for the patient has a role. The ongoing assessment will identify when some of the diagnoses are outdated and when new ones are added. As the nurse most frequently at the bedside caring directly for the patient, the LPN gathers data on a continual basis. The LPN may be in a leadership role in continuing care areas where they are the only nurse. In an acute care setting where the LPN is a member of the team caring for the client the LPN remains competent to make nursing diagnosis and develop the plan of care but this will more likely be in collaboration with other health professionals caring for the client and reflective of the partnership role in care delivery.

In its [Working Paper](#) the Council discussed the distinction between assessment and diagnosis:

The Council believes it important to distinguish between diagnosis and assessment. Essentially, diagnosis is the identification of the cause of signs or symptoms. Assessment is a process of observation and evaluation of the physical status or progress of a patient, which may involve observation of symptoms, but does not include naming or identifying a disease, disorder, or condition as the cause of these symptoms.

In the Council's view, all health care practitioners assess a client's progress and response to services rendered. Practitioners who offer assessments have provided information to the Council

on this issue, either in recent applications for designation or in submissions in the scope of practice review. Such practitioners include: counsellors, rehabilitation practitioners, prosthetists and orthotists, athletic trainers and recreation therapists.

In the Council's view, it is the identification of a disease, disorder or condition as the cause of signs or symptoms of the individual which should be a reserved act, and the process of assessment should continue to be in the public domain. Both regulated and unregulated practitioners would be free to perform assessments during the course of providing health care services, subject always to the proposed general risk of harm clause.

The services described in the College's submission constitute assessment, not diagnosis, and therefore this reserved act is not granted to LPNs.

b. Physically Invasive or Manipulative Procedures

- (1) procedures on tissue below the dermis**
- (2) procedures below the surface of a mucous membrane**

The CLPNBC states that LPNs have had the prerequisite knowledge and skill to perform these procedures since at least 1984 at the entry level and longer for some who graduated as RNs or came from a province or country where they achieved the competency level required.

The LPNs state that an example of this type of intervention would be sterile dressing changes. They state that "LPNs have anatomy and physiology, medical and surgical aseptic technique, the skin as a protective system, types of drainage from a wound and the significance of each, signs of infection or other complication, etc." Other examples of procedures below the dermis include administering substances by injection or inhalation which is addressed in more detail below.

The Council accepts that the performance of these services fall within the core competency of LPNs

- (3) administering a substance by injection, inhalation, instillation or irrigation**

The College states that "LPNs have had the content for administering a substance by inhalation in the pharmacology component of their education program since 1984." Further, in 1995 the competency for administering medication by subcutaneous injection was added most notably for insulin and heparin. The College also states that LPNs "have had the competence related to oral, topical, rectal, vaginal, eye, ear, nose, and throat, inhalation and tube feed medication administration in BC since 1984."

The Council accepts that the performance of these services fall within the core competency of LPNs.

- (4) Physically invasive or manipulative acts of putting an instrument, hand or finger(s) into orifices of the body**

- (i) putting an instrument, hand or finger(s) beyond the external ear canal**

The CLPNBC states LPNs have achieved the competence level to carry out this reserved act since the inception of the program in 1984. An example of this type of procedure is "cleaning beyond the external ear canal or examining the ear with an otoscope."

The Council accepts that the performance of these services fall within the core competency of LPNs.

(ii) putting an instrument beyond the point in the nasal passages where they normally narrow

The CLPNBC states that its members have the prerequisite knowledge and skill to perform this act although they may not have achieved clinical competence within the basic program in BC. It states that only LPNs from other Canadian jurisdictions, RNs who are duly registered or LPNs who have gained competence outside of the traditional hospital setting will have full competence at the clinical level. Inserting nasogastric tubes for feeding is an example of these procedures though the College acknowledges that in many clinical settings LPNs do not perform this procedure.

The Council accepts that LPNs sometimes perform these services but they are not part of the core competency of LPNs.

(iii) putting an instrument beyond the pharynx

The CLPNBC states the LPNs have had the competency at the clinical practice level for this reserved act for many years. Suctioning techniques above the pharynx and inserting airways are examples of these procedures. The CLPNBC states that it has received no complaints about LPNs performing these procedures.

The Council accepts that the performance of these services fall within the core competency of LPNs.

(iv) putting an instrument beyond the opening of the urethra

The CLPNBC states that LPNs have had entry level competency for urinary catheterization for about 15 years. It further states that LPNs have knowledge of anatomy and physiology, the skill of urinary catheterization, medical and surgical asepsis, and common health challenges involving the genitourinary system.

The Council accepts that the performance of these services fall within the core competency of LPNs.

(v) putting an instrument beyond the labia majora

The CLPNBC states that LPNs have had the competency to perform such services for many years, and that an example of such procedures is administration of vaginal ointments and creams requiring the insertion of an applicator.

The Council accepts that the performance of these services fall within the core competency of LPNs.

(vi) putting an instrument beyond the anal verge

The CLPNBC states that LPNs have traditionally been the care providers who administer rectal enemas to patients. It states that LPNs have knowledge of the gastrointestinal system, anatomy and physiology, and administration of all types of enemas.

The Council accepts that the performance of these services fall within the core competency of LPNs.

(vii) putting an instrument into an artificial opening into the body.

The CLPNBC states that LPNs care for patients with a variety of artificial openings such as colostomy, ileostomy and tracheostomy. It states that LPNs sometimes insert enemas for colostomy and ileostomy patients, and are involved in trach care including suctioning the trach and removing and cleaning the inner canula.

The Council accepts that the performance of these services fall within the core competency of LPNs.

(5) Administering by any means a drug listed in Schedule I or II of the *Pharmacists, Pharmacy Operations and Drug Scheduling Act*.

The College states:

Licensed Practical Nurses have had the competence related to oral, topical, rectal, vaginal, eye, ear, nose, and throat, inhalation and tube feed medication administration in BC since 1984 with the subcutaneous injections added in 1995. Many LPNs have expanded the competency of injections to include intramuscular and this is not difficult since they already have the essential components of injection administration routes and would need only to add the routes for intramuscular. As with any category of 'Nurse', not all nurses have all of the competencies required for all of the reserved acts.

They also state that LPNs administer medication, including narcotics through many routes including orally, vaginally, through inhalation and by intramuscular injection.

The Council accepts that the performance of these services generally fall within the core competency of LPNs. However, the Council is not satisfied, and the CLPNBC concedes, that administering substances by intramuscular injection or intravenously is within the core competency of LPNs.

3. The Council's Recommendations

The Council has carefully reviewed all of the information presented.

In its report on registered nursing, the Council states as follows:

[T]he Council discussed the distinction between the delegation of a reserved act and the performance of a reserved act on the order of another health professional. When a reserved act is performed pursuant to an order, nurses may make decisions to initiate the act, within the parameters of the order, and they are competent to perform it independently.

However, several acts performed by nurses, particularly those described by the RNABC and the BCNU as being beyond core competency, are more appropriately dealt with as delegated acts. With delegation, the nurse will be instructed when to initiate the task, and generally speaking, that task would not fall within the core competency of the nursing profession. These acts generally require advanced training and education, and are performed by nurses in specialty practice areas. This process is provided in the Council's delegation guidelines.

The Council also stated that in order to be granted independent reserved acts, a profession must demonstrate that its members both initiate and perform any reserved act.

These general comments are equally applicable to the profession of nursing by LPNs. However, in the case of LPNs, the reserved acts that they perform are carried out as part of the health care team, and are not initiated by LPNs. The evidence does not indicate that LPNs have the training and education necessary to independently initiate any reserved acts.

Therefore, the reserved acts performed by LPNs are either performed on the order of an authorized health professional (usually an RN or a medical practitioner) or are delegated to LPNs.

The Council recommends that the following reserved acts be granted to licensed practical nurses to perform only if the act is ordered by a health practitioner who is authorized by legislation to perform the act:

- a. **Performing the following physically invasive or physically manipulative acts:**
 - i. **Procedures on tissue below the dermis, below the surface of a mucous membrane;**
 - ii. **Administering a substance by injection, inhalation, irrigation, or instillation;**
 - iii. **Putting an instrument, hand or finger(s)**
 - a. **into the external ear canal, but excluding cerumen management,**
 - b. **beyond the pharynx,**
 - c. **beyond the opening of the urethra,**
 - d. **beyond the labia majora, but excluding the insertion of intrauterine devices,**
 - e. **beyond the anal verge, or**
 - f. **into an artificial opening into the body.**
- b. **Administering by any means a drug listed in Schedule I or II of the *Pharmacists, Pharmacy Operations and Drug Scheduling Act*.**

Several of the reserved acts proposed by LPNs are not within the core competency of most LPNs and if performed are done under supervision. These include:

1. Putting an instrument, had or finger(s) beyond the point in the nasal passages, where they normally narrow,

2. allergy challenge testing,
3. casting a fracture of a bone,
4. ordering or applying the application of a hazardous form of energy.

These acts would fall within the Council's guidelines for delegation.

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C. SUPERVISED ACTS

Neither the LPNABC nor the CLPNBC, in its original submission, identify any specific acts which may be performed by persons supervised by LPNs. However, the CLPNBC submits that selected components of the nursing care required by a client can be safely delegated by an LPN to other health care providers, family or other qualified individuals, as long as certain criteria are met when deciding whether the selected components can be delegated. In this regard, the CLPNBC relies on the position statement of the RNABC entitled *Guidelines for Delegating Nursing Tasks and Procedures*.

The [Terms of Reference](#) imply that the Council will, for each reserved act granted to licensed practical nursing, determine the circumstances in which the act may be performed by someone other than a member of that profession. The Council considered this issue in detail in its recent preliminary report regarding the scope of practice of medicine. The Council first noted the submissions of the CPSBC:

In its submission, the College makes a compelling argument that legislation is a blunt instrument to deal with this issue. The College states that the issue of delegation and supervision is a question of individual competence and the circumstances of each case, and that supervision of certain acts can be addressed only after a careful review of all the circumstances surrounding a particular act and by imposing, where necessary, clear guidelines, restrictions or conditions on such supervision.

The College further submits that compiling a list of acts which may be delegated or performed under supervision would not adequately address the complexities of medical situations which present to physicians nor would it protect the public. The College notes that there will be situations where, because of the individuals involved, the site or location, or the specific nature of the presenting problem, it may not be appropriate to delegate an act which might otherwise be capable of delegation.

The Council accepted this submission and stated as follows:

The Council accepts much of this submission, and believes that it would be better to take a general approach to the issue of supervision. The general thrust of the approach is that the decision as to whether an act can be performed under supervision should be left up to the health professions, and that a set of principles embodying the duties of the delegating professional and his or her regulatory college be established and enacted into legislation when the shared scope of practice model takes effect. The principles are derived largely from the CMA's Guidelines for

the Delegation of a Medical Act which the College enclosed with its submission.

As a result, the Council stated that supervised acts would not be dealt with individually for each profession, and made a general recommendation regarding this issue and stated:

The Council believes this general approach to supervised acts more accurately reflects the reality that procedures to be delegated vary from profession to profession and may include subsets and variations of reserved acts and further, may be performed under a myriad of circumstances and conditions.

In its preliminary report on the scope of practice of medicine the Council also noted the following:

- *Although this term of reference refers to "supervised" acts, it is intended to encompass any situation where someone other than the person to whom the reserved act has been granted performs that act. In other words, this term of reference refers to both delegation and supervision.*
- *This proposal is not intended to apply on a case-by-case basis. The requirement for approval of the governing body is meant to apply generally and not to individual cases, and would be satisfied by, for example, a general protocol in respect of delegation of reserved acts.*

This general position should be applied to all professions. The general position is largely a recognition that a regulatory body is in the best place to determine when other health professionals can perform services under supervision, and thus a regulatory body should be charged with determining when delegation is appropriate in accordance with the principles set out above.

The Council wishes to emphasize that the issue of delegation arises only with respect to reserved acts.

Therefore the Council recommends that a provision be enacted which sets out the duties of a health professional and his or her regulatory college when delegating a reserved act. The provision should require the following:

- **The assigning health professional's governing body must provide assent to the proposed reserved act being performed by someone else;**
- **The reserved act to be assigned as well as the level of supervision must be clearly defined and circumscribed by the assigning health professional's governing body;**
- **Where the person to whom the act will be assigned is a member of a self-regulating health profession, his or her governing body must approve of the assigning of the reserved act;**
- **The instruction to perform the act must be made in writing either by way of a general written protocol or through a case-specific instruction;**
- **The assigning health professional must be satisfied that the individual who will be performing the act has the necessary skills and training to perform the act safely;**
- **The assigning health professional must ensure that the person who will be performing the act**

accepts the assignment.

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D. RESERVED TITLES

Reserved titles are titles reserved exclusively to a health profession. Reserved titles afford a means for consumers to identify the different types of health care providers, to distinguish the qualified from the unqualified, and to differentiate those practitioners who are regulated from those who are not. Titles must adequately serve the public in describing the practitioner and the services being provided and must distinguish the practitioner from others performing services outside the jurisdiction of the college.

The LPNABC and the CLPNBC propose to maintain the current title protection, as stated within the *Nurses (Licensed Practical) Act Regulations* under the HPA, for the titles "Licensed Practical Nurse" or "L.P.N.". The CLPNBC also proposes that its members continue to be entitled to use the term "nurse". However, the CLPNBC proposes that the title "nurse" be granted to LPNs within the *Nurses (Licensed Practical) Act Regulations* instead of receiving their legal authority to use the title "nurse" from the *Nurses (Registered) Act*, as is currently the case.

In a May 1996 submission, the CLPNBC proposed that the title "practical nurse" be reserved. It states:

Recently it has come to our attention that there are facilities in B.C., both acute care and extended care, who are allowing individuals not currently licensed with the College as an LPN to use the title "PN". It is the belief of the College that these individuals are, knowingly or unknowingly, holding themselves out to their colleagues and to, the general public to be part of a regulated and monitored profession. This is increasingly apparent with registered nurses who are working as "practical nurses" or formerly licensed practical nurses who have either lapsed their license or had it removed through the discipline process.

There was very little comment on this part of the proposal other than expressions of general support.

The Council is satisfied that the current titles granted to LPNs are appropriate. In addition, the Council accepts the CLPNBC's submission that unregulated use of the term "practical nurse" can be confusing to the public, and therefore that title and the initials "P.N." ought to be reserved to this profession.

Therefore, the Council recommends that the following titles be reserved for members of the profession:

- **Licensed Practical Nurse;**
- **L.P.N.;**
- **Practical Nurse; and**
- **P.N.**

The Council recommends that the title "nurse" be reserved for licensed practical nurses, registered nurses, registered psychiatric nurses, and Christian Science nurses.

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E. OTHER ISSUES

1. Abolition of Separate Nursing Professions

The Council notes that various submissions propose that separate nursing categories be abolished by requiring LPNs to upgrade their education and qualify as RNs. Another submission proposes to abolish the profession of registered psychiatric nursing and yet another calls for the elimination of the category of licensed practical nursing. This issue is beyond the Council's mandate for this review and was not addressed by the Council.

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IV. RECOMMENDATIONS

1. The Council recommends the following scope of practice statement for licensed practical nurses:

The practice of nursing by licensed practical nurses is the provision of health care for the promotion, maintenance and restoration of health; and the treatment and prevention of illness and injury, including assessment of health status and implementation of interventions.

2. The Council recommends that the following reserved acts be granted to licensed practical nurses to perform only if the act is ordered by a health practitioner who is authorized by legislation to perform the act:
 - a. Performing the following physically invasive or physically manipulative acts:
 - i. procedures on tissue below the dermis, below the surface of a mucous membrane;
 - ii. administering a substance by injection, inhalation, irrigation, or instillation;
 - iii. putting an instrument, hand or finger(s)
 - a. into the external ear canal, but excluding cerumen management,

- b. beyond the pharynx,
- c. beyond the opening of the urethra,
- d. beyond the labia majora, but excluding the insertion of intrauterine devices,
- e. beyond the anal verge, or
- f. into an artificial opening into the body.

b. Administering by any means a drug listed in Schedule I or II of the *[Pharmacists, Pharmacy Operations and Drug Schedule Act](#)*.

3. The Council recommends that a provision be enacted which sets out the duties of a health professional and his or her regulatory college when delegating a reserved act. The provision should require the following:

- The assigning health professional's governing body must provide assent to the proposed reserved act being performed by someone else;
- The reserved act to be assigned as well as the level of supervision must be clearly defined and circumscribed by the assigning health professional's governing body;
- Where the person to whom the act will be assigned is a member of a self-regulating health profession, his or her governing body must approve of the assigning of the reserved act;
- The instruction to perform the act must be made in writing either by way of a general written protocol or through a case-specific instruction;
- The assigning health professional must be satisfied that the individual who will be performing the act has the necessary skills and training to perform the act safely;
- The assigning health professional must ensure that the person who will be performing the act accepts the assignment.

4. The Council recommends that the following titles be reserved for members of the profession:

- Licensed Practical Nurse;
- L.P.N.;
- Practical Nurse; and
- P.N.

5. The Council recommends that the title "nurse" be reserved for licensed practical nurses, registered nurses, registered psychiatric nurses, and Christian Science nurses.

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APPENDIX C

GLOSSARY AND ABBREVIATIONS OF NAMES

BC Dietitians' and Nutritionists' Association	BCDNA
BC Medical Association	BCMA
BC Nurses' Union	BCNU
BC Society of Occupational Therapists.	BCSOT
Central Vancouver Island Regional Health Board	CVIRHB
College of Licensed Practical Nurses of BC (formerly the BC Council of Licensed Practical Nurses)	CLPNBC
College of Massage Therapists of BC	CMTBC
College of Psychologists of BC	CPBC
Greater Victoria Hospital Society	GVHS
Health Employers Association of BC	HEABC
Hospital Employees' Union	HEU
Licensed Practical Nurses Association of BC	LPNABC
Ministry of Advanced Education, Training and Technology (formerly Ministry of Education, Skills and Training)	MAETT
Registered Nurses Association of BC	RNABC
Registered Psychiatric Nurses Association of BC	RPNABC
University of British Columbia (School of Nursing)	UBC
University of Victoria (School of Nursing)	UVIC
Vancouver Community College	VCC

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Health Professions Council POST-HEARING UPDATE OF PRELIMINARY REPORT: LICENSED PRACTICAL NURSES

Irvine E. Epstein, Q.C., Chair
Arminée Kazanjian, Member
David MacAulay, Member

March 2001

This Post-Hearing Update should be read in conjunction with the [Preliminary Report](#) for the profession.

The Council issued its *Nurses (Licensed Practical) Scope of Practice (Preliminary Report)* in April 2000. The public hearing was held on 16 May 2000. The following are changes to the *Preliminary Report* which arose from the submissions made either at the public hearing or in subsequent written submissions.

I. SCOPE OF PRACTICE

The Council's *Preliminary Report* recommended the following scope of practice for licensed practical nurses:

The practice of nursing by licensed practical nurses is the provision of health care for the promotion, maintenance and restoration of health; and the treatment and prevention of illness and injury, including assessment of health status and implementation of interventions.

The Licensed Practical Nurses Association of British Columbia (LPNABC) questioned the omission of the words "planning" and "evaluation" in the Council's recommended scope of practice statement. Similarly, the Provincial Practical Nurse Articulation Committee (PPNAC) stated that the proposed scope of practice statement should include planning and evaluation, as they are part of the four stages of the "nursing process." However, the Council's task is not to describe the nursing process but to describe, generally, the scope of practice of the profession. In any event, planning and evaluation are undoubtedly integral to and implicit in the practice of all professions.

The issue of palliation was discussed by the Council in its review of registered nursing, and that term was added to the scope of practice of registered nursing. It should also be added to the scope of practice of licensed practical nursing. Therefore, the Council recommends the following scope of practice statement for licensed practical nursing:

The Health Professions Council recommends the following scope of practice for licensed practical nurses:

The practice of nursing by licensed practical nurses is the provision of health care for the promotion, maintenance and restoration of health; and the prevention, treatment and palliation of illness and injury, including assessment of health status and implementation of interventions.

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II. RESERVED ACTS

A. Independent Reserved Acts

In its *Preliminary Report*, the Council did not recommend the granting of any reserved acts to be performed independently by licensed practical nurses. The Provincial Practical Nurse Articulation Committee (PPNAC), a group comprised of practical nurse educators, submitted that licensed practical nurses are qualified to perform three reserved acts independently:

Performing the physically invasive or physically manipulative act of putting an instrument, hand or finger(s)

1. "into the external ear canal": PPNAC stated that licensed practical nurse students clean their patients' external ear canal, take their tympanic temperature and also use an otoscope to examine cerumen build up. It also stated that "up to the eardrum" constitutes an "ordered" function.
2. "beyond the labia majora, but excluding the insertion of intrauterine devices": PPNAC stated that licensed practical nurse students perform hygiene measures and wash beyond the labia majora to the urethral and vaginal orifice.
3. "beyond the anal verge": PPNAC stated that licensed practical nurse students autonomously perform rectal checks on patients whose assessment warrants this intervention.

The Open Learning Agency made an almost identical submission. After reviewing the information received, the Council is satisfied that licensed practical nurses are qualified to perform reserved acts independently in certain limited circumstances. Therefore, the Council recommends the following reserved acts for licensed practical nurses to be performed independently:

The Health Professions Council recommends the following reserved act for licensed practical nurses:

2(e) For the purpose of assessing an individual or assisting an individual with activities of daily living, performing the physically invasive or physically manipulative act of putting an instrument, hand or finger(s)

- i. into the external ear canal, including applying pressurized air or water, for purposes of cleaning patients' external ear canal, taking their tympanic temperature and using an otoscope to examine cerumen build up;
- v. beyond the labia majora, but excluding the insertion of intrauterine devices, for purposes of performing hygiene measures and washing beyond the labia majora to the urethral and vaginal orifice;
- vi. beyond the anal verge, for purposes of performing rectal checks on patients whose assessment warrants this intervention.

B. Reserved Acts on Order

In its *Preliminary Report*, the Council recommend the following reserved acts for licensed practical nurses to be performed "on order":

1. *Performing the following physically invasive or physically manipulative acts:*
 - a. procedures on tissue below the dermis, below the surface of a mucous membrane;
 - d. administering a substance by injection, inhalation, irrigation or instillation;
 - e. putting an instrument, hand or finger(s)
 - i. into the external ear canal, but excluding cerumen management;
 - ii. beyond the pharynx;
 - iii. beyond the opening of the urethra;
 - iv. beyond the labia majora, but excluding the insertion of intrauterine devices;
 - v. beyond the anal verge; or
 - vi. into an artificial opening into the body.
2. *Administering by any means a drug listed in Schedule I or II of the Pharmacists, Pharmacy Operations and Drug Scheduling Act.*

At the public hearing, the Council received many submissions on this issue. Several participants, including the BCNU and the RNABC, suggested that even for acts "on order," the Council should be more specific and thus limited. The BCNU was concerned some of the reserved acts the Council granted "on order" cannot be safely and competently performed by licensed practical nurses. In the Council's view, the restriction that these acts be

performed on order addresses competency concerns. The profession that orders licensed practical nurses to perform such acts can and will determine the services licensed practical nurses can perform competently, and the circumstances in which they can be carried out. Thus, the order making process can impose strict parameters on the performance of the reserved acts by licensed practical nurses.

The Council was however persuaded that some modifications to the reserved acts granted to licensed practical nurses on order were necessary and in this regard took note of the following submissions. First, the Council was satisfied that licensed practical nurses in certain facilities do compound substances for use in administration of therapeutic diets through enteral or parenteral means. Second, licensed practical nurses do not have the competency to safely perform the reserved act of "putting an instrument, hand or finger(s) beyond the pharynx." Finally, the Council was not satisfied that licensed practical nurses have sufficient competency to perform intramuscular injections.

Therefore, the Council recommends the following reserved acts for licensed practical nurses to perform only if ordered by a health professional authorized to perform the reserved act:

- 2. Performing the following physically invasive or physically manipulative acts:**
 - a. **Procedures on tissue below the dermis or below the surface of a mucous membrane;**
 - d. **administering a substance, other than a drug, by subcutaneous injection, inhalation, irrigation or instillation;**
 - e. **putting an instrument, hand or finger(s)**
 - i. **into the external ear canal, but excluding cerumen management;**
 - iv. **beyond the opening of the urethra;**
 - v. **beyond the labia majora, but excluding the insertion of intrauterine devices;**
 - vi. **beyond the anal verge; or**
 - vii. **into an artificial opening into the body.**

5(a) Administering orally or by subcutaneous injection a drug listed in Schedule I or II of the *Pharmacists, Pharmacy Operations and Drug Scheduling Act*.

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III. RESERVED TITLES

The Council's *Preliminary Report* recommended the following reserved titles for licensed practical nurses:

- *Licensed Practical Nurse,*
- *L.P.N.,*
- *Practical Nurse, and*

- **P.N.**

The Council recommends that the title "nurse" be reserved for licensed practical nurses, registered nurses, registered psychiatric nurses and Christian Science nurses.

The LPNABC submitted that the title "Nurse" be reserved for all three nursing professions. The Council agrees, and recommends that all three nursing professions be entitled to use the title "nurse" either alone or in conjunction with the adjective appropriate to their branch of nursing.

Although the title "Christian Science Nurse" appears in the current *Nurses (Registered) Act*, RSBC 1996, c. 335, the Council received no comment or submission on this title, nor did any of the nursing groups reviewed by the Council request this title. Therefore, the Council did not recommend that it be reserved.

The Health Professions Council recommends the following reserved titles for licensed practical nurses:

- "Licensed Practical Nurse",
- "Practical Nurse",
- "Nurse", and
- any abbreviation of those titles.

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Health Professions Council Registered Nurses Scope of Practice Preliminary Report

Irvine E. Epstein, Q.C., Chair
Arminée Kazanjian, Member
David MacAulay, Member

March 2000

This Preliminary Report should be read in conjunction with the [Post-Hearing Update](#) for the profession.

FOREWORD

This report is the result of the Health Professions Council's review of the scope of practice of nursing by registered nurses (RNs) pursuant to the [Terms of Reference](#) from the Minister of Health and Minister Responsible for Seniors. Under the [Health Professions Act](#), the Health Professions Council is a six-person advisory body appointed by the Government of British Columbia to make recommendations to the Minister of Health and Minister Responsible for Seniors about the regulation of health professions.

In this report the Health Professions Council examines how the existing scope of practice of nursing by RNs should be legislatively defined in order to reflect fairly and accurately the current state of practice and the public interest in the practice of nursing by RNs.

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EXECUTIVE SUMMARY

The Health Professions Council has conducted a review of the scope of practice of nursing by RNs.

The purpose of the review is to provide recommendations to the Minister of Health and Minister Responsible for Seniors regarding four matters: scope of practice statements, reserved acts, supervised acts, and reserved titles.

The Health Professions Council has conducted a detailed consultation process and its recommendations regarding the four elements of the scope review are as follows:

1. The Council recommends the following scope of practice statement for registered nurses:

The practice of nursing by registered nurses is the provision of health care for the promotion, maintenance and restoration of health and the treatment and prevention of illness and injury, primarily by assessment of health status, planning and implementation of interventions, and co-ordination of health services.

2. The Council recommends the following reserved acts be granted to registered nurses:

Performing the physically invasive or physically manipulative act of putting an instrument, hand or

finger(s):

- i. into the external ear canal, up to the eardrum, but excluding cerumen management,
 - ii. beyond the opening of the urethra,
 - iii. beyond the labia majora, but excluding the insertion of intrauterine devices, or
 - iv. beyond the anal verge.
3. The Council recommends that the following reserved acts be granted to registered nurses to perform only if the act is ordered by a health practitioner who is authorized by legislation to perform the act:
- [a.] Performing the following physically invasive or physically manipulative acts:
- i. procedures on tissue below the dermis, below the surface of a mucous membrane, and in the surface of the cornea;
 - ii. administering a substance by injection, inhalation, irrigation, or instillation through enteral or parenteral means;
 - iii. putting an instrument, hand or finger(s)
 - a. beyond the point in the nasal passages, where they normally narrow,
 - b. beyond the pharynx, or
 - c. into an artificial opening into the body.
- [b.] Administering by any means a drug listed in Schedule I or II of the *Pharmacists, Pharmacy Operations and Drug Scheduling Act*.
4. The Council recommends that a provision be enacted which sets out the duties of a health professional and his or her regulatory college when delegating a reserved act. The provision should require the following:
- The assigning health professional's governing body must provide assent to the proposed reserved act being performed by someone else;
 - The reserved act to be assigned as well as the level of supervision must be clearly defined and circumscribed by the assigning health professional's governing body;
 - Where the person to whom the act will be assigned is a member of a self-regulating health profession, his or her governing body must approve of the assigning of the reserved act;
 - The instruction to perform the act must be made in writing either by way of a general written

protocol or through a case-specific instruction;

- The assigning health professional must be satisfied that the individual who will be performing the act has the necessary skills and training to perform the act safely;
- The assigning health professional must ensure that the person who will be performing the act accepts the assignment.

5. The Council recommends that the following titles be reserved for members of the profession:

- Registered Nurse,
- R.N.,
- Licensed Graduate Nurse, and
- L.G.N.

6. The Council recommends that the title "nurse" be reserved for registered nurses, registered psychiatric nurses, licensed practical nurses, and Christian Science nurses.

7. The Council recommends that the name of the regulatory body, the "Registered Nurses Association of BC", be changed to the "College of Registered Nurses of British Columbia".

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I. INTRODUCTION

A. THE NATURE OF THE REVIEW

This is the preliminary report of the review of the scope of practice of nursing by RNs by the Health Professions Council (Council).

The review was conducted pursuant to [Terms of Reference](#) issued by the Minister of Health and Minister Responsible for Seniors in accordance with section 25 of the [Health Professions Act](#), RSBC 1996, c. 183 (HPA). The [Terms of Reference](#) direct the Council to review the scopes of practice of the recognized health professions, of which nursing by RNs is one.

The [Terms of Reference](#), which are included as Appendix A to this report, indicate that there are four main elements to the scope of practice review:

- i. scope of practice statements which describe what the profession does, the methods it uses and the purpose for which it does it;
- ii. reserved acts which are those acts that present such a significant risk of harm that they should be performed only by professionals who are qualified to perform them;

- iii. supervised acts which are reserved acts, or aspects of reserved acts, which may be performed by persons supervised by health professionals; and
- iv. reserved titles which are titles that describe a profession's services and which are reserved exclusively for the health profession.

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B. THE PROCESS FOR THE REVIEW

The general process for the review provides for an initial meeting with the profession, submission of briefs by the regulatory body and professional association, a consultation process involving the health profession and interested parties regarding the profession's submission, drafting of a preliminary report, public hearings and a final report.

The Council held an initial meeting with the Registered Nurses Association of BC (RNABC) on April 19, 1995.

On July 5, 1995, the RNABC made a scope of practice presentation to the Council. It then submitted its brief on July 28, 1995. On September 19, 1995, the Council met with the RNABC to conduct an initial discussion of its brief. The submission was then summarized and distributed to interested groups and individuals including other regulated and unregulated health professions, teaching facilities and other provinces. Many responses were received. Thereafter, the Council met with representatives of the RNABC on June 5, 1997 and with a representative of the British Columbia Nurses Union (BCNU) on May 8, 1997 to discuss the review.

In 1998, the Council issued the [*Shared Scope of Practice Model Working Paper*](#) (*Working Paper*) which described in more detail the regulatory model set out in the *Terms of Reference*.

In March 1999, the BCNU and the RNABC made a joint submission to the Council which substantially revised the earlier RNABC submission. This submission was sent out to all health professions and interested parties. In August, 1999, the BCNU made a further submission regarding the title "nurse".

The Council carefully considered all of the information it received in drafting this report.

This report will be circulated to all health professions and other interested parties who participated in the Council's consultation process. A public hearing will be held on May 15 and 16, 2000 after which a final report will be issued. Persons or organizations who have made written responses to either the original consultation letter or to this preliminary report will be invited to speak at the hearing.

Throughout this report, the Council makes reference to the submissions of the RNABC and the BCNU and to the responses received during the consultation process. The Council has abbreviated its references to many of the responses received and for ease of reference, has included as Appendix C a glossary and abbreviations of names used in this report.

This review of nursing by RNs is being conducted concurrently with the Council's review of nursing by registered psychiatric nurses (RPNs) and nursing by licensed practical nurses (LPNs).

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C. THE REGULATION OF REGISTERED NURSING

Professional organization of nursing in Canada began with the International Council of Nurses in 1899 and the Canadian Nurses Association which was established in 1908 as the Canadian National Association of Trained Nurses. By 1922, every Canadian province had enacted some form of legislation for nursing. Nursing by RNs has been a self-regulating profession in British Columbia since the passage of the *Registered Nurses Act* in 1918. That Act established the Graduate Nurses Association of BC as the body responsible for regulating nursing by RNs. The name was changed to the Registered Nurses Association of BC by the repeal and replacement of the Act in 1935. Numerous amendments have since taken place. The *Nursing Statutes Amendment Act*, SBC 1988, c. 51, replaced the provisions respecting titles with limitations on both the use of "registered nurse" and "nurse". The *Health Professions Statutes Amendment Act*, 1993, introduced amendments to the duties and objects of the RNABC, its inspection powers, and its interim suspension powers in professional disciplinary matters. The current act is called the [*Nurses \(Registered\) Act*](#), RSBC 1996, c. 336.

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II. THE POLICY BACKGROUND

The main impetus for a scope of practice review was the *Report of the British Columbia Royal Commission on Health Care and Costs* (Seaton Commission). The Seaton Commission stated that the existing legislation governing the health professions creates persistent jurisdictional disputes and a distinct lack of cooperation among the health professions, despite the fact that all health professional colleges have the same mandate - to protect the public from preventable harm.

The Seaton Commission stated that the primary reason for the jurisdictional disputes was the present regulatory system's reliance on exclusive scopes of practice. Under the exclusive scope of practice model, the various health professions have been granted an exclusive right to practice within a legislatively defined scope of practice. No one, other than a member in good standing of that profession, can perform acts within the profession's scope of practice unless they are granted an exemption.

The Commission concluded:

...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.

(Closer to Home, The Report of the Royal Commission on Health Care and Costs in British Columbia, Volume 2, 1991, p. D-33)

This recommendation is also consistent with legislative initiatives underway in Alberta.

The Seaton Commission was not the first review body to suggest that the present legislative model of exclusive

scopes of practice was inappropriate. Restricting professional monopolies (exclusive scopes of practice) was also recommended in an earlier study commissioned by the British Columbia Minister of Health. In discussing the conflicts which may arise between the professional college and the public interest, the issue of exclusive scopes of practice was raised:

It must be emphasized that any professional legislation which unduly restricts the scope of practice of skilled personnel may be contrary to the public interest in greater supply and accessibility of service through the development of team practice. Therefore, it is urged that: Professional legislation should not contain narrow restrictions or rigid definitions of scope of practice which are excessively exclusive; that measures should be taken (as indicated below) to reduce the area of interprofessional strain and conflict; and that no prosecutions for violations of scope of practice legislation should be undertaken without the prior consent of the appropriate public authority.

Insofar as may be possible with due regard for public safety, professional law should not place rigid restrictions on the scope of practice of allied health personnel, and greater flexibility should be encouraged in the allocation of roles between the health disciplines.

(Professor J.T. McLeod, *Public Regulation of the Professions in Health Security for British Columbians*, Special Report: *Consumer Participation, Regulation of the Professions, and Decentralization* (1974), the report of Richard D. Foulkes, B.A., M.D., F.A.P.H.A. to the Minister of Health, Province of British Columbia, Tome Three, p. 145)

Thus, the trend in regulatory policy for the health professions has been towards reducing exclusivity in order to enhance interdisciplinary practice, improve accessibility to health care services and increase consumer choice, while at the same time maintaining the fundamental objective of protecting the public.

These policy trends are clearly reflected in the [Terms of Reference](#) for the scope of practice review which provide the basis for a new regulatory framework for health professions in British Columbia. The core elements of the new framework are scope of practice statements and reserved acts.

Under the present system, scope of practice statements are exclusive. In the new system, scope statements will not be exclusive but professions may be granted reserved acts.

Reserved acts are those elements of a profession's scope of practice which present such a significant risk of harm that they should be reserved to a particular profession, or shared amongst particular professions. Thus, unlike the present system in which each profession is granted exclusivity within its entire defined scope of practice (subject to specified exceptions), only those acts which present a significant risk of harm will be reserved.

In short, the government has assigned the Council the task of creating a regulatory model based on broad, non-exclusive scope of practice statements and narrowly defined reserved acts.

The government has the responsibility to ensure that those services which are accessible are safe and that the regulatory framework for the practice of health professions protects the public from incompetent, impaired, or unethical practitioners. At the same time, the regulatory framework should not entrench a paternalistic function for professions or reserve exclusive areas of practice simply to enhance professional status and control.

The new system of overlapping scopes of practice and narrow reserved acts removes barriers to interdisciplinary practice and offers greater choice and accessibility to the public. In the Council's view, the public interest is served by professional legislation which promotes quality in the delivery of health care services within safe parameters. Indeed, the Council's primary policy objective in conducting its review is achieving the optimum balance between safe practice and consumer choice.

With this policy background in mind, the Council proposes to consider the practice of nursing by RNs having regard to the four elements of the scope review.

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III. DISCUSSION OF ISSUES

The main issues raised by this review are the four elements listed above: scope of practice statement, reserved acts, supervised acts and reserved titles.

A. SCOPE OF PRACTICE

The scope of practice statement describes what the profession does, the methods it uses, and the purpose for which it does it. Unlike the present regulatory system, the statement itself does not grant an exclusive scope of practice. Nonetheless, the statement is important because: 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; and it informs the public about the services practitioners are qualified to perform. It is expected that the Council's recommendations will increase overlapping scopes of practice.

The Council believes that it is not necessary or useful to itemize every facet of a profession's scope of practice. Rather, a scope of practice definition should be sufficiently descriptive so that other health professions and members of the public alike can understand what the particular health professional does.

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1. Current Scope of Practice of Nursing by Registered Nurses

The existing scope of practice of nursing by RNs is set out in the rules under the [Nurses \(Registered\) Act](#), RSBC 1996, c. 336 (NRA):

the practice of nursing means the performance for others of health care services which require the application of professional nursing knowledge and skills and includes

- a) promoting, maintaining or restoring the health of the general public,*
- b) teaching nursing theory or practice,*

- c) *counselling persons in respect of health care,*
- d) *coordinating health care services, and*
- e) *engaging in administration, supervision, education, consultation, teaching or research for any of the foregoing.*

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2. Proposed Scope of Practice

The RNABC initially proposed to maintain the existing scope of practice under the *NRA*. In the March 1999 joint submission by the BCNU and the RNABC, however, the two groups propose the following revision of the scope of practice statement:

The practice of registered nursing means the performance for others of health services for the purposes of health promotion, maintenance, restoration, or palliation and illness or injury prevention , which require the application of professional nursing knowledge, judgment and skills, and includes:

- (a) *assessing health status, making a diagnosis, planning and implementing interventions, including care, counselling and advocacy and evaluating outcomes ;*
- (b) *co-ordinating health services; and*
- (c) *engaging in administration, supervision, education, consultation, teaching or research for any of the foregoing.*

Words added to the current scope of practice statement of RNs are underlined.

The BCNU and the RNABC state that the wide range of health services makes it impossible to list every type of function RNs perform. They further state that the proposed amended definition removes ambiguity from the current definition and is sufficiently broad to include areas of practice other than direct patient care.

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3. Regulation of Registered Nursing in Other Provinces

The Council reviewed the scope of practice definitions in other provinces.

In Ontario, the nursing profession is governed by both the *Regulated Health Professions Act*, SO 1991, c.18 and the *Nursing Act*, SO 1991, c.32. The *Nursing Act* outlines the nurses' scope of practice as follows:

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

Although Ontario has two classes of membership - registered nurses and practical nurses - all nurses are regulated through the College of Nurses of Ontario, and the scope of practice statement applies to both.

In New Brunswick, two regulated health professions provide nursing services: registered nurses and registered nursing assistants. The scope of practice for nursing is defined in *An Act Respecting the Nurses Association of New Brunswick*, as follows:

"nursing" means the practice of nursing and includes the nursing assessment and treatment of human responses to actual or potential health problems and the nursing supervision thereof;

Quebec maintains two nursing categories: registered nursing and practical nursing. The Quebec *Nurses Act*, LRQ, c.l-8, contains a broad definition of nursing in section 36, and a prohibition against practising nursing without a license in section 41. Section 36 states:

Every act the object of which is to identify the health needs of persons, contribute to methods of diagnosis, provide and control the nursing care required for the promotion of health, prevention of illness, treatment and rehabilitation, and to provide care according to a medical prescription constitutes the profession of nursing.

Alberta maintains three categories of nurses: registered nurses, psychiatric nurses, and licensed practical nurses. The latter two are regulated under the *Health Disciplines Act*, RSA 1980, c. H-3.5. The practice of registered nursing is defined in the *Nursing Profession Act*, SA 1983, c. N-14.5, as follows:

A registered nurse and a certified graduate nurse are entitled to apply professional nursing knowledge for the purpose of

- a. *promoting, maintaining or restoring health;*
- b. *preventing illness, injury or disability;*
- c. *caring for the injured, disabled or incapacitated;*
- d. *assisting in childbirth;*
- e. *teaching nursing theory or practice;*
- f. *caring for the dying;*
- g. *co-ordinating health care;*
- h. *engaging in the administration, education, teaching or research required to implement or complement exclusive nursing practice or all or any of the matters referred to in clauses*

(a) to (g).

In Saskatchewan, registered nurses are regulated under the *Registered Nurses Act*, SS 1988-89, c.R-12.2, which defines the practice of registered nursing as follows:

"*practice of nursing*" means the performance or co-ordination of health care services including but not limited to:

- i. observing and assessing the health status of clients and planning, implementing and evaluating nursing care; and
- ii. the counselling, teaching, supervision, administration and research that is required to implement or complement health care services;

for the purpose of promoting, maintaining or restoring health, preventing illness and alleviating suffering where the performance or co-ordination of those services requires:

- iii. the knowledge, skill or judgment of a person who qualifies for registration pursuant to section 19 or 20;
- iv. specialized knowledge of nursing theory other than that mentioned in subclause (iii);
- v. skill or judgment acquired through nursing practice other than that mentioned in subclause (iii); or
- vi. other knowledge of biological, physical, behavioural, psychological and sociological sciences that is relevant to the knowledge, skill or judgment described in subclause (iii).

Finally, Manitoba also has the three nursing categories of registered nurses, registered psychiatric nurses and licensed practical nurses. The Manitoba *Registered Nurses Act*, RSM 1987, c. R40, defines the scope of practice of RNs as follows:

"nursing practice" or "the practice of nursing" means representing oneself as a registered nurse while carrying out the practice of those functions which, directly or indirectly in collaboration with a client and with other health workers, have as their objective, promotion of health, prevention of illness, alleviation of suffering, restoration of health and maximum development of health potential and without restricting the generality of the foregoing includes

- a. collecting data relating to the health status of an individual or groups of individuals,
- b. interpreting data and identifying health problems,
- c. setting care goals,
- d. determining nursing approaches,
- e. implementing care, supportive or restorative of life and wellbeing,
- f. implementing care relevant to medical treatment,

- g. assessing outcomes, and
- h. revising plans.

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4. Responses to Original Consultation

Many groups responded to the scope of practice initially proposed by the RNABC in June 1995. A subsequent joint submission of the RNABC and the BCNU in March 1999 has revised much of that submission. However, the scope statement proposed in the initial submission is similar to the revised scope statement. Therefore, the initial responses are summarized below.

The British Columbia Association of Podiatrists (BCAP) agreed with the proposal and stated that the scope definition must reflect the fact that nursing is a generalist field which cannot be easily reduced to defined barriers.

The College of Psychologists of BC (CPBC) supported the proposal with the addition of a requirement that all duties be carried out under the direction of a physician. It further stated that exemptions from exclusive scopes of practice or reserved acts of other professions, which was part of the RNs' original submission, should be specified and detailed and then submitted to the concerned health professions for comment.

Several respondents believed the current definition to be too general. For example, the College of Midwives of BC (CMBC) stated that the definition does not enable the public to determine the boundaries of what RNs do. The CMBC recognized that defining the scope of nursing by RNs is difficult as the scope of practice is broad, but it believed the public requires such a definition. The College of Massage Therapy of BC (CMTBC) made a similar submission, as did the College of Physicians and Surgeons of BC (CPSBC), the British Columbia Society of Massage Therapy (BCSMT), and the British Columbia Health Association (BCHA).

Other respondents, representing educators, made the general point that the scope of practice statements for the three nursing professions must reflect the unique characteristics of each profession.

Douglas College stated that there is little differentiation between the three nursing bodies' proposals. Similarly, the Ministry of Education, Skills and Training (MEST) stated that it is difficult to differentiate the three nursing professions, and thus difficult to assess what educational preparation is required.

Finally, Manitoba Health stated that the scope statements for the three nursing professions should follow a similar format.

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5. Responses to the Joint Submission of the BCNU and the RNABC

Many respondents approve of the scope of practice statement proposed by the BCNU and RNABC on March 3, 1999.

The College of Licensed Practical Nurses of BC (CLPNBC) states that it has no concern but adds that the proposed scope of practice could apply almost equally to LPNs since they perform a significant part of the RNs' proposed scope of practice. The CLPNBC also states that the proposed scope of practice illustrates the difficulty of establishing different scope of practice statements for RNs, RPNs and LPNs.

The Licensed Practical Nurses Association of BC (LPNABC) finds the proposed scope of practice appropriate and adds that the definition of the practice of "nursing" could serve as the definition for all three disciplines of nursing.

The Hospital Employees' Union (HEU) supports the proposed scope of practice statement and adds that it parallels the role statement for LPNs.

The BC Dietitians' and Nutritionists' Association (BCDNA) supports the amended definition of nursing practice and states that it reflects what nurses currently do.

The Capital Health Region concurs with the proposed scope submission and states that it accurately reflects the anticipated health needs of the population.

University of Victoria, School of Nursing (UVIC) believes the proposed scope of practice statement is clear and incorporates all the essentials of the profession's scope in a succinct manner.

Vancouver Community College (VCC) believes the revised scope of practice will not have an impact on the education of practical nurses.

Some respondents disagree with the proposed scope of practice.

The BC Medical Association (BCMA) states that the inclusion of "making a diagnosis" is inappropriate. It states that the responsibility of making a diagnosis is one of the most important requirements of fitness to acquire a license to practise medicine, and that RNs do not have the necessary training and education.

The BC Psychological Association (BCPA) disagrees with the proposed scope of practice statement and finds it overly broad. Specifically, it states that mental illness and neuropsychology are areas in which RNs lack preparation, and therefore should not be included within their scope of practice.

The BC Association of Podiatrists (BCAP) submits that RNs do not have the extensive and specialized knowledge to make most podiatric diagnoses.

Castlegar and District Hospital (Castlegar) states that the proposed scope of practice appears to broaden the scope to the point of recognizing all nurses as practitioners who will act in an independent and autonomous manner. Castlegar questions who will be in charge of patient care, a responsibility currently resting with the physician.

6. The Council's Conclusions

The Council has carefully reviewed the revised proposed scope of practice statement. The Council agrees with the BCNU and the RNABC that the practice of nursing by RNs requires a broad and general scope of practice statement to reflect the breadth of practice by the profession. However, several portions of the proposed definition are unnecessary in the legislative context. The phrase "*which require the application of professional nursing knowledge*" does not add to the definition. Item (c), "*engaging in administration, supervision, education, consultation, teaching or research for any of the foregoing*", encompasses activities which implicitly fall within the scope of practice of all professions, and have not been included in other scope of practice statements.

Finally, the issue of diagnosis, which was proposed by the RNs, and addressed by the BC Psychological Association (BCPA), the BC Association of Podiatrists (BCAP) and the BC Medical Association (BCMA), will be dealt with under the reserved acts section of this report.

Therefore, the Council recommends the following scope of practice statement for registered nurses:

The practice of nursing by registered nurses is the provision of health care for the promotion, maintenance and restoration of health and the treatment and prevention of illness and injury, primarily by assessment of health status, planning and implementation of interventions, and co-ordination of health services.

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B. RESERVED ACTS

The rationale underlying the granting of reserved acts is to protect the public by limiting provision of those particularly dangerous acts to members of specific professions who are qualified to perform them. Only those acts which present a significant risk of harm will be reserved. The Council developed a list of reserved acts, and included it in a 1998 report, entitled the [Shared Scope of Practice Model Working Paper \(Working Paper\)](#).

The list is the Council's working list of activities which present such a significant risk of harm that they should be reserved to regulated health professionals. The list has been revised during the course of the Council's review process. The latest version is attached as Appendix B to this report.

The Council's review will determine which parts of the list will be granted to each profession.

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1. Proposed Reserved Acts

In its original submission, the RNABC contended that it is not possible to create a list of reserved acts to capture the full range of nursing practice. It took the position that rather than proposing specific reserved acts, it should receive an exemption from the reserved acts of other professions. In short, the RNABC proposed an expanded scope of practice through exemptions from other professions' reserved acts.

Many of the respondents to the initial consultation criticized this submission, and submitted that it amounted to a request that RNs be granted the same scope of practice as physicians. Those responses will not be reviewed as the RNABC has revised its position.

In the joint submission by the BCNU and the RNABC, the following reserved acts are proposed for RNs:

1. *Making a diagnosis, identifying a disease, disorder or condition as the cause of signs or symptoms of the individual.*
2. *Performing the following physically invasive or physically manipulative acts:*
 - a. *procedures on tissue below the dermis, below the surface of a mucous membrane, and in the surface of the cornea;*
 - b. *setting or casting a simple fracture of a bone or reducing a dislocation of a joint;*
 - c. *administering a substance by injection, inhalation, instillation or irrigation ;*
 - d. *putting an instrument, hand or finger(s)*
 - i. *into the external ear canal, up to the eardrum,*
 - ii. *beyond the point in the nasal passages where they normally narrow,*
 - iii. *beyond the pharynx,*
 - 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;*
- and the maintenance or removal of instruments .
3. *Managing labour and conducting vaginal delivery of a baby within an institutional setting .*
4. *Applying or ordering the application of a hazardous form of energy including diagnostic ultrasound, electricity, magnetic resonance imaging, lithotripsy, laser and x-ray.*

5. *Prescribing, compounding, dispensing or administering by any means a drug listed in Schedule A-1 or A-3.2 of the Pharmacists, Pharmacy Operations and Drug Scheduling Act.*
6. *Administering and monitoring initial doses of listed drugs for unstable clients or those with unpredictable outcomes .*

Words added to the Council's reserved acts list are underlined.

The BCNU and the RNABC state that RNs already competently and independently carry out most of the activities in the Council's reserved acts list. They are performed either in cases where a patient's medical needs are urgent and a physician is unavailable, or in accordance with institutional protocols or physician orders. The RNABC and the BCNU cite the following activities that RNs currently perform:

- *initiate oxygen when required by clients in respiratory distress;*
- *irrigate blocked intravenous catheters by injecting normal saline;*
- *select the type of solutions and dressings to use in wound care;*
- *manage normal labour and delivery;*
- *remove endotracheal tubes that are blocked;*
- *adjust respirator settings and/or increase sedative medication for patients on respirators demonstrating symptoms of inadequate ventilation;*
- *insert urinary catheters for post operative patients who are unable to void;*
- *determine when and how much of a prescription medication to give to a client; and*
- *titrate insulin doses for diabetic patients.*

The RNABC and the BCNU state that RNs often carry out these activities even though they are currently prevented from doing so by legislative and administrative barriers. They state that RNs, after intervening on a client's behalf, advise the physician of what they have done to obtain the currently required order so as to appear that they did not breach institutional and legislative requirements. Further, the RNABC and the BCNU suggest that delegating medical functions to RNs is another mechanism to circumvent legal rigidities in order to meet client needs in a timely fashion.

They state that RNs' competence to carry out these activities is gained in various ways, including through basic nursing education programs, or through on-the-job experience or post-graduate education. The RNABC and the BCNU also state that the RNABC is prepared to develop additional regulatory mechanisms to ensure that only competent RNs perform a particular reserved act. The mechanisms proposed would be developed after a wide consultation with key stakeholders and would involve self-assessment and formal assessment procedures.

The Council accepts that RNs have the core competency (acquired through basic nursing education) to perform many of services on the Council's reserved acts list in a variety of settings, frequently with little supervision.

However, there is an important distinction between competency to perform a reserved act and competency to initiate a reserved act. As the RNABC stated in an August 7, 1998 letter to the Council regarding licensed practical nursing:

It is our understanding the Health Professions Council intends that when a reserved act is assigned to a specific profession, members of the profession have the authority both to (1) make the decision that the act is required and (2) carry out the act.

Thus the general concept of reserved acts is that once granted, the profession initiates and performs the act independently.

The RNABC appears to recognize this distinction in its *Guidelines for Specialized Nursing Skills and Delegated Medical Functions*. The guidelines distinguish between "basic nursing skills" and "specialized nursing skills". The former are acquired through a basic nursing education program while the latter require post-basic nursing education or inservice programs and work experience. In the same guidelines, the RNs also recognize that they perform medical functions upon delegation.

Nursing is a unique profession because while much of its practice can be considered independent, it is generally carried out as part of a health care team. Nurses are often given the discretion to decide when to initiate a procedure, usually through a physician's order.

Physicians frequently provide orders and rely on nursing professionals to determine when and how they will be carried out. The process of granting discretion to determine when to initiate and perform an act is best described as "performing an act under the order of another profession." Generally, the ability to perform such acts is within the core competency of RNs.

This process is different from the concept set out in the Council's delegation guidelines. Those guidelines contemplate that the delegation will be structured, including some indication of how the delegated act will be performed. It would generally apply when an act is an advanced or specialist practice which does not fall within the core competency of RNs.

To summarize, when a reserved act is performed pursuant to an order, nurses may make the decision to initiate the act, within the parameters of the order, and they are competent to perform it independently. In contrast, with delegation, nurses will be instructed when to initiate the task, and generally speaking, that task would not fall within the core competency of the nursing profession.

Finally, there are some instances in which RNs will independently initiate and perform a reserved act.

The Council will deal with each proposed reserved act in turn, having regard to these preliminary remarks.

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a. Making a Diagnosis

This proposed reserved act on diagnosis is identical to the Council's reserved act #1. The BCNU and the RNABC state the following:

When a registered nurse makes a diagnosis, the nurse determines the nature, cause or manifestation of a client's condition based on an assessment of the information obtained from the individual's history, the findings or a comprehensive health examination and, where necessary, laboratory or diagnostic tests, or other examinations.

The BCNU and the RNABC further state that the traditional distinction between medical diagnosis and "other" or nursing diagnosis is unnecessary. They add that diagnosis falls within the current and proposed scope of practice of RNs. More importantly, the RNABC and the BCNU contend that if granted this reserved act, RNs must be able to order the tests necessary to undertake differential diagnosis and necessary, subsequent treatment. Finally, the RNABC and the BCNU argue that RNs must also have access to the laboratory and diagnostic facilities where tests are performed. They state that there should be no artificial barriers that prevent laboratory physicians from accepting referrals or requests for laboratory tests from RNs.

With respect to RNs' competence to make diagnoses, the RNABC and the BCNU state that they develop their competence like physicians, by a combination of academic education and hands-on experience, which includes:

- comprehensive health assessment techniques for all developmental stages, using a systems-based approach and including history taking and physical assessment and the use of an appropriate range of diagnostic tests and screening tools to determine the health status of clients across the life span;
- critical thinking and diagnostic reasoning skills in assessing, diagnosing and managing the care of clients in all health care settings; and
- knowledge of the pathophysiology of acute and chronic illnesses and injuries.

Further, the RNABC and the BCNU state that RNs presently independently diagnose a client's condition in a variety of settings, such as:

- community health RNs diagnosing communicable diseases such as chicken pox and measles;
- RNs in acute and long-term facilities diagnosing atrial fibrillation, fetal distress, venous stasis ulcer, hypo/hyperglycemia, myocardial infarction, fractured hip and renal colic; and
- RNs in a number of settings (e.g. Medical Services Branch Nursing Station Facilities or hospital emergency rooms) diagnosing allergies and allergic reactions, dental problems, respiratory conditions, hemorrhage, thermal injuries, and seizure disorders including febrile convulsions.

The RNABC and the BCNU stress that RNs must be aware of their limitations in making a full and accurate diagnosis, and if a situation exists that is beyond an RN's competence, then the RN either consults with or refers the patient to another health care practitioner such as a physician.

The Capital Health Region agrees with the rationale for the reserved act on diagnosis and states that diagnosis is an essential component of independent practice of RNs and a reality in many regions of BC.

University of Victoria School of Nursing (UVIC) stresses that it fully agrees that RNs be granted the reserved act of diagnosis and thereby put an end to semantic variations of the term diagnosis in an attempt to stay within the current nursing scope of practice.

The Licensed Practical Nurses Association of BC (LPNABC) questions the competence of RNs to perform diagnosis.

The BC Psychological Association (BCPA) states that if RNs are granted the reserved act of diagnosis, a qualifying statement should be added so that diagnosis of mental illness is excluded. The BCPA states that RNs lack the competency to diagnose or treat mental illness.

With respect to the request that RNs be allowed to order tests to undertake differential diagnosis, Castlegar and District Hospital (Castlegar) states this reflects a "physician assistant" role which goes beyond current training levels of educational institutions and would lengthen the training course.

The BC Medical Association (BCMA) submits that "*the [RNs'] statement that a diagnosis is a diagnosis no matter what profession is performing the function is unsubstantiated.*" With respect to the claim that no artificial barrier be created to prevent laboratory physicians from accepting referrals for laboratory tests from RNs, the BCMA states that such referrals and requests are accepted from no group that has not given proof of adequate education and training in the selection and interpretation of tests. The BCMA states that it is essential that tests are ordered only by persons with fundamental training and background as a diagnostician. Also, the BCMA states that the final statement regarding the limitations in ability to make a full and accurate diagnosis betrays the necessity for proper and extensive education and training prior to accepting responsibility for making a diagnosis. In short, the BCMA submits that RNs are not trained or educated to perform diagnosis.

Finally, the BC Association of Podiatrists (BCAP) and the Board of Examiners in Podiatry (BOEP) state that diagnosis should be restricted to situations where a doctor is not reasonably available.

In its Working Paper the Council stated:

The Council believes it important to distinguish between diagnosis and assessment. Essentially, diagnosis is the identification of the cause of signs or symptoms. Assessment is a process of observation and evaluation of the physical status or progress of a patient, which may involve observation of symptoms, but does not include naming or identifying a disease, disorder, or condition as the cause of these symptoms.

In the Council's view, all health care practitioners assess a client's progress and response to services rendered. Practitioners who offer assessments have provided information to the Council on this issue, either in recent applications for designation or in submissions in the scope of practice review. Such practitioners include: counsellors, rehabilitation practitioners, prosthetists and orthotists, athletic trainers and recreation therapists.

In the Council's view, it is the identification of a disease, disorder or condition as the cause of signs or symptoms of the individual which should be a reserved act, and the process of assessment should continue to be in the public domain. Both regulated and unregulated practitioners would be free to perform assessments during the course of providing health care services, subject always to the proposed general risk of harm clause.

Thus, there is a distinction between diagnosis and assessment.

The services described in the joint submission constitute assessment, not diagnosis and therefore this reserved act should not to be granted to RNs. To the extent that certain groups of nursing professionals, such as out-post nurses, provide diagnostic services, the issue can be addressed through the Council's delegation guidelines.

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b. Physically Invasive or Manipulative Procedures

(1) Procedures on tissue below the dermis

The RNABC and the BCNU state that RNs commonly and independently perform the wound and skin management care that falls within this reserved act, and the following specific activities:

- Insertion of an intravenous catheter;
- Venipuncture and arterial puncture to obtain blood specimen;
- Wound debridement, irrigation or packing; and
- Wound suturing or removal of suture.

The BC Association of Podiatrists (BCAP) and the Board of Examiners in Podiatry (BOEP) state that procedures below the dermis should be more clearly defined to avoid giving RNs the licence to use this reserved act to perform surgery.

The BC Medical Association (BCMA) questions whether nurses have the education and training necessary to determine when these acts ought to be initiated.

The Council accepts that the performance of these services falls within the core competency of RNs.

(2) Procedures in the surface of the cornea

The RNABC and the BCNU state that although RNs do not currently perform procedures below the surface of the cornea, they perform procedures on, or in the surface of the cornea, in many situations and that nurses have the required competency to be able to perform this act.

The Council accepts that the performance of these services falls within the core competency of RNs.

(3) Setting or casting a simple fracture of a bone or reducing a dislocation of a joint

The BCNU and the RNABC propose to narrow the Council's reserved act by adding the word "simple" to exclude complex or compound fractures. The RNABC and the BCNU believe that the latter type of fractures require medical expertise. They also state that RNs do not carry out these activities unless they have received additional, or on-the-job training and education. The RNABC indicates its readiness to develop additional regulatory mechanisms to ensure competency for this reserved act.

Further, the RNABC and the BCNU state that the narrower act of setting or casting "simple" fractures is usually performed by RNs through medical protocols. However, the RNABC and the BCNU also indicate that RNs, while under the direction of a physician's order, usually make the initial diagnosis, immobilize or cast a simple fracture, or reduce a dislocated joint.

The BC Association of Podiatrists (BCAP) and the Board of Examiners in Podiatry (BOEP) comment that setting and casting a simple fracture should not be interpreted to allow RNs to treat podiatric fractures as they are not

trained or educated to perform this service.

The BC Medical Association (BCMA) states this act is requested without any reference to the RNs' education and competence in the ordering and reading of x-rays.

The Council accepts that nurses sometimes perform such services but they are not part of the core competency of RNs.

(4) Administering a substance by injection or inhalation, instillation or irrigation

The Council's reserved act #2(d) presently reserves "*administering a substance by injection, inhalation, or instillation through enteral or parenteral means*".

The BCNU and the RNABC interpret this reserved act to include the administration of substances such as intravenous fluids, oxygen and gases that do not qualify as listed drugs under the Council's reserved act #5, prescribing, compounding, dispensing or administering a drug. The RNABC and the BCNU state that RNs routinely administer intravenous fluids, oxygen and gases such as entonox and nitrous oxide.

Further, the RNABC and the BCNU have added the words, "instillation or irrigation" because these procedures carry potential risk of harm to the public:

For example, irrigation can result in dislodgment of a venous or arterial clot, rupture of a urinary catheter, or dislodgment of a shunt or drain in an operative site.

The College of Licensed Practical Nurses of BC (CLPNBC) agrees with the joint submission that the act of instillation and irrigation be added to the Council's list of reserved acts.

As a result of the report on the designation of dietetics and nutrition, the Council has added "instillation" to the list of reserved acts. The Council also agrees that irrigation presents a significant risk of harm, and has added it to the Council's list of reserved acts.

The Council accepts that the performance of these services falls within the core competency of RNs.

(5) Physically invasive or manipulative acts of putting an instrument, hand or finger(s) into orifices of the body

(i) putting an instrument, hand or finger(s) into the external ear canal, up to the eardrum

The BCNU and the RNABC agree with the BC Association of Speech/Language Pathologists and Audiologists that the reserved act of "putting an instrument, hand or finger(s) beyond the external ear canal" should state "into the external ear canal...". The Council agrees and has amended the reserved acts list. The RNABC and the BCNU state that this reserved act is initiated and performed by RNs without an order from a physician or other health care practitioner.

The RNABC and the BCNU state in their joint submission:

Registered nurses commonly use an otoscope to assess the inner ear and remove cerumen with an ear syringe inserted into the external ear canal. As with previous examples, registered nurses initiate these procedures and are capable of doing so without an order from a physician or other health care practitioner.

The Licensed Practical Nurses Association of BC (LPNABC) argues that all reserved acts of performing physically invasive and physically manipulative acts should be granted to RNs and also to LPNs.

The BC Association of Podiatrists (BCAP) and the Board of Examiners in Podiatry (BOEP) see this part of the request as another broad definition with the potential to allow RNs to perform surgery.

The performance of these acts for the most part falls within the core competency of RNs. However, the Council is of the view that cerumen management requires advanced certification including formal training and education, and therefore, does not fall within the core competency of RNs.

(ii) putting an instrument, hand or finger(s)

- **beyond the point in the nasal passages where they normally narrow,**
- **beyond the pharynx, and**
- **into an artificial opening into the body**

The RNABC and the BCNU state that RNs insert naso-gastric tubes for purposes of feeding, aspiration or lavage. RNs also perform oropharyngeal suctioning to assist stroke or frail patients to clear chest secretions. Finally, the RNABC and the BCNU state that RNs perform ostomy irrigation, change tracheostomy tubes and change gastronomy buttons and tubes.

The RNABC and the BCNU state that the reserved acts are carried out in completing physicians' orders. However, they state that RNs are competent to independently assess and initiate these procedures.

The Council accepts that these services fall within the core competency of RNs.

(iii) putting an instrument, hand or finger(s)

- **beyond the opening of the urethra and**
- **beyond the anal verge**

With regard to the above reserved acts the BCNU and the RNABC state that both are carried out with or without a physician's order, and where a physician's order exists, it is so broadly stated that full authority to determine the need and performance of the procedure is effectively delegated to the RNs.

The Council accepts that the performance of these services falls within the core competency of RNs.

(iv) putting an instrument, hand or finger(s) beyond the labia majora

The RNABC and the BCNU state that the above reserved act is within RNs' current scope of practice and can be performed independently by them. They cite several examples where RNs currently perform this reserved act, including insertion of a speculum to obtain a pap smear, or a swab for obtaining a vaginal or cervical

specimen, or forensic specimens subsequent to a sexual assault; insertion of fingers beyond the labia majora to determine cervical dilatation; and insertion of intrauterine devices or a dispenser for purposes of administering medication.

The Council accepts that the performance of these services falls within the core competency of RNs, except with respect to the insertion of intrauterine devices.

(v) maintenance or removal of instruments

Finally, the RNABC and the BCNU also ask that the reserved act of putting an instrument, hand or finger(s) into orifices of the body be clarified to define the word instrument and that RNs be granted the reserved act of maintaining and removing the instruments. The RNABC and the BCNU believe that the maintenance or removal of instruments presents a significant risk of harm that is separate from the act of putting an instrument, hand or finger(s) into body orifices.

Such services do not warrant inclusion on the Council's reserved acts list as they are essential safety services provided by virtually all health professions in the course of their practice, and no independent risk of harm has been established.

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c. Managing Labour and Conducting Vaginal Delivery of a Baby Within an Institutional Setting

The BCNU and the RNABC state that this act falls within RNs' current scope of practice. The RNABC and the BCNU clarify that though derived from a delegated medical function, the delegation for this reserved act is so open ended that RNs essentially make independent decisions. The Council notes that the proposed reserved act is limited to "vaginal delivery of a baby" and "within an institutional setting". The BCNU and the RNABC propose this narrowed act due in part to the reserved acts granted to midwives and to their view that an apparently uncomplicated labour and delivery can change and require immediate medical intervention. The RNABC indicates its readiness to implement additional regulatory mechanisms to ensure competence if granted the reserved act.

The Midwives Association of BC (MABC) and the College of Midwives of BC (CMBC) strongly oppose the RNs' request for this reserved act.

They state that the scope expansion undermines the safety, security, comfort and faith of birthing women, and is unnecessary in light of emerging professional midwifery services in BC. They oppose the proposal of the RNs to redefine their scope of practice to include managing labour and conducting vaginal delivery. They believe the requested act is a departure from the current nursing mandate insofar as it enables RNs to independently perform health services for which they currently must seek permission and direction from a physician. The MABC and the CMBC further state that the RNs' request to entrench a more specific version of current reserved acts does not serve the needs of BC women and their families, and undermines the emerging role of professional midwives. Further, the MABC and the CMBC contend that neither nursing education nor on-the-job experience prepares RNs to manage labour and delivery from a primary care perspective.

With respect to demonstrating competency, the MABC and the CMBC argue that the RNABC and the BCNU have neither the mandate nor jurisdiction to determine if their members are competent to provide primary care

for labour and delivery. With the establishment of the MABC and the CMBC, there are now established formal standards by which midwives must be evaluated. These standards have been set to protect the public and ensure a high quality of care for BC women. The MABC and the CMBC contend that less stringent assessments should not be allowed to diminish birthing women's confidence in the safety and competence of their care providers. Further, the MABC and the CMBC state that the RNABC and the BCNU have not suggested any concrete methods for formal assessment of competence of their members.

The MABC and the CMBC ask the Council to examine proposed changes to the scope of practice for RNs regarding managing labour and vaginal delivery in the context of the Council's own comments in its *Working Paper*.

The Midwifery Task Force of BC (MTFBC) states it is inappropriate to include normal vaginal delivery in the RNs' scope of practice without first demonstrating there would be significant improvement in the care for birthing women. It also states that the RNABC/BCNU proposal to allow RNs to manage normal labour delivery contradicts the RNABC's previous support and recommendation for the integration of midwifery services. Specifically, it contradicts an RNABC statement supporting a model of maternity care where continuity of care exists. Further, the MTFBC states that if nurses were permitted to conduct normal vaginal deliveries in hospitals, it foresees a future where such hospitals would be even less likely to grant privileges to registered midwives than they presently do.

With regard to the claim that RNs already "*conduct normal deliveries as a delegated medical function*", the MTFBC states that it has seen no documentation supporting the statement, and if nurses are indeed conducting vaginal deliveries on a regular basis, there is currently no structure in place to assess their competency to do so. In sum, the MTFBC states that RNs who wish to conduct normal vaginal deliveries must first be required to undertake extensive training, similar to the training required for midwives, in order to provide for public safety.

The BC Medical Association (BCMA) does not support this request and states that the accuracy of the self-reported assessment and the actual rate of registered nurse-managed deliveries need to be verified.

The Council does not doubt that RNs are involved in various aspects of managing and conducting delivery. However, such RNs specialize in this practice area, and the Council does not accept that these services fall within the core competency of RNs.

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d. Applying or Ordering the Application of a Hazardous Form of Energy

The RNABC and the BCNU identify several forms of hazardous energy that RNs commonly apply or order independently: bilirubin lights for neonates or x-rays for diagnostic purposes, defibrillation, cooling/heating blankets and external pacemakers. The RNABC and the BCNU explain that in some situations, both the authority to order and apply are required such as with defibrillation, cooling/heating blankets and external pacemakers.

The BC Association of Medical Radiation Technologists (BCAMRT) is opposed to RNs performing this reserved act. It believes that these procedures should be ordered by a physician as they are highly sophisticated examinations and require expertise beyond that of a registered nurse. The BCAMRT agrees that in special circumstances where a physician is unavailable a registered nurse should be allowed to proceed with the order

of basic x-rays to expedite the speedy treatment of the patient. It also questions the ability of the registered nurse to correctly interpret x-rays.

The BC Medical Association (BCMA) states that the RNs did not supply information about adequate theoretical and practical education regarding this reserved act.

The Council does not accept that these services fall within the core competency of RNs.

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e. Prescribing, Compounding, Dispensing or Administering a Listed Drug

The RNABC and the BCNU adopt the definitions found in the Council's reserved acts list for this reserved act. They state that RNs commonly prescribe medications under the authority of medical protocols in different settings, such as in rural communities where physicians are unavailable, in acute care settings or in community health centres. The RNABC and the BCNU recognize the need for additional education and possible regulatory mechanisms by the RNABC before a RN is granted prescriptive authority.

The RNABC and the BCNU also state that if granted the authority to prescribe drugs, RNs must also be granted the authority to dispense medications. The two groups state a process is currently in place which allows RNs to dispense a defined quantity of medications in emergency or specified conditions, such as when no in-hospital pharmacist and physician is available and no community pharmacy is accessible, or when there is urgency to the dispensing because of the patient's unique needs.

Further, the RNABC and the BCNU state that the act of compounding a drug is carried out by RNs on a daily basis. With regard to administering drugs, the RNABC and the BCNU state that this falls within RNs' current scope of practice and is common to virtually every RNs' practice.

University of Victoria School of Nursing (UVIC) emphasizes that this reserved act be granted to RNs in their role as primary providers of direct care to clients in all settings where health care is delivered, and as the profession in most regular contact with patients.

The College of Licensed Practical Nurses of BC (CLPNBC) requests that this reserved act be carried out by LPNs. It states that LPNs have had the competence to administer drugs since 1984. The CLPNBC clarifies that it is not asking for the reserved act of prescribing or dispensing a drug.

The BC Medical Association (BCMA) is strongly opposed to granting this reserved act to RNs. The BCMA states that this reserved act is the most hazardous of all the acts requested. It states that nurses have not obtained anything approaching the level of knowledge and application of pharmacology and pharmacotherapeutics acquired by a physician. It states that further evidence is needed of the training in the nursing program.

This reserved act is very dangerous. Improper prescription or administration of a drug can have fatal consequences. Further, the incidence of drug related complications is significant.

The Council is not satisfied that this entire reserved act, particularly "prescription", is within RNs' core competency. However, the administration of drugs prescribed by a physician is clearly within the core

competency of RNs.

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f. Administration of and Monitoring Initial Doses of Drugs for Unstable Clients or Those with Unpredictable Outcomes

The BCNU and the RNABC propose that this reserved act be added to the Council's reserved acts list and be granted to RNs. Further, the two groups offer the following definitions:

For the purpose of this reserved act:

"administration" of the initial dose includes the prior assessment of the patient, and giving the listed drug

"monitoring" means evaluating the patient for signs of efficacy or side effects of the administered listed drug; and

"initial dose" means the amount of a listed drug that is to be administered in a period of time defined by the manufacturer's specifications as being sufficient for the efficacy or side effects of the drug to become apparent.

The RNABC and the BCNU state that the intent of this proposed reserved act is to ensure that health providers who are competent to determine the appropriateness of a medication and recognize and deal with potentially negative side effects, in a timely fashion, administer and monitor the initial dose for unstable patients or those with unpredictable outcomes. They state that RNs' education program enables them to look for and recognize negative drug-on-drug or drug-on-patient effects.

This proposed act is already encompassed within the current version of reserved act #5 of the Council's list, "*prescribing, compounding, dispensing or administering by any means a [listed drug]*".

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2. General Comments From Respondents Regarding Proposed Reserved Acts

The College of Licensed Practical Nurses of BC (CLPNBC) generally agrees with the proposed reserved acts for RNs, with the exception of reserved act e), prescribing, compounding, dispensing or administering a listed drug, above. Further, the CLPNBC states that the initiation of reserved acts for nursing should not be done solely by RNs but by all three nursing groups.

The Licensed Practical Nurses Association of BC (LPNABC) finds the proposed reserved acts appropriate but adds that they will limit the current practice of other nursing disciplines, including LPNs. The LPNABC asserts that the self-assessment of competence process described by the RNABC also applies to LPNs as they are

expected to recognize the limits of their competence. The LPNABC states it would be counter-productive if the reserved acts proposed by the BCNU and the RNABC are granted solely to RNs. The Health Employees' Union (HEU) echoes the statements of the CLPNBC and the LPNABC and states that all three nursing categories, including LPNs, have the competence to initiate care and services associated with the appropriate reserved acts.

The BC Association of Podiatrists (BCAP) and the Board of Examiners in Podiatry (BOEP) have serious concerns with the revised scope of practice submission, particularly with podiatric nursing care. The BCAP and the BOEP question the claim by the RNABC and the BCNU regarding training and regulatory mechanisms with respect to nursing foot care. The BCAP and the BOEP state they have not been consulted on either issue. Further, they question the reliability of the self-assessment method proposed by the RNABC and the BCNU in the face of increasing "entrepreneurial endeavours" by RNs who provide podiatric care.

Castlegar and District Hospital (Castlegar) states that adding to the scope of reserved acts and then developing additional regulatory mechanisms appears to add red tape and bureaucracy. Generally, it characterizes the proposals as ambitious.

The BC Medical Association (BCMA) states that the RNs must demonstrate competence for all requested reserved acts. It states that it is incumbent upon any profession to develop and define standards of education, training and evaluation prior to seeking the right to expand its scope of practise.

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3. The Council's Recommendations

On [previous pages](#) the Council discussed the distinction between the delegation of a reserved act and the performance of a reserved act on the order of another health professional. When a reserved act is performed pursuant to an order, nurses may make decisions to initiate the act, within the parameters of the order, and they are competent to perform it independently.

However, several acts performed by nurses, particularly those described by the RNABC and the BCNU as being beyond core competency, are more appropriately dealt with as delegated acts. With delegation, the nurse will be instructed when to initiate the task, and generally speaking, that task would not fall within the core competency of the nursing profession. These acts generally require advanced training and education, and are performed by nurses in specialty practice areas. This process is provided in the Council's delegation guidelines.

The Council has accepted that nurses initiate and perform some of the reserved acts independently, without an order.

Therefore, the Council recommends the following reserved acts be granted to registered nurses:

Performing the physically invasive or physically manipulative act of putting an instrument, hand or finger(s):

- i. **into the external ear canal, up to the eardrum, but excluding cerumen management,**
- ii. **beyond the opening of the urethra,**
- iii. **beyond the labia majora, but excluding the insertion of intrauterine devices, or**
- iv. **beyond the anal verge.**

Other reserved acts are performed by the RNs but not initiated by them.

The Council recommends that the following reserved acts be granted to registered nurses to perform only if the act is ordered by a health practitioner who is authorized by legislation to perform the act:

a. Performing the following physically invasive or physically manipulative acts:

- i. **Procedures on tissue below the dermis, below the surface of a mucous membrane, and in the surface of the cornea;**
- ii. **Administering a substance by injection, inhalation, irrigation, or instillation through enteral or parenteral means;**
- iii. **putting an instrument, hand or finger(s)**
- iv. **beyond the point in the nasal passages, where they normally narrow,**
- v. **beyond the pharynx, or**
- vi. **into an artificial opening into the body.**

b. Administering by any means a drug listed in Schedule I or II of the *Pharmacists, Pharmacy Operations and Drug Scheduling Act*.

Several of the acts listed in the joint submission are not within the core competency of most RNs, require advanced training, and are performed only by RNs practising within specialty areas. These include:

1. Making a diagnosis, identifying a disease, disorder or condition as the cause of signs or symptoms of the individual;

2. Performing the physically invasive or physically manipulative act of setting or casting a simple fracture of a bone or reducing a dislocation of a joint;
3. Managing labour and conducting vaginal delivery of a baby within an institutional setting;
4. Applying or ordering the application of a hazardous form of energy including diagnostic ultrasound, electricity, magnetic resonance imaging, lithotripsy, laser and x-ray;
5. Administering and monitoring initial doses of listed drugs for unstable clients or those with unpredictable outcomes.

Involvement of RNs in these acts is better dealt with through the Council's delegation guidelines.

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C. SUPERVISED ACTS

The RNABC does not identify any specific acts which may be performed by persons supervised by RNs.

The RNABC's position is that creating a list of supervised tasks is not feasible given the broad range of nursing services provided by RNs. The RNABC is of the view that their *Guidelines for the Delegation of Nursing Tasks and Procedures* are sufficient to allow safe provision of nursing tasks and procedures by persons other than RNs, including LPNs and family members.

The *Terms of Reference* imply that the Council will, for each reserved act granted to nursing by RNs, determine the circumstances in which the act may be performed by someone other than a member of that profession. The Council considered this issue in detail in its recent preliminary report regarding the scope of practice of medicine. The Council first noted the submissions of the CPSBC:

In its submission, the College makes a compelling argument that legislation is a blunt instrument to deal with this issue. The College states that the issue of delegation and supervision is a question of individual competence and the circumstances of each case, and that supervision of certain acts can be addressed only after a careful review of all the circumstances surrounding a particular act and by imposing, where necessary, clear guidelines, restrictions or conditions on such supervision.

The College further submits that compiling a list of acts which may be delegated or performed under supervision would not adequately address the complexities of medical situations which present to physicians nor would it protect the public. The College notes that there will be situations where, because of the individuals involved, the site or location, or the specific nature of the presenting problem, it may not be appropriate to delegate an act which might otherwise be capable of delegation.

The Council accepted this submission and stated as follows:

The Council accepts much of this submission, and believes that it would be better to take a general approach to the issue of supervision. The general thrust of the approach is that the decision as to whether an act can be performed under supervision should be left up to the health professions, and that a set of principles embodying the duties of the delegating professional and his or her regulatory college be established and enacted into legislation when the shared scope of practice model takes effect. The principles are derived largely from the CMA's Guidelines for the Delegation of a Medical Act which the College enclosed with its submission.

As a result, the Council stated that supervised acts would not be dealt with individually for each profession, and made a general recommendation regarding this issue and stated:

The Council believes this general approach to supervised acts more accurately reflects the reality that procedures to be delegated vary from profession to profession and may include subsets and variations of reserved acts and further, may be performed under a myriad of circumstances and conditions.

In its preliminary report on the scope of practice of medicine the Council also noted the following:

- *Although this term of reference refers to "supervised" acts, it is intended to encompass any situation where someone other than the person to whom the reserved act has been granted performs that act. In other words, this term of reference refers to both delegation and supervision.*
- *This proposal is not intended to apply on a case-by-case basis. The requirement for approval of the governing body is meant to apply generally and not to individual cases, and would be satisfied by, for example, a general protocol in respect of delegation of reserved acts.*

This general position should be applied to all professions. The general position is largely a recognition that a regulatory body is in the best position to determine when other health professionals can perform services under supervision, and thus a regulatory body should be charged with determining when delegation is appropriate in accordance with the principles set out above.

The Council wishes to emphasize that the issue of delegation arises only with respect to reserved acts.

Therefore the Council recommends that a provision be enacted which sets out the duties of a health professional and his or her regulatory college when delegating a reserved act. The provision should require the following:

- **The assigning health professional's governing body must provide assent to the proposed reserved act being performed by someone else;**
- **The reserved act to be assigned as well as the level of supervision must be clearly defined and circumscribed by the assigning health professional's governing body;**
- **Where the person to whom the act will be assigned is a member of a self-regulating health profession, his or her governing body must approve of the assigning of the reserved act;**
- **The instruction to perform the act must be made in writing either by way of a general written protocol or through a case-specific instruction;**

- **The assigning health professional must be satisfied that the individual who will be performing the act has the necessary skills and training to perform the act safely;**
- **The assigning health professional must ensure that the person who will be performing the act accepts the assignment.**

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D. RESERVED TITLES

Reserved titles are titles reserved exclusively to a health profession. Reserved titles afford a means for consumers to identify the different types of health care providers, to distinguish the qualified from the unqualified, and to differentiate those practitioners who are regulated from those who are not. Titles must adequately serve the public in describing the practitioner and the services being provided and must distinguish the practitioner from others performing services outside the jurisdiction of the college.

The RNABC proposes to maintain the current titles in the [Nurses \(Registered\) Act](#) (NRA): "Registered Nurse", "R.N.", "Licensed Graduate Nurse", "L.G.N.", and "Nurse". Presently, the generic term "nurse" is granted to registered nurses, registered psychiatric nurses, licensed practical nurses, and Christian Science nurses.

The RNABC states that the licensed graduate nurse (LGN) category was created to "grandfather" in a group of nurses. LGNs are persons who did not meet the requirements for registration as RNs in 1988. They were granted the title licensed graduate nurse, as long as they were employed in a capacity substantially equivalent to an RN and had graduated from a school of nursing that had standards substantially equivalent to those of any approved school of nursing. The RNABC states that the LGN category is now closed and will eventually disappear as individual LGNs leave the profession or become registered.

The BCNU for the most part agrees with the RNABC submission but makes an additional submission about the use of the generic title "nurse". The BCNU states that only RNs and RPNs should be entitled to use the term "nurse", and that LGNs be allowed to use the title only until such time that they are registered under the HPA as RNs.

The BCNU proposes that LPNs, Christian Science nurses, and student nurses not be allowed to use the title. The BCNU submits that LPNs should not call themselves nurses because they do not share the same scope of practice with RPNs, LGNs and RNs, and they receive significantly less training. Removing LPNs' ability to use the title "nurse" would decrease the public confusion which, the BCNU states, now exists. The BCNU also makes reference to the NRA provision allowing for use of the title "nurse" by RNs or RPNs from another jurisdiction who are employed in BC for 30 days or less. The BCNU suggests that the HPA include wording to show that the extra-provincial registrants are not registrants of the RNABC.

With respect to Christian Science nurses the BCNU explains that the Ministry of Health justified the use of the title "nurse" after representatives of Christian Science lobbied the government for it. The BCNU states that no other Canadian jurisdiction has created a similar amendment to its nursing legislation. It asserts that Christian

Science nurses' education is different from RNs, LGNs and RPNs, and their knowledge is derived from spiritual rather than from science and empirical health care practice.

Finally, as regards student nurses, the BCNU states that like physicians/surgeons who take their undergraduate medical training and are not permitted to call themselves "doctor", "physician" or "surgeon", student nurses should not be allowed to call themselves "nurse" until they are registered with either the RNABC or the RPNABC.

The College of Licensed Practical Nurses of BC (CLPNBC) agrees with the proposed reserved titles listed in the joint submission. It also states that it cannot understand the BCNU proposal to eliminate the title "nurse" as a reserved title. The Licensed Practical Nurses Association of BC (LPNABC) argues that the title "nurse" should be reserved as per the comments of the RNABC. It strongly disagrees with the contention by the BCNU that the title "nurse" be taken away from LPNs.

The Health Employees' Union (HEU) strongly objects to the BCNU position. It states that LPNs have been an integral part of the nursing profession in BC. It cites the Ontario situation where practical nurses and RNs are regulated by the same body and are authorized to perform the same controlled (i.e., reserved) acts. The HEU states that the competency of BC's LPNs parallel those in Ontario and other provinces.

Many submissions express general support for the RNABC's submission on titles, including the BC Society of Occupational Therapists (BCSOT), the BC Association of Community Care (BCACC), the BC Medical Association (BCMA), the BC Association of Podiatrists (BCAP), the College of Psychologists of BC (CPBC), the Greater Victoria Hospital Society (GVHS) and the Skeena Health Board.

Several submissions, such as the Licensed Practical Nurses Association of BC (LPNABC), the Registered Psychiatric Nurses Association of BC (RPNABC) and Manitoba Health state that the title "nurse" should always be accompanied by a descriptive title, such as "Registered" or "Licensed Practical".

The Health Employers Association of BC (HEABC) indicates that the widespread use of the titles "nurse", may be confusing given that it may be used by nurses with widely varying levels of certification. A similar submission was made by BC Institute of Technology (BCIT), and the Ministry of Education, Skills and Training (MEST).

The Council has carefully considered the BCNU's proposal regarding the title "nurse", and the submissions received. The proposal is a request to change the existing law regarding the use of the title "nurse". The Council's *Terms of Reference* indicate that the primary criteria for considering reserved titles is whether they adequately serve the public. The Council has not been presented with any significant evidence that the use of the current system for use of the generic term "nurse", which allows RNs, RPNs and LPNs to use the title, has led to any confusion amongst the public.

Therefore, the Council recommends that the following titles be reserved for members of the profession:

- **Registered Nurse,**
- **R.N.,**
- **Licensed Graduate Nurse, and**
- **L.G.N.**

The Council recommends that the title "nurse" be reserved for registered nurses, registered psychiatric nurse, licensed practical nurses and Christian Science nurses.

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E. OTHER ISSUES

1. Name of the Regulatory Body

In British Columbia, the name of the body responsible for regulating nursing by RNs is the "Registered Nurses Association of BC". Generally speaking, it is customary within the health professions to refer to the regulatory body as the "College", while the professional body is identified as the "Association". This is the practice in British Columbia, and most other Canadian jurisdictions. This practice greatly assists the public in determining the respective roles of the two bodies.

Therefore, the Council recommends that the name of the regulatory body, the "Registered Nurses Association of BC", be changed to the "College of Registered Nurses of British Columbia".

2. Abolition of Separate Nursing Categories

The Council notes that various submissions propose that separate nursing categories be abolished by requiring LPNs to upgrade their education and qualify as RNs. Another submission proposes to abolish the profession of registered psychiatric nursing and yet another calls for the elimination of the category of licensed practical nursing. This issue is beyond the Council's mandate for this review and was not addressed by the Council.

3. Nurse Practitioners

The implication of much of the BCNU and RNABC submission is that all members of the RNABC should be entitled to practice as independent nurse practitioners. For example, they state:

Granting registered nurses reserved acts should also improve access to a number of health care services that are currently provided exclusively by physicians. It should reduce health care costs as nurse practitioners are known to assist clients to more effectively manage their own health issues, prescribe fewer medications and other interventions, and focus more on health promotion and illness prevention. [Emphasis added.]

The notion of wholly independent practice by nurses is embodied in the nurse practitioner concept. A nurse practitioner is a professional trained and educated to perform primary health care similar to that provided by medical practitioners.

The Ontario government has created just such an independent class of nursing professionals through legislation. The initiative was preceded by a lengthy review process and in particular, by establishing an appropriate training program. Early in 1994, the Ontario Ministry of Health formally launched a nurse practitioner project to consolidate and acknowledge the role that nurse practitioners had been fulfilling in Ontario for a

number of years.

According to the Ontario Minister of Health, nurse practitioners are RNs who have additional nursing education. The Minister proposed amendments in favour of nurse practitioners to a regulation under the *Regulated Health Professions Act*, SO 1991, c.18 (RHPA) which exempts certain persons from the prohibition against performing controlled acts. This proposed exemption was met with strong opposition leading the Minister to refer the intended amendment to the HPRAC.

In March 1996, the Health Professions Regulatory Advisory Council (HPRAC) of Ontario submitted its report, *Advice to the Minister of Health, Nurse Practitioner Referral*, to the Minister of Health. The report is a 65-page comprehensive report that deals with the issue of whether nurse practitioners should be authorized to perform certain requested controlled acts.

Of the 13 controlled acts contained in the *RHPA*, nurse practitioners were granted three, as follows:

- Communicating a diagnosis, subject to the limit that diagnoses can only be communicated which:
 - » are reached through considering the individual's history, the findings of a comprehensive health examination, and where necessary, the results of laboratory tests and other investigations that the member is authorized to order or perform; and
 - » are reached after complying with the mandatory indicators for consultation or referral.
- Ordering a form of energy limited to diagnostic ultrasound, and in principle, the ordering of x-rays, subject to a review of the education program for nurse practitioners.
- Prescribing drugs limited to those designated in the regulations.

In contrast, the vast majority of regular members of the College of Nurses are currently authorized under section 4 of the *Nursing Act*, SO 1991, c. 32, to perform the following three controlled acts, on the order of a medical practitioner or some other health care professionals:

- Performing a prescribed procedure below the dermis;
- Administering a substance by inhalation or injection; and
- Putting an instrument, hand or finger beyond body orifices.

Nurse practitioners in Ontario are authorized to perform six of the 13 controlled acts, with significant limitations as to the controlled acts of diagnosis, ordering a form of energy, and prescribing drugs. In contrast, the vast majority of RNs perform reserved acts only on the order of a medical practitioner.

In the RNABC and BCNU submission a request is made for six of the seven reserved acts on the Council's list. RNs in BC are asking for more reserved acts than what the nurse practitioners of Ontario were granted. Further, they are requesting that all of its registrants be granted the six requested reserved acts. In contrast, the Ontario nurse practitioner program is limited to a defined class of registrants.

The Council is not suggesting that a nurse practitioner role is unwarranted. On the contrary, the Council concludes that the concept of nurse practitioners is sound, and ought to be explored further by the Minister. This type of review is beyond the Council's mandate for this scope of practice review.

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IV. RECOMMENDATIONS

1. The Council recommends the following scope of practice statement for registered nurses:

The practice of nursing by registered nurses is the provision of health care for the promotion, maintenance and restoration of health and the treatment and prevention of illness and injury, primarily by assessment of health status, planning and implementation of interventions, and co-ordination of health services.

2. The Council recommends the following reserved acts be granted to registered nurses:

Performing the physically invasive or physically manipulative act of putting an instrument, hand or finger(s):

- i. into the external ear canal, up to the eardrum, but excluding cerumen management,
 - ii. beyond the opening of the urethra,
 - iii. beyond the labia majora, but excluding the insertion of intrauterine devices, or
 - iv. beyond the anal verge.
- 3 The Council recommends that the following reserved acts be granted to registered nurses to perform only if the act is ordered by a health practitioner who is authorized by legislation to perform the act:
 - a. Performing the following physically invasive or physically manipulative acts:
 - i. procedures on tissue below the dermis, below the surface of a mucous membrane, and in the surface of the cornea;
 - ii. administering a substance by injection, inhalation, irrigation, or instillation through enteral or parenteral means;
 - iii. putting an instrument, hand or finger(s)
 - a. beyond the point in the nasal passages, where they normally narrow,

- b. beyond the pharynx, or
- c. into an artificial opening into the body.

b. Administering by any means a drug listed in Schedule I or II of the Pharmacists, Pharmacy Operations and Drug Scheduling Act.

4. The Council recommends that a provision be enacted which sets out the duties of a health professional and his or her regulatory college when delegating a reserved act. The provision should require the following:

- The assigning health professional's governing body must provide assent to the proposed reserved act being performed by someone else;
- The reserved act to be assigned as well as the level of supervision must be clearly defined and circumscribed by the assigning health professional's governing body;
- Where the person to whom the act will be assigned is a member of a self-regulating health profession, his or her governing body must approve of the assigning of the reserved act;
- The instruction to perform the act must be made in writing either by way of a general written protocol or through a case-specific instruction;
- The assigning health professional must be satisfied that the individual who will be performing the act has the necessary skills and training to perform the act safely;
- The assigning health professional must ensure that the person who will be performing the act accepts the assignment.

5. The Council recommends that the following titles be reserved for members of the profession:

- Registered Nurse,
- R.N.,
- Licensed Graduate Nurse, and
- L.G.N.

6. The Council recommends that the title "nurse" be reserved for registered nurses, registered psychiatric nurses, licensed practical nurses, and Christian Science nurses.

7. The Council recommends that the name of the regulatory body, the "Registered Nurses Association of BC", be changed to the "College of Registered Nurses of British Columbia".

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APPENDIX C

GLOSSARY AND ABBREVIATIONS OF NAMES

BC Association of Community Care	BCACC
BC Association of Medical Radiation Technologists	BCAMRT
BC Association of Podiatrists	BCAP
College of Licensed Practical Nurses of BC (formerly the BC Council of Licensed Practical Nurses)	CLPNBC
BC Dietitians and Nutritionists Association	BCDNA
BC Health Association	BCHA
British Columbia Institute of Technology	BCIT
BC Medical Association	BCMA
BC Nurses Union	BCNU
BC Psychological Association	BCPA
BC Society of Medical Technologists	BCSMT
BC Society of Occupational Therapists.	BCSOT
Board of Examiners in Podiatry	BOEP
Castlegar and Hospital District	Castlegar
College of Licensed Practical Nurses of BC	CLPNBC
College of Massage Therapists of BC	CMTBC
College of Midwives of BC	CMBC
College of Physicians and Surgeons of BC	CPSBC
College of Psychologists of BC	CPBC
Greater Victoria Hospital Society GVHSthe Health Employers Association of BC	HEABC
Health Professions Regulatory Advisory Council	HPRAC
Hospital Employees' Union	HEU
Licensed Practical Nurses Association of BC	LPNABC
Midwifery Task Force of BC	MTFBC
Midwives Association of BC	MABC
Ministry of Education, Skills and Training	MEST
Registered Nurses Association of BC	RNABC
Registered Psychiatric Nurses Association of BC	RPNABC
University of Victoria (School of Nursing)	UVIC
Vancouver Community College	VCC

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Health Professions Council POST-HEARING UPDATE OF PRELIMINARY REPORT: REGISTERED NURSES

Irvine E. Epstein, Q.C., Chair
Arminée Kazanjian, Member
David MacAulay, Member

March 2001

This Post-Hearing Update should be read in conjunction with the [Preliminary Report](#) for the profession.

The Council issued its [Registered Nurses Scope of Practice Review \(Preliminary Report\)](#) in March 2000. The public hearing was held on 12-13 June 2000. The following are changes to the *Preliminary Report* which arose from the submissions made either at the public hearing or in subsequent written submissions.

I. SCOPE OF PRACTICE

The Council's *Preliminary Report* recommended the following scope of practice for registered nurses:

The practice of nursing by registered nurses is the provision of health care for the promotion, maintenance and restoration of health and the treatment and prevention of illness and injury, primarily by assessment of health status, planning and implementation of interventions, and co-ordination of health services.

Many participants at the public hearing submitted that the scope of practice statement should refer to "palliation" as it is a significant part of nursing practice. The Registered Nurses Association of British Columbia (RNABC) stated:

(T)he omission of the word palliation is problematic, since no other word in the scope statement describes this important aspect of nursing. Scope of practice statements for registered nurses in other jurisdictions, such as Saskatchewan and Manitoba, make reference to this particular aspect of nursing's scope of practice. The phrase "promotion, maintenance and restoration of health" does not include the supportive activities that are part palliative care.

The School of Nursing, University of Victoria stated:

The administration of comfort and palliative measures is core to registered nursing practice in virtually every setting. With increased numbers of elders and chronically ill clients, most registered nurses can expect to care for dying people (and their families) regularly. The SOP statement, in requiring nurses to focus only on "promotion, maintenance and restoration of health", ignores the reality of dying and the vital role of nurses in caring for individuals (and their families) at the end of life. If palliation does not fall within nursing's scope of practice, who will provide nursing care to the dying?

Similar submissions were made to the Council by the Health Employers Association of British Columbia, the Public Health Nursing Leaders Council, the B.C. Cancer Agency, the Children's & Women's Health Centre of British Columbia, Providence Health Care, and the Vancouver Hospital and Health Sciences Centre.

The scope of practice statement is not intended to list all the activities a profession performs. It is intended to be succinct and generally to describe what a profession does and how it does it so that other professions and the public will know what to expect from the profession.

In developing the scope of practice statement for registered nursing the Council included the treatment of illness and injury and the planning and implementation of interventions. It was not the intention to exclude palliation but rather the Council felt it was included within the scope statement. However, as a result of the extensive submissions on this point, the Council is prepared to include palliation in the description of what registered nurses do.

Another issue mentioned in several submissions was that diagnosis should be added to the scope statement. The Council has decided not to include diagnosis in the scope statement and will address this issue when it considers reserved acts.

The Health Professions Council recommends the following scope of practice for registered nurses:

The practice of nursing by registered nurses is the provision of health care for the promotion, maintenance and restoration of health; the prevention, treatment and palliation of illness and injury, primarily by assessment of health status, planning and implementation of interventions; and co-ordination of health services.

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II. RESERVED ACTS

In its *Preliminary Report*, the Council recommended several reserved acts for registered nurses, some to be performed independently and some to be performed on the order of an authorized health professional:

The Council recommends that the following reserved acts be granted to registered nurses:

1. *Performing the physically invasive or physically manipulative act of putting an instrument, hand or finger(s):*
 - a. *into the external ear canal up to the eardrum but excluding cerumen management,*

- b. *beyond the opening of the urethra,*
- c. *beyond the labia majora but excluding the insertion of intrauterine devices, or*
- d. *beyond the anal verge.*

The Council recommends that the following reserved acts be granted to registered nurses to perform only if the act is ordered by a health practitioner who is authorized by legislation to perform the act:

1. *Performing the following physically invasive or physically manipulative acts:*
 - a. *procedures on tissue below the dermis, below the surface of a mucous membrane and in the surface of the cornea;*
 - b. *administering a substance by injection, inhalation, irrigation or instillation through enteral or parenteral means;*
 - c. *putting an instrument, hand or finger(s)*
 - i. *beyond the point in the nasal passages where they normally narrow,*
 - ii. *beyond the pharynx, or*
 - iii. *into an artificial opening into the body.*
2. *Administering by any means a drug listed in Schedule I or II of the Pharmacists, Pharmacy Operations and Drug Scheduling Act.*

Most of the submissions at the hearing criticised this portion of the Council's report. The submissions fell into two general categories. First were those who indicated that many of the reserved acts which the Council had recommended be performed on order were actually performed independently. Second, many respondents objected to the term "order," and felt that it would unduly restrict the practice of nursing. The Council will deal with the second point when it discusses in more detail the issue of order-initiated reserved acts.

On the first point, the Council is satisfied, based on the submissions received at the hearing, that some changes are necessary to its recommendations on reserved acts. In considering these changes, the Council reviewed the controlled acts granted to registered nurses in Ontario, as it is the only jurisdiction in Canada that has formally introduced a regulatory model similar to the one described in the Council's *Terms of Reference*.

Diagnosis (reserved act 1)

Reserved act 1 on the Council's list states as follows:

Making a diagnosis identifying a disease, disorder or condition as the cause of signs or symptoms of the individual.

In its *Preliminary Report*, the Council did not recommend granting diagnosis to registered nurses, and recommended that they only perform diagnosis when it is delegated to them by other health professionals authorized to perform it.

In reaching that conclusion, the Council was mindful of its distinction between assessment and diagnosis that it discussed in the *Shared Scope of Practice Model Working Paper (Working Paper)*. There, the Council described diagnosis as the identification of the cause of signs or symptoms. Assessment was described as a process of observation and evaluation, which may involve observation of symptoms but does not include identifying a disease, disorder or condition as the cause of those symptoms.

The Council felt that the process described by registered nurses is assessment, not diagnosis. At the hearing,

the College of Physicians and Surgeons supported this conclusion and stated that "(d)agnosis is beyond the scope of the average registered nurse."

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1. Pre-Hearing Submissions

Several submissions prior to the hearing suggested that most registered nurses do not perform diagnosis. For example, the LPNABC stated:

On review of the information submitted, it appears that diagnosing at a nursing level should be a post-basic competency of the Registered Nurse or that of a Nurse Practitioner. The question may be raised would this be beyond the scope of practice in the majority of cases without post-basic education? The Registered nurse does not have the education of a doctor, lab or x-ray technician.

The B.C. Psychological Association (BCPA) stated that if registered nurses are granted the reserved act of diagnosis, a qualifying statement should be added so that diagnosis of mental illness is a reserved act shared by psychology and psychiatry. The BCPA further stated that registered nurses lack the competency to order or interpret tests regarding possible mental illness or neuropsychological conditions. The College of Psychologists of British Columbia made a similar statement. It contended that registered nurses lack adequate training in diagnosing mental disorders and illnesses and neuropsychological disorders.

With respect to the registered nurses' request that they be allowed to order tests to undertake differential diagnosis if granted the reserved act of diagnosis, Castlegar and District Hospital stated this reflects a "physician assistant" role which goes beyond current training levels of educational institutions and would lengthen the training course.

The B.C. Medical Association made the following statement:

The statement that "a diagnosis is a diagnosis no matter what profession is performing that function" is unsubstantiated. ... It is unreasonable to expect a nurse with either two or four years training to assume the same responsibility as a physician who has studied for nine years.

The BCNU conceded that registered nurses are not competent to perform the whole reserved act of diagnosis as it is worded in the Council's Reserved Acts List. It stated that while registered nurses do identify conditions as the cause of signs or symptoms in a patient, for the most part registered nurses do not have the entry-level competencies to make such diagnoses.

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2. Public Hearing Submissions

Several participants at the public hearing submitted that diagnosis is an integral part of registered nursing. For example, the South Fraser Health Region stated:

By excluding diagnosis in the proposed statement, registered nursing practice as it currently exists in the South Fraser Health Region is not represented. Our RNs regularly use diagnosis as part of their daily activities. We believe that diagnosis represents the culmination of assessment, problem solving, professional judgement and decision making.

Similarly, the RNABC stated that it is common for registered nurses to identify diseases, disorders or conditions. However, they acknowledge that diagnosis of diseases and disorders is less common than diagnosis of conditions. They also state that in many cases registered nurses assess clients in order to reach a "presumptive" diagnosis in order to conduct further tests or refer to another health professional.

Several participants referred to the practice of public health nurses, stating that they frequently diagnose communicable diseases. For example, Simon Fraser Health Region states that public health nurses are "frequently contacted by the public to diagnose a communicable disease."

The Council also heard that other specialized or advanced practice nurses, such as those involved in First Call or Outpost Nursing Programs, may diagnose diseases and disorders. However, such diagnosis is generally carried out through detailed guidelines and/or protocols developed by specialist nurses who have advanced training and education. Unlike in Ontario, there is no formal program, recognized through legislation, which permits independent, primary care practice by nursing.

A joint submission to the Council's *Preliminary Report* by the B.C. Cancer Agency, Children's and Women's Health Centre of British Columbia, Providence Health Care, and Vancouver Hospital and Health Sciences Centre also stated that registered nurses diagnose and that excluding the reserved act of diagnosis from registered nursing practice will have negative consequences for patients. The following groups also submitted that diagnosis should be a reserved act for registered nurses:

- Clinical Nurse Specialist Group at Vancouver Hospital Health Sciences Centre,
- the B.C. Occupational Health Nurses Professional Practice Group – Vancouver Sub-Group,
- the Elk Valley and South Country Nurses Advisory Group, and
- the Vancouver/Richmond Health Board.

The Simon Fraser Health Region also submits that registered nurses diagnose and that they ought to be granted this reserved act. In this regard, the Health Region offered several definitions of the term, including:

Websters definition of diagnosis:

- *The act or process of deciding the nature of a diseased condition by examination of the symptoms; a careful examination and analysis of the facts in an attempt to understand or explain something; a decision or opinion based on such examination.*
- *The ability to "recognize, determine, assess, discern and decide appropriate interventions for clients"*
- *The statement that registered nurses "state client status in practice setting terminology, using verifiable information"*
- *"A decision about a problem/need that requires nursing intervention and management"*
- *It is common nursing practice to examine, assess and analyze symptoms and based on this process to decide a course of action*

The Health Region also refers to the term "nursing diagnosis" from the RNABC Standards of Practice which provides:

Nursing Diagnosis. A clinical judgment about individual, family or community responses to actual or potential health problems or life processes. Nursing diagnoses provide the basis for selection of nursing interventions to achieve outcomes for which the nurse is accountable.

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3. Ontario and Diagnosis

The Council has also considered the regulation in Ontario. There, the vast majority of registered nurses cannot communicate a diagnosis. Ontario did however create a special class of registered nurses, the extended class (EC), through which practitioners who meet the legislative requirements can act as independent, primary care practitioners. The entrance requirements include specialized training and education and successful completion of an examination. Members of the EC may communicate a diagnosis but only in a limited fashion. Diagnosis is limited to diseases or disorders that can be identified from

- i. the patient's health history,
- ii. the findings of a comprehensive health examination, or
- iii. the results of laboratory or other tests that the member is authorized to perform.

The tests which may be carried out by registered nurses (EC) are limited to those specifically prescribed in the regulations.

Further, registered nurses (EC) who diagnose are required to follow the prescribed standards of practice as set out in the *Expectations for Consultation with Physicians by Registered Nurses in the Extended Class (Primary Health Care Nurse Practitioners)*. The *Expectations for Consultation* focus on situations in which making and communicating a diagnosis extend beyond primary health care nurse practitioner practice into medical practice. Under the standards, the term consultation means an explicit request by a registered nurse (EC) for a specific physician to become involved in the care of a client for which the registered nurse (EC) has primary responsibility. Consultation is required when the registered nurse (EC) reaches the limits of primary health care nurse practitioner practice, beyond the registered nurse's (EC) ability for independent care.

The degree of participation by the physician may vary. Consultation may be in the form of an opinion and recommendation; an opinion, recommendation and concurrent intervention; or a transfer of care. The *Expectations for Consultation* are based on collaboration, assumptions and certain procedural and clinical expectations for consultation. Collaboration means working together with one or more members of the health care team who each make a unique contribution to achieving a common goal. The assumptions include accountability by the registered nurse (EC) and the establishment of a working relationship with the consulted physician, as well as the development of mutually agreeable structures and processes for consultation. The procedural expectations require the registered nurse (EC) to present the reason for and describe the consultation requested. The registered nurse (EC) must also appropriately document the request and outcome of the consultation. The clinical expectations describe in detail the symptoms or signs exhibited by the patient that alert the registered nurse (EC) to consult a physician.

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4. Conclusion

The Council accepts that these statements accurately describe the involvement of registered nurses in "diagnosis." The Health Region's submission, and many others, are based on the notion that it is inappropriate to distinguish between a "nursing diagnosis" and a "medical diagnosis." Many participants have described the process of nurses arriving at a conclusion and initiating interventions. Many terms were used to define this process, including "presumptive" diagnosis, "interim" diagnosis and "working" diagnosis. Confusion has arisen based on different understandings of the term diagnosis.

In communication with a Practice Adviser of the College of Nurses of Ontario, the difference between medical and nursing diagnosis was clarified. The Practice Adviser described medical diagnosis as done from the perspective of the pathology, physiology and anatomical framework. Nursing diagnosis is the conclusion reached at the end of the assessment of all the factors and is made from the perspective of what the nurse can then do to deal with the condition of the patient. Nursing diagnosis looks at the impact on the patient and at other factors that may stem from the disease. The Adviser stated that nurses do not diagnose the underlying disease but the sequelae.

The Council also found assistance regarding the distinction between medical and nursing diagnoses in the following definitions from *Taber's Medical Dictionary (17th edition)*:

Nursing diagnosis: Nurses, esp. those involved in patient care, are in virtually constant need to make decisions and diagnoses based on their clinical experience and judgment. In many instances, that process dictates a course of action for the nurse that is of vital importance to the patient. As the nursing profession evolves and develops, nursing diagnosis will be defined, and indeed specified, in accordance with the specialized training and experience of nurses, particularly for nurse practitioners and clinical nurse specialists.

Medical diagnosis: The entire process of determining the cause of the patient's illness or discomfort. The method of arriving at the diagnosis will depend upon a number of factors including the type of illness or injury present. Indeed, making the diagnosis of a simple and superficial laceration of the skin of the lower leg will be much less involved than would making the diagnosis of a laceration of the scalp. In the latter, the depth of the wound will be of utmost importance in determining the number of layers of the scalp to be sutured. Also the diagnosis of an obscure infectious disease or of an unexplained fever will involve clinical skills as well as sophisticated laboratory investigations that would not be required to diagnose a simple cold or influenza. Medical diagnosis is to be differentiated from nursing diagnosis, q.v.

Based on its review, the Council concludes that registered nurses do more than assess patients. They also make clinical judgments based on these assessments and take further actions as necessary. This process is described in the RNABC Standards of Practice referred to above. Therefore, the Council recommends the following reserved act for registered nurses which describes the nature of diagnosis in the practice of registered nursing.

The Health Professions Council recommends the following reserved act for registered nurses:

- 1. Performing a nursing diagnosis by making a clinical judgment of the patient's mental and physical condition that can be ameliorated or resolved by appropriate interventions of the nurse or nursing team to achieve outcomes for which the nurse is accountable.**

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B. Invasive or Manipulative Acts (Reserved Act 2)

Procedures on tissue below the dermis [Reserved Act 2(a)]

In its *Preliminary Report*, the Council recommended that registered nurses be granted the right to perform any procedures on tissue below the dermis with an order. The Council received several submissions that registered nurses perform many procedures below the dermis independently.

In Ontario, general class registered nurses are entitled to perform many procedures below the dermis, particularly activities associated with wound care and intravenous treatment.

Section 15(4)(1) and (2) of the *Ontario Nursing Act Regulations* state:

(4) The following are the procedures referred to in subsections (1), (2) and (3):

1. *With respect to the care of a wound below the dermis or below a mucous membrane, any of the following procedures:*
 - i. *cleansing,*
 - ii. *soaking,*
 - iii. *irrigating,*
 - iv. *probing,*
 - v. *debriding,*
 - vi. *packing,*
 - vii. *dressing.*
2. *Venipuncture to establish peripheral intravenous access and maintain patency, using a solution of normal saline (0.9 per cent), in circumstances in which,*
 - i. *the individual requires medical attention, and*
 - ii. *delaying venipuncture is likely to be harmful to the individual.*

Many of the submissions provided examples of situations in which nurses perform these services independently. In particular, many submissions referred to registered nurses' involvement with wound care and intravenous procedures, similar to those granted to registered nurses in Ontario. The Council is satisfied that such services do fall within the core competency of registered nursing.

The Health Professions Council recommends the following reserved act for registered nurses:

2(a)(i) For the purpose of wound care, performing the following physically invasive or physically manipulative act of procedures on tissue below the dermis or below the surface of the mucous membrane:

- **cleansing,**
- **soaking,**
- **irrigating,**
- **probing,**
- **debriding,**
- **packing,**
- **dressing.**

2(a)(ii) For the purpose of establishing peripheral intravenous access and maintaining patency using a solution of normal saline (0.9 per cent), performing the physically invasive or physically manipulative act of venipuncture.

The Health Professions Council recommends the following reserved act for registered nurses to perform only if the act is ordered by a health practitioner who is authorized by legislation to perform the act:

2(a) For purposes other than wound care, performing the physically invasive or physically manipulative act of procedures on tissue below the dermis, below the surface of a mucous membrane and in or below the surface of the cornea.

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2. Administering a substance [Reserved Act 2(d)]

In its *Preliminary Report*, the Council recommended that registered nurses be granted this procedure as a reserved act to be performed on order. This is the same situation as in Ontario where general class registered nurses may only administer substances by injection or inhalation on the order of an authorized health professional. Although various nursing groups outlined registered nurses' involvement with this reserved act, the Council is of the view that such services are performed on the order of another health profession. However, as the Council granted registered nurses the reserved act of venipuncture to establish peripheral intravenous access and maintain patency, using a solution of normal saline (0.9 per cent), this reserved act will have to be modified.

The Health Professions Council recommends the following reserved act for registered nurses to perform only if the act is ordered by a health practitioner who is authorized by legislation to perform the act:

2(d) Performing the physically invasive or physically manipulative act of administering a substance, other than a drug, by injection or inhalation, except as provided in reserved act 2(a)(ii).

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3. Putting an instrument, hand or finger into orifices in the human body [Reserved Act 2(e)]

The Council in its *Preliminary Report* recommended that registered nurses be granted the following parts of this reserved act to perform independently:

Performing the physically invasive or physically manipulative act of putting an instrument, hand or finger(s)

- i. *into the external ear canal up to the eardrum but excluding cerumen management,*
- ii. *beyond the opening of the urethra,*
- iii. *beyond the labia majora but excluding the insertion of intrauterine devices, or*
- iv. *beyond the anal verge.*

The Council also recommended that registered nurses perform the following parts of this reserved act only if ordered by a health practitioner who is authorized by legislation to perform them:

Performing the physically invasive or physically manipulative act of putting an instrument, hand or finger(s)

- i. *beyond the point in the nasal passages where they normally narrow,*
- ii. *beyond the pharynx, or*
- iii. *into an artificial opening into the body.*

Many submissions at the public hearing disagreed with the Council's recommendations on this reserved act. The B.C. Nurses' Union (BCNU), in its response to the Council's *Preliminary Report*, stated that the above order-initiated procedures fall within entry level competencies of registered nurses, and therefore, need not be order-initiated reserved acts. Likewise, the B.C. Occupational Health Nurses Professional Practice Group – Vancouver Sub-group stated that occupational health nurses are performing these acts currently without orders.

In Ontario, sections 15(4)(3.), (4.) and (5.) of the *Nursing Act Regulations* grant the following controlled acts to both general class registered nurses and registered nurses (EC):

3. A procedure that, for the purpose of assisting an individual with health management activities, requires putting an instrument

- i. beyond the point in the individual's nasal passages where they normally narrow,
 - ii. beyond the individual's larynx, or
 - iii. beyond the opening of the individual's urethra.
4. A procedure that, for the purpose of assessing an individual or assisting an individual with health management activities, requires putting an instrument or finger
- i. beyond the individual's anal verge, or
 - ii. into an artificial opening into the individual's body.

5. A procedure that, for the purpose of assessing an individual or assisting an individual with health management activities, requires putting an instrument, hand or finger beyond the individual's labia majora.

In addition to the foregoing, Ontario registered nurses (EC) are authorized to perform some of these acts specifically for the purpose of assessment or treatment of an individual. Section 17 of the *Nursing Act Regulations* states:

17. For the purpose of clause 5(1) of the Act, a registered nurse in the extended class may perform any of the following procedures if he or she meets all of the conditions set out in subsection 15(5):

...

3.. a procedure that, for the purpose of assessing or treating an individual or assisting an individual with health management activities, requires putting an instrument

- i. beyond the point in the individual's nasal passages where they normally narrow,
- ii. beyond the individual's larynx, or
- iii. beyond the opening of the individual's urethra.

At the public hearing the Council heard submissions that registered nurses in B.C. are performing similar activities.

The Council believes that there is an important distinction between performing physically invasive acts for the purposes of assessing an individual or assisting an individual with health management activities and for the purposes of treating an individual. Assessing means observing or evaluating a patient. Assisting with health management activities generally means helping people with self-care and activities of daily living. In contrast, treatment involves the application of a particular procedure for the amelioration or resolution of a disease, disorder or condition. Performing these physically invasive acts for the purposes of treatment presents a greater risk of harm and ought only to be performed by registered nurses on the order of an authorized health professional.

After reviewing these submissions and after examining Ontario's model, the Council is prepared to change its recommendation with respect to this reserved act.

The Health Professions Council recommends the following reserved act for registered nurses:

2(e) For the purpose of assessing an individual or assisting an individual with activities of daily living, performing the physically invasive or physically manipulative act of putting an instrument, hand or finger(s)

- i. into the external ear canal, including applying pressurized air or water;
- ii. beyond the point in the nasal passages where they normally narrow;
- iii. beyond the pharynx;
- 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.

The Health Professions Council recommends the following reserved act for registered nurses to perform only if ordered by a health practitioner who is authorized by legislation to perform the act:

2(e) For the purpose of treatment, performing the physically invasive or physically manipulative act of putting an instrument, hand or finger(s)

- i. into the external ear canal, including applying pressurized air or water;
- ii. beyond the point in the nasal passages where they normally narrow;
- iii. beyond the pharynx;
- 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.

C. Managing Labour or delivery of a baby (Reserved Act 3)

The Council's reserved act 3 states, "managing labour or delivery of a baby." The BCNU and RNABC proposed that registered nurses be granted a limited portion of this reserved act: "managing labour and conducting vaginal delivery of a baby within an institutional setting." The joint proposal indicated that a special class of obstetrical nurses, who have additional post-graduate training and expertise in obstetrics, provide these services in many institutional settings.

In its *Preliminary Report* the Council stated that it did not "doubt that registered nurses are involved in various aspects of managing and conducting delivery." However, the Council felt that such registered nurses "specialize in this practice area," and that these services do not fall within the core competency of most registered nurses.

Several submissions received prior to and at the hearing reiterated the BCNU/RNABC proposal, and indicated that registered nurses frequently perform services in this area.

The RNABC submitted:

As indicated in the RNABC-BCNU joint submission to the Health Professions Council, managing labour currently falls within the scope of nursing practice (BCNU & RNABC, p. 16). Other than prescribing medications, nurses manage the normal progress of labour and identify any deviations from normal. These are entry-level competencies for registered nurses and are in the blueprint for the Canadian Registered Nurse Examination (1999). Most nurses who work in the perinatal area have more advanced competencies, which they have attained through specialty certification programs such as BCIT's certification program for perinatal nursing. RNABC believes that independent authority for the reserved act of managing labour must be granted to registered nurses.

...

Conducting a normal vaginal delivery of a baby within an institutional setting is common to perinatal registered nursing practice. RNABC believes it is not appropriate to use the emergency exemption for reserved acts for managing deliveries when this is a common occurrence and nurses in many settings are expected to deliver babies in the absence of the primary provider.

Many submissions at the hearing gave examples of registered nurses' involvement in this reserved act. Some referred to registered nurse involvement in monitoring labour; virtually all indicated that registered nurses are frequently called upon to deliver babies when physicians are unavailable. Generally, all participants conceded that this is an area of specialized practice for registered nurses. For example, the Simon Fraser Health Region stated:

Managing labour and delivery in institutional settings is a specialized nursing practice. Nurses employed in these areas within SFHR have the specialized knowledge, education and experience to practice in labour and delivery and in fact are required to possess such advance education, certification and experience prior to hiring. In addition, their competency is maintained and assessed annually through ongoing formal orientation, education and clinical practice support.

The discussion of this reserved act raised a more general criticism of the Council's preliminary recommendations, one which was advanced strongly by the RNABC. It stated that the Council's preliminary reserved act only granted reserved acts when it was satisfied that services fell within the core competency of registered nurses and thus failed to recognize advanced and specialized nursing practice.

The Council does not doubt that registered nurses with specialty training do perform the services proposed by the BCNU/RNABC, but we were not presented with detailed information about the programs in place to allow for advanced training and education of such practitioners. Moreover, the information received at the hearing confirmed that there is no universally accepted certification system in place, and a wide array of training and educational programs, which vary amongst institutions, are used to establish advanced practice capability. Such diverse arrangements are not in the public interest, and universal certification programs, regulated through the College, ought to be established for specialty and advanced practice. Indeed, the Council notes that both the RNABC and BCNU conceded towards the end of the hearing that additional regulatory mechanisms ought to be created. Both groups made detailed written submissions on this issue after the hearing.

The Council is prepared to recommend the granting of this reserved act to registered nurses to perform independently but only if additional regulatory mechanisms are established. This issue will be discussed further in the advanced/specialized practice section of this report.

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D. Application of Energy (Reserved Act 4)

In its *Preliminary Report* the Council decided that applying hazardous forms of energy is not within the core competency of registered nurses to perform independently. The Council did, however, recommend that registered nurses be entitled to perform this reserved act as a delegated function.

In Ontario, general class registered nurses are not authorized to perform this controlled act. However, registered nurses (EC) in Ontario are authorized to order x-rays and diagnostic ultrasounds. With regard to x-rays, registered nurses (EC) are authorized to order x-rays of the chest, the ribs, the arm, the wrist, the hand, the leg, the ankle or the foot of a human being, and mammography. Registered nurses (EC) are not authorized to operate the x-ray machine. With respect to ultrasounds, registered nurses (EC) are authorized to order the application of soundwaves for a diagnostic ultrasound of the abdomen, the pelvis (including obstetrical ultrasound) and the breast. It does not include performing or interpreting the ultrasound. Any other x-ray or ultrasound must be ordered by a physician either by means of a medical directive or a client-specific order.

Many participants submitted that registered nurses should be granted this reserved act. The Health Employers Association of British Columbia commented:

Nurses in acute care settings and rural clinics are required to apply potentially hazardous forms of energy in several ways, including cardiac defibrillation, external cardiac pacemakers, TENS (transcutaneous electric neuromuscular stimulator) as a pain control method, electrocardiography, ordering of x-rays and neonatal monitoring through ultrasound.

The RNABC believes that registered nurses perform this reserved act so frequently that it does not require additional regulatory mechanisms.

The Simon Fraser Health Region stated:

RNs initiate (order) X-rays routinely to confirm tube placements. This ensures safe and prompt instillation of enteral and parenteral substances. RNs apply electrical energy independently during cardiac arrest management (defibrillation) and adjust external pacemaker setting to ensure capture. In maternal child areas RNs routinely apply bilirubin lights to neonates. All of these practices are governed by agency guidelines, protocols and standards which have been developed by interdisciplinary teams at the regional level. RNs receive formal training and yearly testing in these specialized skills. Standards and protocols are annually reviewed to ensure best practice. [Emphasis added.]

The Council accepts that portions of this reserved act are often performed by registered nurses in many different settings. As confirmed in the Simon Fraser Health Region submission, the activities described in the submissions are generally performed under protocols, guidelines or patient-specific orders, and not independently. The Council now recommends that this reserved act should be an order-initiated act and not one performed as a delegated function.

The Health Professions Council recommends the following reserved act for registered nurses to perform only if the act is ordered by a health practitioner who is authorized by legislation to perform the act:

- 4. Applying a hazardous form of energy including diagnostic ultrasound and X-ray.**

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E. Prescribing, Compounding, Dispensing or Administering a Listed Drug [Reserved Act 5(a)]

In its *Preliminary Report*, the Council determined that the reserved act of administering a drug independently is not within the core competency of most registered nurses and therefore recommended it as an order-initiated reserved act. The Council did not grant registered nurses the reserved act of compounding a drug. This is similar to the situation in Ontario where general class registered nurses must receive an order to administer drugs and registered nurses were not granted compounding.

In Ontario, registered nurses (EC) have a broader scope to perform this reserved act. They are authorized to prescribe a range of drugs as per section 5.1(1)3 and 5.1(1)4 of the *Nursing Act* which state:

- 3. Prescribing a drug designated in the regulations.*
- 4. Administering, by injection or inhalation, a drug that the member may prescribe under paragraph 3.*

The Ontario *Nursing Act Regulations* list the specific drugs registered nurses (EC) may prescribe:

19.(1) For the purposes of paragraph 3 of subsection 5.1(1) of the Act, the following drugs are designated:

- 1. An immunizing agent set out in Schedule 2.*
- 2. A drug set out in Schedule 3.*
- 3. Any drug that may be lawfully purchased or acquired without a prescription.*

(2) If circumstances are set out opposite a drug set out in Schedule 3, a registered nurse in the extended class shall only prescribe the drug under paragraph 2 of subsection (1) in those circumstances.

The Ontario *Standards of Practice for Registered Nurses in the Extended Class* describes this reserved act in greater detail. Basically, Schedule 2 lists immunizing agents and Schedule 3 lists drugs that a registered nurse (EC) may prescribe. Section 19 (2) restricts the use of some of these substances by specifying the route and/or purpose for which they may be used. Thus, registered nurses (EC) cannot independently prescribe or administer substances not included on the lists and, for drugs for which the proposed purpose or route is included on the list, must comply with the stated requirements. Over the counter drugs are not included on the list as they do not require a prescription.

1. Compounding

The Council received submissions indicating that registered nurses in B.C. frequently compound substances as, for example, when drugs or supplements are added to IV solutions. The Council accepts this submission and believes that the act of compounding should be granted as a reserved act for registered nurses to be performed on order.

Thus, registered nurses will be entitled to compound a drug on the order of an authorized health professional.

2. Administration of Schedule II Substances

The Council also heard that registered nurses routinely recommend and administer substances on Schedule II of the *Pharmacists, Pharmacy Operations and Drug Scheduling Act*. Schedule II includes substances which are available without prescription but are kept in restricted areas of a pharmacy. Several submissions questioned why registered nurses should be prevented from accessing and using these substances when they are widely available to the public. The Council accepts these submissions.

The Health Professions Council recommends the following reserved act for registered nurses to perform only if the act is ordered by a health practitioner who is authorized by legislation to perform the act:

5(a) Administering or compounding by any means a drug listed in Schedule I of the *Pharmacists, Pharmacy Operations and Drug Scheduling Act*.

For the purposes of this reserved act, "compounding" means mixing ingredients, at least one of which is a drug listed in Schedule I of the *Pharmacists, Pharmacy Operations and Drug Scheduling Act*.

The Health Professions Council recommends the following reserved act for registered nurses:

5(a) Administering or compounding a drug listed in Schedule II of the *Pharmacists, Pharmacy Operations and Drug Scheduling Act*.

For the purposes of this reserved act, "compounding" means mixing ingredients, at least one of which is a drug listed in Schedule II of the *Pharmacists, Pharmacy Operations and Drug Scheduling Act*.

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The Council also heard that some registered nurses with specialty training prescribe and administer drugs independently. Reference was made to registered nurses operating in community health clinics, and other primary care nursing programs. The Council accepts that such practice is generally in the public interest.

However, as is the case with managing delivery, the Council believes that this is an advanced practice and that additional regulatory mechanisms ought to be in place.

Finally, the Council notes that BCNU, in its submission dated 5 June 2000, requests that reserved act 5(b) (designing, compounding or dispensing therapeutic diets) be granted to registered nurses "either by inference or necessary implication." BCNU states that neither RNABC nor BCNU requested this reserved act in their joint submission of March 1999 since the reserved act was first articulated by the Council only in August 1999. RNABC raised this issue with the Council in its response to the Council's application report on dietetics. BCNU contends that registered nurses design therapeutic diets for enteral administration and compound diets by mixing ingredients. It concedes, however, that registered nurses do not design or dispense diets for parenteral administration, and that registered nurses would require some minimum amount of post-basic training to perform this reserved act competently.

The Council is satisfied that this reserved act should be granted to registered nurses on order.

The Health Professions Council recommends the following reserved act for registered nurses to perform only if the act is ordered by a health practitioner who is authorized by legislation to perform the act:

5(b) Designing, compounding or dispensing therapeutic diets where nutrition is administered through enteral or parenteral means.

For the purposes of this reserved act, the following definitions shall apply:

"designing": the selection of appropriate ingredients for enteral or parenteral nutrition.

"compounding": mixing ingredients for enteral or parenteral nutrition

"dispensing": filling a prescription for enteral or parenteral nutrition.

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F. Allergy challenge testing (Reserved Act 7)

In its *Preliminary Report* the Council did not address this reserved act as it was not raised by the RNABC. In its presentation at the public hearing the RNABC stated:

This reserved act was not requested in the original RNABC-BCNU joint proposal. Registered nurses do not initiate this reserved act independently. However, they frequently carry out this act under the order of a physician and are able to recognize and treat anaphylaxis when necessary. RNABC requests that the Health Professions Council clarify that registered nurses are able to carry out these activities when they have a physician's order and not through delegation.

The Health Professions Council recommends the following reserved act for registered nurses to perform only if the act is ordered by a health practitioner who is authorized by legislation to perform the act:

7. Allergy challenge testing or allergy desensitizing treatment involving injection, scratch tests or inhalation, and allergy challenge testing by any means with respect to a patient who has had a previous anaphylactic reaction.

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III. RESERVED TITLES

The Council's *Preliminary Report* recommended the following reserved titles for registered nurses:

- *Registered Nurse,*
- *R.N.,*
- *Licensed Graduate Nurse, and*
- *L.G.N.*

The Council recommends that the title "nurse" be reserved for registered nurses, registered psychiatric nurses, licensed practical nurses and Christian Science nurses.

Although the title "Christian Science Nurse" appears in the current *Nurses (Registered) Act*, RSBC 1996, c. 335, the Council received no comment or submission on this title, nor did any of the nursing groups reviewed by the Council request this title. Therefore, the Council did not recommend that it be reserved.

The Health Professions Council recommends the following reserved titles for registered nurses:

- **"Registered Nurse",**
- **"Licensed Graduate Nurse",**
- **"Nurse", and**
- **any abbreviation of those titles.**

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IV. THE MEANING OF ORDER

In the *Preliminary Report*, the Council recommended that registered nurses be granted the right to perform several reserved acts on the order of another health professional who is authorized to perform the reserved act independently. There was widespread criticism of this term which indicated variously that such a requirement would seriously impair the ability of registered nurses to assist patients in a timely and effective manner. Much

of this criticism is misplaced as it is based on a misunderstanding about the use of the term "order." The Council did not intend the term to be interpreted as requiring a patient-specific instruction in every case. Rather, the term was meant to encompass the many means by which registered nurses currently perform many services.

The Council was presented with several different definitions of the term "order." Indeed, it appeared that each speaker had its own interpretation of the term, none of which properly conveyed the Council's intention as expressed in the *Preliminary Report*. In commenting on the issue of "orders," the BCNU made a valuable submission regarding terminology:

[T]he BCNU would caution the HPC not to rely on terms or definitions that different parties use in different context.

...

Because there is no agreement as to what these terms [protocols, guidelines] mean or a consensus that the HPC could rely on, the BCNU would suggest that it would be very useful if the Council created its own definitions of the terms it uses. In that way, everyone reading the Council's final report will be working from the Council's understanding of these terms, rather than applying their own, perhaps mistaken, interpretations.

In this respect, it is not critical that the HPC's definitions correspond with any particular definition used in the literature, the common law or current practice. The BCNU would suggest that what is more important is that these terms be defined by the Council so that their subsequent use by the Council can be understood by all without the need for further research or debate. In doing so, it is also important that the Council make it clear what the differences are between its defined terms.

The Council agrees with this submission and will clarify what was meant by the use of the term "order." Virtually all of the submissions dealing with this issue referred to such terms as "clinical practice guidelines," "clinical practice standards," "agency protocols" and "pre-printed orders." For example, the Simon Fraser Health Region, in speaking about various reserved acts, stated, "RNs develop and are guided by clinical practice guidelines and agency protocols for the safe enactment of these competencies." The submission also indicated that these processes are generally created through a collaborative process involving administrators and health care professionals.

Simon Fraser Health Region included several examples of such guidelines and protocols with its submission. As a general comment, it stated that regulatory structures must be "flexible" and create the ability to "adapt to the increasing chaos of change." The Council supports the need for flexibility, and indeed its intention with regard to order-initiated reserved acts was intended to ensure first, public safety and second, that health professionals and administrators would develop the processes themselves to meet the needs of the public. In other words, the Council's impression was that the present system of guidelines and protocols works well and should be facilitated by our recommendations.

For example, the Council heard from several participants at the hearing about public health nursing. The deputy provincial health officer stated:

As you have heard from my co-presenters, 50 per cent of B.C.'s routine immunizations are delivered by trained public health nurses operating according to defined provincial program policies and standards.

Similarly, prior to the hearing, the Public Health Nursing Leaders' Council stated:

Historically, public health nursing practice has been guided by various acts and regulations and by delegation of function by the medical officer of health.

...

For instance, the medical health officer is charged with responsibility for the health safety of children in the school setting. This duty is discharged by delegation of function to various health professionals, including public health nurses who provide well-defined immunization programs and work collaboratively with school district staff in the promotion of health and prevention of disease in the school population.

...

The current process of delegation as outlined in the Health Act is the most prudent for the delivery of population based services.

The process followed by public health nurses is set out in the *Health Act*, RSBC 1996, c. 179, and its regulations. The B.C. Centre for Disease Control is the primary co-ordinating body for prevention and control of communicable diseases in the province. Its authority to act on behalf of the provincial health officer is set out in the *Health Act*.

At the hearing, the College of Physicians and Surgeons of British Columbia stated that primary immunization programs:

[are] delegated by the provincial health officers to public health nurses with carefully worked out protocols for preliminary assessment, recognition of contraindications, administration and the giving of advice regarding complications and their management.

At the local level, immunization programs are carried out by local health authorities. Within each health authority, the medical health officer is responsible for prevention and control of communicable diseases in the community. Public health nurses collaborate with the medical health officers to provide immunizations and, where applicable, distribute vaccines to physicians and health care facilities in the community. Public health nurses deliver immunization through provincial policy and guidelines. The B.C. Centre for Disease Control's manual, *Communicable Disease Control Immunization Program* is one such guideline. Public health nurses must undergo an orientation process where they are supervised by more senior public health nurses before actual immunizations are performed.

The Ontario *Standards of Practice for Nurses in the Extended Class* contains a useful discussion of the term "medical directive" which serves to clarify further the Council's intention:

What is a "Medical Directive"?

First, it is important to understand what the terms "medical directive" and "medical protocol" mean, and how they relate to the terms "order" and "standing order".

- A medical "order" is a prescription for treatment or an intervention. It can apply to an individual client by means of a client-specific order, or to more than one individual by means of medical directive. As such, a medical order exists in one of two forms:
 - A "direct order" is client specific. It is a prescription of a procedure, treatment or intervention of a particular client, is written by an individual physician for a specific procedure/treatment/intervention to be administered at a specific time(s).
 - A "medical directive" or "medical protocol" is not client specific. It is a prescription for a procedure, treatment or intervention that may be performed for a range of clients who meet certain conditions. The medical directive identifies a specific treatment or range of treatments, the specific conditions that must be met and any specific circumstances that must exist before the directive can be implemented.

The Ontario Standards of Practice for Nurses in the Extended Class also states that the term "standing order" is not supported by either the College of Nurses of Ontario or the College of Physicians and Surgeons of Ontario:

In the past, a "standing order" was implemented for every client, regardless of the circumstances, with no judgment expected by the person implementing the order regarding its appropriateness. It is now recognized that knowledge, skill and judgment are critical, and that no order for treatment, regardless of how routine it may seem, should be automatically implemented.

Thus, in Ontario the term order refers to both patient-specific and general orders, but not standing orders. Similarly, the Council intended that the term order encompass both. The Ontario Standards of Practice provides further details about orders.

When is a Medical Order Required?

The health care team needs to determine whether a procedure can safely be ordered by means of a medical directive, or whether direct assessment of the client by the physician is required before the procedure is implemented. Procedures that require direct assessment of the client by the physician require a client-specific order.

What Information Does a Medical Directive Need to Include?

There are a number of specific components required in a medical directive. These are:

- A description of the procedure(s) being ordered;
- Specific client conditions which must be met before the procedure(s) can be implemented;
- any circumstances which must exist before the procedure(s) can be implemented; and
- any contraindications for implementing the procedure(s).

The degree to which client conditions and situational circumstance are specified will depend on the client population, the nature of the orders involved and the expertise of the health professionals implementing the directive. The following are also required:

- the name and signature of the physician authorizing the medical directive; and

- the date and signature of the administrative authority approving the medical directive (for example, the Intensive Care Unit Advisory Committee).

Who Should be Involved in the Development of a Medical Directive?

A medical directive is an order for one or a series of procedures. Although it is by definition a medical document, the collaborative involvement of health care professional affected directly or indirectly by the medical directive is strongly encouraged.

The Council's intention was that an order could apply generally or to a specific patient. The professions involved in the process should develop orders of a general nature which would authorize nurses to proceed to perform the reserved acts assigned to them for certain classification of patients in situations which meet the criteria and parameters set forth in the general orders. Specific orders would continue to be used as they are now in those situations where, for example, medical practitioners order specific reserved acts to be performed on specific patients. A number of submissions acknowledge that this does not represent a marked departure from the current practice and that such protocols or orders are in fact generally in place.

The Council expects the professions themselves, together with others involved in the process such as hospital administrators, to work together to determine the best way to implement the initiation of reserved acts where the interest of the patients require them to be done by registered nurses who have the competence to perform them.

The Health Professions Council recommends that the following definition be adopted for the term "order":

An "order" is a prescription for a procedure, treatment or intervention. It can apply to an individual client by means of a direct order or to more than one individual by means of an indirect order:

- A "direct order" is client-specific. It is a prescription for a procedure, treatment or intervention to be administered at specific times for a specific client, written by a health professional authorized by legislation to perform the procedure, treatment or intervention.
- An "indirect order" is not client-specific. It includes protocols or clinical guidelines or medical directives and is a prescription for a procedure, treatment or intervention that may be performed for a range of clients who meet certain conditions. The indirect order identifies a specific treatment or range of treatments, the specific conditions that must be met and any specific circumstances that must exist before the indirect order can be implemented.

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V. ADVANCED PRACTICE/PRIMARY CARE NURSING

Several submissions suggested that the Council's *Preliminary Report* addressed only entry level competencies and did not recognize that many registered nurses attain advanced competencies through specialized training and education as they progress through their career. Other submissions outlined the various specialty areas for registered nurses. For example, the Simon Fraser Health Region described several areas of specialized practice including renal services, emergency care, public health, mental health and maternal-child. Still other submissions criticized the Council for failing to consider primary care nursing performed by, for example, public health nurses, outpost nursing and nurses acting within the First Call Program.

The First Call Program was developed as a joint solution to a physician shortage by registered nurses, physicians and the Ashcroft Hospital together with the BCNU and RNABC. The First Call model is based on a triage system, where a registered nurse assesses a patient admitted to emergency and assigns a level of care: non-urgent, urgent or emergent. Nurses wishing to practise within the First Call Program are required to complete an education program at the University College of the Cariboo and demonstrate competence in practice.

The common element in all of these practice areas is that these registered nurses have additional training and education to perform services beyond entry level competencies.

The Council strongly supports the individuals and agencies which have taken the initiative to create these advanced and specialized programs. Clearly, the programs are in the public interest and represent a valuable addition to the health care system. However, the Council is concerned that there is little consistency in the programs in use at present. Currently, a wide array of mechanisms are used to ensure competency, virtually all of which are created and followed by employers without RNABC oversight. These mechanisms include agency based training and education, certification through various national nursing bodies and education through the community college system. While this diverse system for achieving advanced competency has a necessary element of flexibility, the Council believes strongly that the RNABC needs to take a more active role in regulating advanced and specialized practice. Without a centralized, universal system for evaluating and monitoring competency for such practitioners, the Council is reluctant to recommend the granting of specific reserved acts to advanced or specialized registered nurses.

Some participants at the hearing supported the Council's views on this issue. For example, a joint presentation by the B.C. Cancer Agency, Children's & Women's Health Centre of B.C., Providence Health Care, Vancouver Hospital and Health Sciences Centre stated:

*It is understood that nurses who have advanced educational preparation and extensive experience in a particular clinical practice area are more competent to **initiate** reserved acts that may carry substantial risk than are novice practitioners. It is legitimate to question how the profession will control the initiation of reserved acts to those who have the necessary competence. However, rather than limit the independent performance of reserved acts for all nurses to those that can be safely performed by novice practitioners we would urge the HPC to challenge the regulatory body to develop mechanisms to regulate nurses performing reserved acts, including: managing labour (Reserved Act 3), ordering hazardous forms of energy (Reserved Act 4) and prescribing, compounding, dispensing (Reserved Act 5). The model should require that nurses proposing to perform the above-named reserved acts be allowed to do so only after providing evidence of competence to the regulatory body. [Emphasis added.]*

Both the BCNU and the RNABC also recognize the need for additional regulatory mechanisms in this area. The RNABC acknowledges that while many registered nurses acquire additional training and education, there is currently no consistent, formal system in place to recognize advanced competency of registered nurses. The RNABC stated that it is in the process of developing just such a system which is described in its submission:

The Regulatory Framework

RNABC has identified that for some reserved acts, such as prescribing, additional regulatory mechanisms will be required. This will be addressed using a combination of two approaches – through regulation of the process and through regulation of the individual.

Regulation of the Process

Regulation of the process would be modeled on the current specialized nursing skills system. Specialized nursing skills are generally not part of a basic nursing education program, but are acquired through a post-basic nursing education or inservice program. The decision to designate an activity as a specialized nursing skill rests with the agency. Where reserved acts require additional regulatory mechanisms, organizations wishing to authorize registered nurses to carry out activities within these reserved acts will be required to follow the Rules under the Nurses (Registered) Act established by RNABC. Regulation of the process will be used only when the reserved act is carried out in limited circumstances. Examples of activities that could be regulated this way include RN First Call protocols that include the prescribing of medication, administration of listed drugs (based on protocol rather than physician orders) carried out by registered nurses in a variety of critical care areas, treatment of sexually transmitted disease, and provision of birth control pills. Standing orders from physicians will be neither needed nor acceptable. Regulation of the process requires that registered nurses are authorized by their employer to carry out these activities.

RNABC will develop rules related to five areas that will need to be adhered to by organizations wishing to authorize registered nurses to carry out reserved acts requiring additional regulatory authority. The five areas are :

- *determination of client best interest;*
- *development of the protocol;*
- *template for the protocol;*
- *certification; and*
- *qualifications of instructor.*

RNABC currently does not have authority at the organizational level. The best way to ensure that rules are adhered to at the organizational level needs to be established in discussion with stakeholders.

Regulation of the Individual

These individuals will practice in a broad variety of environments including acute care, residential care, mental health and community practice (including primary health care settings). The common characteristics of registered nurses in these roles include a specialized knowledge base and a wide variety of activities that require a high degree of independent judgment in initiating and carrying out reserved acts not currently within the scope of practice of all registered nurses (e.g., prescriptive authority).

RNABC will outline the broad competencies needed by registered nurses in these roles. A system will be developed to verify the competencies of these registered nurses prior to

authorizing them to carry out activities that require additional regulatory mechanisms. The competencies should be used in the development of educational programs to prepare these registered nurses. RNABC is participating in a national process with the Canadian Nurses Association and all provincial and territorial regulatory bodies for registered nursing to consider the development of common competencies and a national system to verify competencies. The need for an additional title for these registered nurses is also being considered.

RNABC believes that the scope of practice of registered nurses, regulated as individuals by RNABC, should not be limited by the use of lists of drugs and diseases. The scope of nursing is too broad and the contexts in which nurses practice are too varied to effectively define a list of diseases and medications that registered nurses are qualified to treat and prescribe. RNABC will develop a profile of practice that will outline the competencies that registered nurses must achieve, the common contexts of practice and any limitations on the practice of these individuals.

Thus, the RNABC is suggesting that a regulatory system combining both specific tasks (regulation of the process) and classes of nurses (regulation of the person) be developed to address the issue of advanced and specialty practice.

The Council supports this initiative. It is important that the RNABC, as the regulatory body for registered nurses, maintain a strong supervisory role in this process. However, the Council has one concern about the RNABC proposal. On regulating the process, the regulatory mechanism must not simply direct that advanced and specialized competency programs be established by agencies and employers in accordance with RNABC guidelines. The RNABC should be responsible for approving such programs.

As discussed above, primary care nursing is one of several advanced or specialized nursing practices. The Council recognizes the urgent need for programs such as First Call. We support any measures undertaken by health care providers to augment the province's health care system in the public interest. The Council has been provided with overwhelming evidence that advanced practice registered nurses performing as primary care practitioners in various federal or provincial programs are performing several reserved acts safely and independently. This expansion of the traditional role of registered nurses is in the public interest.

However, the Council is concerned that proper regulatory mechanisms are not in place to govern these activities. Unlike Ontario, B.C. has not established a legislatively defined class of advanced nurse practitioner. The Council believes, and the BCNU and RNABC acknowledge, that a formal regulatory system is necessary and could become part of the RNABC's proposal for regulation of the individual. Any advanced practice programs must be supported by detailed legislative and regulatory mechanisms, such as those proposed by the RNABC. The new system likely would include provisions for such registered nurses to perform reserved acts additional to those granted to the general class of registered nurses. In order to ensure accountability of the profession, all regulatory mechanisms in this area should be set out in regulations to be approved by Cabinet.

The Council believes that the new regulatory model provides the structure necessary to promote both primary care nursing and advanced practitioner nursing.

The Health Professions Council supports advanced practice and primary care nursing and recommends that legislative or regulatory mechanisms be established to enable the regulatory body for registered nursing to develop a formal regulatory system for both.

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Health Professions Council Registered Psychiatric Nurses Scope of Practice Preliminary Report

Irvine E. Epstein, Q.C., Chair
Arminée Kazanjian, Member
David MacAulay, Member

March 2000

This Preliminary Report should be read in conjunction with the [Post-Hearing Update](#) for the profession.

FOREWORD

This report is the result of the Health Professions Council's review of the scope of practice of nursing by registered psychiatric nurses (RPNs) pursuant to the [Terms of Reference](#) from the Minister of Health and Minister Responsible for Seniors. Under the [Health Professions Act](#), the Health Professions Council is a six-person advisory body appointed by the Government of British Columbia to make recommendations to the Minister of Health and Minister Responsible for Seniors about the regulation of health professions.

In this report the Health Professions Council examines how the existing scope of practice of nursing by RPNs should be legislatively defined in order to reflect fairly and accurately the current state of practice and the public interest in the practice of nursing by RPNs.

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EXECUTIVE SUMMARY

The Health Professions Council has conducted a review of the scope of practice of nursing by RPNs.

The purpose of the review is to provide recommendations to the Minister of Health and Minister Responsible for Seniors regarding four matters: scope of practice statements, reserved acts, supervised acts, and reserved titles.

The Health Professions Council has conducted a detailed consultation process and its recommendations regarding the four elements of the scope review are as follows:

1. The Council recommends the following scope of practice statement for registered psychiatric nurses:

The practice of nursing by registered psychiatric nurses is the provision of health care for the promotion, maintenance and restoration primarily of mental, emotional and developmental health, and of associated physical conditions by assessment of mental and physical health, planning and implementation of interventions and co-ordination of health services.

2. The Council recommends the following reserved acts be granted to registered psychiatric nurses:

Performing the physically invasive or physically manipulative act of putting an instrument, hand or finger(s)

- i. into the external ear canal, up to the eardrum, but excluding cerumen management,
- ii. beyond the opening of the urethra,
- iii. beyond the labia majora, but excluding the insertion of intrauterine devices, or
- iv. beyond the anal verge.

3. The Council recommends that the following reserved acts be granted to registered psychiatric nurses to perform only if the act is ordered by a health practitioner who is authorized by legislation to perform the act:

- a. Performing the following physically invasive or physically manipulative acts:
 - i. procedures on tissue below the dermis, below the surface of a mucous membrane;
 - ii. administering a substance by injection or inhalation, irrigation, or instillation through enteral and parenteral means;
 - iii. putting an instrument, hand or finger(s)
 - a. beyond the point in the nasal passages, where they normally narrow,
 - b. beyond the pharynx, or
 - c. into an artificial opening into the body.

- b. Administering by any means a drug listed in Schedule I or II of the Pharmacists, Pharmacy Operations and Drug Schedule Act.
4. The Council recommends that a provision be enacted which sets out the duties of a health professional and his or her regulatory college when delegating a reserved act. The provision should require the following:
 - The assigning health professional's governing body must provide assent to the proposed reserved act being performed by someone else;
 - The reserved act to be assigned as well as the level of supervision must be clearly defined and circumscribed by the assigning health professional's governing body;
 - Where the person to whom the act will be assigned is a member of a self-regulating health profession, his or her governing body must approve of the assigning of the reserved act;
 - The instruction to perform the act must be made in writing either by way of a general written protocol or through a case-specific instruction;
 - The assigning health professional must be satisfied that the individual who will be performing the act has the necessary skills and training to perform the act safely;
 - The assigning health professional must ensure that the person who will be performing the act accepts the assignment.
5. The Council recommends that the following titles be reserved for members of the profession:
 - Registered Psychiatric Nurse;
 - R.P.N.;
 - Licensed Graduate Psychiatric Nurse; and
 - L.G.P.N.
6. The Council recommends that the title "nurse" be reserved for registered psychiatric nurses, registered nurses, licensed practical nurses, and Christian Science nurses.

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I. INTRODUCTION

A. THE NATURE OF THE REVIEW

This is the preliminary report of the review of the scope of practice of registered psychiatric nursing by the Health Professions Council (Council).

The review was conducted pursuant to [Terms of Reference](#) issued by the Minister of Health and Minister Responsible for Seniors in accordance with section 25 of the [Health Professions Act](#), RSBC 1996, c. 183 (HPA). The [Terms of Reference](#) direct the Council to review the scopes of practice of the recognized health professions, of which registered psychiatric nursing is one.

The [Terms of Reference](#), which are included as Appendix A to this report, indicate that there are four main elements to the scope of practice review:

1. scope of practice statements which describe what the profession does, the methods it uses and the purpose for which it does it;
2. reserved acts which are those acts that present such a significant risk of harm that they should be performed only by professionals who are qualified to perform them;
3. supervised acts which are reserved acts, or aspects of reserved acts, which may be performed by persons supervised by health professionals; and
4. reserved titles which are titles that describe a profession's services and which are reserved exclusively for the health profession.

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B. THE PROCESS FOR THE REVIEW

The general process for the review provides for an initial meeting with the profession, submission of briefs by the regulatory body and professional association, a consultation process involving the health profession and interested parties regarding the profession's submission, drafting of a preliminary report, public hearings and a final report.

On April 19, 1995, the Council held an initial meeting with the Registered Psychiatric Nurses Association of BC (RPNABC).

The RPNABC made its submission on July 13, 1995. On September 19, 1995, the Council met with the RPNABC to conduct an initial discussion of its brief. On February 16, 1996, the Council sent its consultation letter to all health professions and interested parties.

The submissions were then summarized and distributed to interested groups and individuals including other regulated and unregulated health professions, teaching facilities and other provinces. Many responses were received. The Council has carefully considered all of this information in drafting this preliminary report.

In 1998, the Council issued the [Shared Scope of Practice Model Working Paper](#) (*Working Paper*) which discusses the Council's list of reserved acts. The *Working Paper* has been revised during the Council's review process. The latest version of the reserved acts list is attached as Appendix B. Health professions were invited to make a submission to the *Working Paper*. The RPNABC made a submission in July, 1998 in response to the Council's *Working Paper*. The submissions included revisions to the initial submission of the RPNABC.

Since April 1999, the profession of registered psychiatric nursing has been governed by the *HPA*, and the name of the regulatory body is now the College of Registered Psychiatric Nurses of BC (College). The Council will refer to the College instead of the RPNABC.

This report will be circulated to all health professions and other interested parties who participated in the Council's consultation process. A public hearing will be held on May 15 and 16, 2000 after which a final report will be issued. Persons or organizations who have made written responses to either the original consultation letter or to this preliminary report will be invited to speak at the hearing.

Throughout this report, the Council makes reference to the submissions of the College and to the responses received during the consultation process. The Council has abbreviated its references to many of the responses received and for ease of reference, the Council has included as an Appendix C a glossary and abbreviations of names used in this report.

This review of nursing by RPNs is being conducted concurrently with the Council's review of nursing by registered nurses (RNs) and nursing by licensed practical nurses (LPNs).

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C. THE REGULATION OF REGISTERED PSYCHIATRIC NURSING

Professional organization of nursing in Canada began with the International Council of Nurses in 1899 and the Canadian Nurses Association which was established in 1908 as the Canadian National Association of Trained Nurses. By 1922, every Canadian province had enacted some form of legislation for nurse registration. In BC it was known as the *Registered Nurses Act*, SBC 1918, c.65.

Registered psychiatric nursing was first granted separate legislation in 1951 through the *Psychiatric Nurses Act*, SBC 1951, c.59. At the date of enactment, there were 400 graduates from the School of Psychiatric Nursing and 300 graduates who were members of the BC Psychiatric Nurses Association. The Act created the Council of Psychiatric Nurses to regulate the profession, and provided for restricted use of the title " " and the abbreviation " ".

Various amendments have taken place since 1951. In 1957, amendments were introduced to provide for licensing of nurses who graduated from psychiatric nursing programs. The term "Licensed Nurse in Mental Deficiency" was defined, and other provisions were amended to include references to the term.

The *Psychiatric Nurse Act* was repealed in 1968 with the passage of the *Registered Psychiatric Nurses Act*. The Psychiatric Nurses Association of BC was established as the governing body for the profession. The 1968 act also provided for restricted use of the abbreviation "R.P.N.", instead of "Psych. N.".

In 1979, the name of the act was changed to the *Nurses (Psychiatric) Act*, and in 1985, it was changed to the [Nurses \(Registered Psychiatric\) Act](#).

The *Health Professions Statutes Amendment Act*, 1993, introduced amendments to the duties and objects clause, the RPNABC's inspection powers, and its interim suspension powers in professional disciplinary

matters. In April 1999 the [Nurses \(Registered Psychiatric\) Act](#) was repealed when RPNs were designated as a health profession under the *HPA*. The Registered Psychiatric Nurses Association of BC was renamed the College of Registered Psychiatric Nurses of BC.

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II. THE POLICY BACKGROUND

The main impetus for a scope of practice review was the *Report of the British Columbia Royal Commission on Health Care and Costs* (Seaton Commission). The Seaton Commission stated that the existing legislation governing the health professions creates persistent jurisdictional disputes and a distinct lack of cooperation among the health professions, despite the fact that all health professional colleges have the same mandate - to protect the public from preventable harm.

The Seaton Commission stated that the primary reason for the jurisdictional disputes was the present regulatory system's reliance on exclusive scopes of practice. Under the exclusive scope of practice model, the various health professions have been granted an exclusive right to practice within a legislatively defined scope of practice. No one, other than a member in good standing of that profession, can perform acts within the profession's scope of practice unless they are granted an exemption.

The Commission concluded:

...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.

(*Closer to Home, The Report of the Royal Commission on Health Care and Costs in British Columbia*, Volume 2, 1991, p. D-33)

This recommendation is also consistent with legislative initiatives underway in Alberta.

The Seaton Commission was not the first review body to suggest that the present legislative model of exclusive scopes of practice was inappropriate. Restricting professional monopolies (exclusive scopes of practice) was also recommended in an earlier study commissioned by the British Columbia Minister of Health. In discussing the conflicts which may arise between the professional college and the public interest, the issue of exclusive scopes of practice was raised:

It must be emphasized that any professional legislation which unduly restricts the scope of practice of skilled personnel may be contrary to the public interest in greater supply and accessibility of service through the development of team practice. Therefore, it is urged that: Professional legislation should not contain narrow restrictions or rigid definitions of scope of practice which are excessively exclusive; that measures should be taken (as indicated below) to reduce the area of interprofessional strain and conflict; and that no prosecutions for violations of scope of practice legislation should be undertaken without the prior consent of the appropriate public authority.

Insofar as may be possible with due regard for public safety, professional law should not place rigid restrictions on the scope of practice of allied health personnel, and greater flexibility should be encouraged in the allocation of roles between the health disciplines.

(Professor J.T. McLeod, *Public Regulation of the Professions in Health Security for British Columbians*, Special Report: *Consumer Participation, Regulation of the Professions, and Decentralization* (1974), the report of Richard D. Foulkes, B.A., M.D., F.A.P.H.A. to the Minister of Health, Province of British Columbia, Tome Three, p. 145)

Thus, the trend in regulatory policy for the health professions has been towards reducing exclusivity in order to enhance interdisciplinary practice, improve accessibility to health care services and increase consumer choice, while at the same time maintaining the fundamental objective of protecting the public.

These policy trends are clearly reflected in the [*Terms of Reference*](#) for the scope of practice review which provide the basis for a new regulatory framework for health professions in British Columbia. The core elements of the new framework are scope of practice statements and reserved acts.

Under the present system, scope of practice statements are exclusive. In the new system, scope statements will not be exclusive but professions may be granted reserved acts.

Reserved acts are those elements of a profession's scope of practice which present such a significant risk of harm that they should be reserved to a particular profession, or shared amongst particular professions. Thus, unlike the present system in which each profession is granted exclusivity within its entire defined scope of practice (subject to specified exceptions), only those acts which present a significant risk of harm will be reserved.

In short, the government has assigned the Council the task of creating a regulatory model based on broad, non-exclusive scope of practice statements and narrowly defined reserved acts.

The government has the responsibility to ensure that those services which are accessible are safe and that the regulatory framework for the practice of health professions protects the public from incompetent, impaired, or unethical practitioners. At the same time, the regulatory framework should not entrench a paternalistic function for professions or reserve exclusive areas of practice simply to enhance professional status and control.

The new system of overlapping scopes of practice and narrow reserved acts removes barriers to interdisciplinary practice and offers greater choice and accessibility to the public. In the Council's view, the public interest is served by professional legislation which promotes quality in the delivery of health care services within safe parameters. Indeed, the Council's primary policy objective in conducting its review is achieving the optimum balance between safe practice and consumer choice.

With this in mind, the Council proposes to consider the practice of nursing by RPNs having regard to the four elements of the scope review.

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III. DISCUSSION OF ISSUES

The main issues raised by this review are the four elements listed above: scope of practice statement, reserved acts, supervised acts and reserved titles.

A. SCOPE OF PRACTICE

The scope of practice statement describes what the profession does, the methods it uses, and the purpose for which it does it. Unlike the present legislative scheme, the statement itself does not grant an exclusive scope of practice. Nonetheless, the statement is important because: 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; and it informs the public about the services practitioners are qualified to perform. It is expected that the Council's recommendations will increase overlapping scopes of practice.

The Council believes that it is not necessary or useful to itemize every facet of a profession's scope of practice. Rather, a scope of practice definition should be sufficiently descriptive so that other health professions and members of the public alike can understand what the particular health professional does.

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1. Current Scope of Practice of Nursing by Registered Psychiatric Nurses

The scope of practice of nursing by RPNs is not currently defined in the legislation or rules. However, in its initial submission, the College stated:

The clearest statement which sets out the scope of practice statement of psychiatric nursing practice is:

Psychiatric/mental health nursing practice is comprised of the function performed in clinical, administrative, educational and research roles where the specific knowledge base consists of:

- 1.) *effecting the provision of the [Nurses \(Registered Psychiatric\) Act](#),*
- 2.) *Promoting and maintaining an enlightened and progressive standard of psychiatric/mental health nursing education and practice,*
- 3.) *Ensuring standards of practice and code of ethics,*
- 4.) *Providing consultation and support to members on personal matters and nursing issues,*
- 5.) *Promoting activities which contribute to mental health.*

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2. Proposed Scope of Practice

The College initially proposed the following scope of practice:

Psychiatric Nursing provides services to individuals whose primary care needs relate to mental, emotional and developmental health especially serious disorders and persistent disabilities. The core knowledge and skills of psychiatric nursing are developed from the nursing, psycho-social, biological and physical sciences. The basis of psychiatric nursing is a caring, therapeutic relationship with others which includes empathy, acknowledgement of the uniqueness of the individual, a nonjudgemental attitude, respect for the rights, beliefs and values of others; and a willingness to share, learn and grow. Psychiatric nursing focuses on the influence of psychosocial forces on health while committed to the promotion, restoration and maintenance of optimal health.

RPN practice has, as its primary focus, the application of the therapeutic level of interpersonal relationship skills, and the development of a therapeutic milieu to promote positive change. Comprehensive psychiatric nursing care, through the process of assessment, diagnosis, planning, implementation and evaluation, assists the individual to meet psycho-social, physiological and developmental needs. Psychiatric nursing care is provided for individuals, families and groups at any stage of life.

The College also proposed that its scope of practice include placing electrodes on clients undergoing Electroconvulsive Therapy (ECT) and operating the electroconvulsive apparatus. This issue will be dealt with in the reserved acts section of this report.

In its July 1998 response to the Council's [Shared Scope of Practice Model Working Paper](#) (*Working Paper*), the College proposed a revised scope of practice statement:

The practice of psychiatric/mental health nursing is the application of psychiatric nursing knowledge and skills to work with individuals of all ages, families, groups and communities encompassing health promotion and preventative health care including assessment of physical and mental health, development of nursing diagnosis, planning, implementation and evaluation of nursing care.

In the July 1998 submission the College states:

One's psychological (mental) state and one's physical state are inseparable, because each affects the other. The ability to assess both domains is essential to the determination of alterations in physical and mental health. Hence the psychiatric nurse is educationally prepared and has the responsibility to expand his/her roles and functions by adding the necessary knowledge and skills required to assess and teach health promotion and the prevention of illness as an integral part of their regular practice.

...

Psychiatric nurses are specialized practitioners of psychiatric nursing, just as intensive care cardio-vascular nurses are specialized practitioners of medical nursing.

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3. Regulation of Psychiatric Nurses in Other Provinces

The Council also reviewed the scope of practice definitions in other provinces. Only Alberta, Saskatchewan and Manitoba have separate nursing categories for psychiatric nursing.

Alberta maintains three categories of nurses: registered nurses, registered psychiatric nurses and licensed practical nurses. The latter two are governed by regulation under the *Health Disciplines Act*, RSA 1980, c. H-3.5. Registered psychiatric nurses are regulated under the *Psychiatric Nurses Regulation*, AR 509/87, and defined as follows:

1. *A registered member may, in accordance with the policy of his employer and if he possesses the appropriate educational training, provide the following health services:*
 - a. *client assessment;*
 - b. *determination of treatment needs and provision of input to treatment plans;*
 - c. *assessment and evaluation of client progress;*
 - d. *monitoring and evaluation of physical limitations, symptoms and reactions, behavioural changes and mental emotional status;*
 - e. *nursing treatments including, without limitation, the administration of medication, dressing changes, wound care, suture removal, drain removal, oxygen therapy, nasogastric drainage, suction, cardiopulmonary resuscitation, intravenous monitoring, catheterization and monitoring vital signs and neurovital signs;*
 - f. *repealed AR 167/98 s 11;*
 - g. *liaison with other members of the health care team and with others who have a direct interest in the care of a client to facilitate the co-ordination and continuity of individualized care;*
 - h. *assisting clients with identification of treatment and support resources;*
 - i. *preventive mental health services;*
 - j. *education, research and administration related to the provision of services referred to in clauses (a) to (i).*
2. *A registered member who is registered under section 5 or 7 as a registered psychiatric nurse may provide psychotherapy and counselling.*
3. *A registered member who is registered under section 5, 5.1 or 7 as a registered mental deficiency nurse may provide behaviour therapy and counselling.*

In Saskatchewan RPNs are regulated under the *Registered Psychiatric Nurses Act*, SS 1993, c.R-13.1. However, that act does not contain a definition of scope of practice.

The Manitoba *Registered Psychiatric Nurses Act*, RSM 1987, c. P170, defines the scope of practice of RPNs as follows:

"psychiatric nursing" or "the practice of psychiatric nursing" means representing oneself as a registered psychiatric nurse while carrying out those functions

- (a) which promote the total well-being of the individual through the promotion of mental health and the prevention of mental illness,
- (b) which minimize the effects of mental illness and developmental handicaps, and
- (c) which involve the planning and implementation of therapies and programs which assist the individual with emotional, developmental or associated physical or mental difficulties to develop to the maximum potential of the individual.

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4. Responses to Consultation

The College's July 1995 proposed scope of practice statement was sent out for consultation along with the RNs' and LPNs' proposals. Some respondents made general comments about the three proposals. While the College's revised July 1998 proposal was not sent out for consultation, many of the comments received are applicable to the revised scope of practice statement.

Some respondents express general support for the scope statement, including the BC Society of Occupational Therapists (BCSOT), the BC Association of Community Care (BCACC), the Licensed Practical Nurses Association of BC (LPNABC), the Registered Nurses Association of BC (RNABC), the Greater Victoria Hospital Society (GVHS), and the Central Vancouver Island Regional Health Board (CVIRHB).

The BC Dietitians' and Nutritionists' Association (BCDNA) feels that the College's proposal is not specific enough, as does the College of Psychologists of BC (CPSBC) and the Ministry of Advanced Education, Training and Technology (MAETT, formerly Ministry of Education, Skills and Training).

The College of Psychologists of BC (CPBC) feels the statement initially proposed is more of a mission statement, and that with some minor modifications the scope of practice statement for RNs could be used. The College of Massage Therapists of BC (CMTBC) makes a similar submission.

The BC Medical Association (BCMA) states that RPNs should be directed, if not directly supervised, by physicians for all medical acts.

Several of the respondents to the consultation make the general point that it is important that the scope of practice for each of the three nursing professions be sufficiently different to indicate their unique characteristics.

Douglas College comments that there is little differentiation between the three nursing bodies' proposals. Similarly, the Ministry of Advanced Education, Training and Technology (MAETT) states that it is difficult to differentiate the three categories of nurses, and therefore difficult to assess what educational preparation is required.

Manitoba Health states that the scope statements for the three nursing professions should follow a similar format.

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5. The Council's Conclusions

The [Terms of Reference](#) direct the Council to recommend a concise legislative definition of the tasks and services of the profession. The Council has carefully reviewed the proposed scope of practice statement. The Council agrees with the College that the scope of practice statement for registered psychiatric nursing must recognize that physical and mental health cannot be separated. The statement must also be sufficiently broad to recognize the RPNs' breadth of practice. However, the inclusion of "*the practice of psychiatric/mental health nursing is the application of psychiatric nursing knowledge and skills*" does not assist in describing the profession. Further, the issue of "nursing diagnosis" will be dealt with in the reserved acts section of this report.

Nevertheless, the College's revised proposal, with some modifications, constitutes an appropriate scope of practice statement for RPNs.

Therefore, the Council recommends the following scope of practice statement for registered psychiatric nurses:

The practice of nursing by registered psychiatric nurses is the provision of health care for the promotion, maintenance and restoration primarily of mental, emotional and developmental health, and of associated physical conditions by assessment of mental and physical health, planning and implementation of interventions and co-ordination of health services.

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B. RESERVED ACTS

The rationale underlying the granting of reserved acts is to protect the public by limiting provision of those particularly dangerous acts to members of specific professions who are qualified to perform them. Only those acts which present a significant risk of harm will be reserved. The Council developed a list of reserved acts, and included it in a 1998 report, entitled the [Shared Scope of Practice Model Working Paper](#) (*Working Paper*).

The list is the Council's working list of activities which present such a significant risk of harm that they should be reserved to regulated health professionals. The list has been revised during the course of the Council's review process. The latest version is attached as Appendix B to this report.

The Council's review will determine which parts of the list will be granted to each profession.

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1. Proposed Reserved Acts

The College initially decided not to propose specific reserved acts for RPNs. Rather, it took the same position as that of the College of Licensed Practical Nurses of BC (CLPNBC) and the Registered Nurses Association of BC (RNABC) – that RPNs should receive an exemption from the reserved acts of other professions. That proposal was criticized by several respondents to the initial consultation, including the College of Midwives of BC (CMBC), the BC College of Chiropractors (BCCC), and the College of Massage Therapists of BC (CMTBC). In its July 1998 submission, the College submitted a revised scope of practice statement, and proposed that it be granted the following reserved acts, some of which would be performed independently and some under supervision:

1. *making a diagnosis;*
2. *physically invasive or manipulative acts:*
 - a. *procedures on tissue below the dermis;*
 - b. *procedures below the surface of a mucous membrane;*
 - c. *the administration of a substance by injection or inhalation;*
 - d. *the insertion of an instrument:*
 - i. *beyond the external ear canal;*
 - ii. *beyond the point in the nasal passages where they normally narrow;*
 - iii. *beyond the pharynx;*
 - iv. *beyond the opening of the urethra;*
 - v. *beyond the labia majora;*
 - vi. *beyond the anal verge;*
 - vii. *into an artificial opening into the body;*
3. *casting a fracture of a bone;*
4. *applying or the application of a hazardous form of energy including electricity, magnetic resonance imaging, lithotripsy & x-ray;*
5. *prescribing, compounding, dispensing or administering by any means a drug listed in Schedule A-1 or A-3.2 of the [Pharmacists, Pharmacy Operations and Drug Schedule Act](#); and*
6. *allergy challenge testing in which a positive result of the test is a significant allergic response; or allergy desensitizing treatment in which there is a risk of significant allergic response.*

In its preliminary report on registered nursing the Council discussed the distinctions between performing a reserved act independently, performing a reserved act on an order from another health professional, and performing a reserved act under the Council's delegation guidelines, as follows:

Nursing is a unique profession because while much of its practice can be considered independent, it is generally carried out as part of a health care team. Nurses are often given the discretion to decide when to initiate a procedure, usually through a physician's order.

Physicians frequently provide orders and rely on nursing professionals to determine when and how they will be carried out. The process of granting discretion to determine when to initiate and

perform an act is best described as "performing an act under the order of another profession." Generally, the ability to perform such acts is within the core competency of RNs.

This process is different from the concept set out in the Council's delegation guidelines. Those guidelines contemplate that the delegation will be structured, including some indication of how the delegated act will be performed. It would generally apply when an act is an advanced or specialist practice which does not fall within the core competency of RNs.

To summarize, when a reserved act is performed pursuant to an order, nurses may make the decision to initiate the act, within the parameters of the order, and they are competent to perform it independently. In contrast, with delegation, nurses will be instructed when to initiate the task, and generally speaking, that task would not fall within the core competency of the nursing profession.

Finally, there are some instances in which RNs will independently initiate and perform a reserved act.

These comments apply equally to the Council's analysis of the reserved acts proposed by the College.

For each of its proposed reserved acts the College gives examples of the types of procedures RPNs perform. The Council will deal with each proposed reserved act in turn.

a. Making a Diagnosis

The College submits that RPNs' education and experience enables them to make a " ". It states that RPNs have been doing so for the last twenty years and submits as follows:

Psychiatric nursing diagnoses standardized clinical nursing practice which then becomes the basis for the care plan. It follows that the standardization of psychiatric nursing actions and common terminology are important in the provision of consistent care over time among nurses across shifts and among different health care agencies.

In other words, a nursing diagnosis describes a patient's problems that can be addressed within the scope of nursing practice. It expresses your professional evaluation of the patient's clinical status, his emotional and social well-being, his responses to illness and treatment and his nursing care needs.

The College of Psychologists of BC (CPBC) does not comment specifically on the RPN proposal but in its submission regarding registered nursing it states that diagnosis of mental illness should be reserved to only psychologists and medical practitioners.

In its *Working Paper* the Council discussed the distinction between assessment and diagnosis:

The Council believes it important to distinguish between diagnosis and assessment. Essentially, diagnosis is the identification of the cause of signs or symptoms. Assessment is a process of observation and evaluation of the physical status or progress of a patient, which may involve observation of symptoms, but does not include naming or identifying a disease, disorder, or condition as the cause of these symptoms.

In the Council's view, all health care practitioners assess a client's progress and response to services rendered. Practitioners who offer assessments have provided information to the Council on this issue, either in recent applications for designation or in submissions in the scope of practice review. Such practitioners include: counsellors, rehabilitation practitioners, prosthetists and orthotists, athletic trainers and recreation therapists.

In the Council's view, it is the identification of a disease, disorder or condition as the cause of signs or symptoms of the individual which should be a reserved act, and the process of assessment should continue to be in the public domain. Both regulated and unregulated practitioners would be free to perform assessments during the course of providing health care services, subject always to the proposed general risk of harm clause.

The services described in the College's submission constitute assessment, not diagnosis, and therefore this reserved act is not granted to RPNs.

b. Physically Invasive or Manipulative Procedures

The College lists what it believes RPNs are competent to perform. The list includes the following:

- procedures on tissue below the dermis;
- procedures below the surface of a mucous membrane;
- the administration of a substance by injection or inhalation;
- the insertion of an instrument:
 - i. beyond the external ear canal,
 - ii. beyond the point in the nasal passages where they normally narrow,
 - iii. beyond the pharynx,
 - iv. beyond the opening of the urethra,
 - v. beyond the labia majora,
 - vi. beyond the anal verge,
 - vii. into an artificial opening into the body.

As part of its submission, the College included a document, *Competencies Expected of the Beginning Practitioner of Psychiatric Nursing*. The document indicates that the basic practice of registered psychiatric nursing includes many invasive procedures, including inserting oral airways, performing suctioning technique, administering oxygen therapy, maintaining intravenous lines, inserting naso-gastric tubes, administering gastric feedings, performing urinary catheterization, administering enemas and suppositories, providing ostomy care, irrigating bladders and obtaining specimens.

The Council accepts that these services fall within the core competency of RPNs.

c. Casting a Fracture of a Bone

The College states that RPNs have the knowledge to perform this act under supervision of the appropriate health professional.

The College's description of this service includes reference to supervision by medical practitioners in

accordance with applicable guidelines and procedures. Therefore, this act would fall within the Council's delegation protocol.

d. Applying Hazardous Forms of Energy

The College states that its members may perform this act with appropriate training and under supervision.

In its initial submission, the College requested that its scope of practice include placing electrodes on clients undergoing Electroconvulsive Therapy (ECT) and operating the electroconvulsive apparatus. The College stated:

One of the tasks currently performed by Registered Psychiatric Nurses in Manitoba and the United Kingdom under the supervision of a Psychiatrist is Electroconvulsive Therapy. There the RPN can place the electrodes on the client and operate the electroconvulsive apparatus. This is safely done by an RPN so long as the following procedures are in place:

- *Clearly understood procedures and guidelines*
- *Identification of staff to carry out the procedure*
- *Training of staff*

The College clarified that RPNs would only perform the ECT related services after completion of the appropriate training and education.

The College of Massage Therapists of BC (CMTBC) states that the College has not provided specific evidence of training and qualifications.

The BC Society of Occupational Therapists (BCSOT) states that some restriction of this activity is warranted, but in conjunction with physicians.

Some respondents, such as Vancouver Community College (VCC), feel it is unusual to see such a specific task separated out.

The College's description of this service includes reference to supervision by medical practitioners in accordance with applicable guidelines and procedures. Therefore, this act would fall within the Council's delegation protocol.

e. Prescribing, Compounding, Dispensing or Administering By Any Means a Listed Drug

The College indicates that part of RPNs' core competency is administering oral, rectal, vaginal, topical, intramuscular, intravenous, and subcutaneous medications. RPNs also recognize the effects and side effects of drugs, and follow established procedures for safe administration of medicines.

The College also states that RPNs may mix ingredients, of which one is a drug, and also dispense a drug independently.

The Council is not satisfied that this entire reserved act is within the core competency of RPNs. However, the administration of drugs prescribed by a medical practitioner is within the core competency of RPNs.

f. Allergy Challenge Testing

The College states that its members may perform this act under the appropriate supervision of a competent professional. In light of the reference to supervision, this act falls within the Council's delegation protocol.

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2. The Council's Recommendations

In its report on registered nursing, the Council states as follows:

[T]he Council discussed the distinction between the delegation of a reserved act and the performance of a reserved act on the order of another health professional. When a reserved act is performed pursuant to an order, nurses may make decisions to initiate the act, within the parameters of the order, and they are competent to perform it independently.

However, several acts performed by nurses, particularly those described by the RNABC and the BCNU as being beyond core competency, are more appropriately dealt with as delegated acts. With delegation, the nurse will be instructed when to initiate the task, and generally speaking, that task would not fall within the core competency of the nursing profession. These acts generally require advanced training and education, and are performed by nurses in specialty practice areas. This process is provided in the Council's delegation guidelines.

These same comments are equally applicable to the profession of nursing by RPNs. Therefore, after carefully considering this matter, the Council makes the following recommendations:

Therefore, the Council recommends the following reserved acts be granted to registered psychiatric nurses:

Performing the physically invasive or physically manipulative act of putting an instrument, hand or finger(s)

- i. **into the external ear canal, up to the eardrum, but excluding cerumen management,**
- ii. **beyond the opening of the urethra,**
- iii. **beyond the labia majora, but excluding the insertion of intrauterine devices, or**
- iv. **beyond the anal verge.**

Other reserved acts are performed by the RPNs but not initiated by them.

The Council recommends that the following reserved acts be granted to registered psychiatric nurses to perform only if the act is ordered by a health practitioner who is authorized by legislation to perform the act:

- 1. Performing the following physically invasive or physically manipulative acts:**
 - i. procedures on tissue below the dermis, below the surface of a mucous membrane;
 - ii. administering a substance by injection or inhalation, irrigation, or instillation through enteral and parenteral means;
 - iii. putting an instrument, hand or finger(s)
 - a. beyond the point in the nasal passages, where they normally narrow,
 - b. beyond the pharynx, or
 - c. into an artificial opening into the body.
- 2. Administering by any means a drug listed in Schedule I or II of the *Pharmacists, Pharmacy Operations and Drug Schedule Act*.**

Several of the acts listed in the College's submission are not within the core competency of most RPNs. These include:

1. making a diagnosis;
2. casting a fracture of a bone;
3. applying or the application of a hazardous form of energy including electricity, magnetic resonance imaging, lithotripsy & x-ray; and
4. allergy challenge testing in which a positive result of the test is a significant allergic response; or allergy desensitizing treatment in which there is a risk of significant allergic response.

Involvement of RPNs in these acts is better dealt with through the Council's delegation guidelines.

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C. SUPERVISED ACTS

The College does not identify any specific acts which may be performed by persons supervised by RPNs.

The [Terms of Reference](#) imply that the Council will, for each reserved act granted to registered psychiatric nursing, determine the circumstances in which the act may be performed by someone other than a member of that profession. The Council considered this issue in detail in its recent preliminary report regarding the scope of practice of medicine. The Council first noted the submissions of the CPSBC:

In its submission, the College makes a compelling argument that legislation is a blunt instrument to deal with this issue. The College states that the issue of delegation and supervision is a question of individual competence and the circumstances of each case, and that supervision of certain acts can be addressed only after a careful review of all the circumstances surrounding a particular act and by imposing, where necessary, clear guidelines, restrictions or conditions on such supervision.

The College further submits that compiling a list of acts which may be delegated or performed under supervision would not adequately address the complexities of medical situations which present to physicians nor would it protect the public. The College notes that there will be situations where, because of the individuals involved, the site or location, or the specific nature of the presenting problem, it may not be appropriate to delegate an act which might otherwise be capable of delegation.

The Council accepted this submission and stated as follows:

The Council accepts much of this submission, and believes that it would be better to take a general approach to the issue of supervision. The general thrust of the approach is that the decision as to whether an act can be performed under supervision should be left up to the health professions, and that a set of principles embodying the duties of the delegating professional and his or her regulatory college be established and enacted into legislation when the shared scope of practice model takes effect. The principles are derived largely from the CMA's Guidelines for the Delegation of a Medical Act which the College enclosed with its submission.

As a result, the Council stated that supervised acts would not be dealt with individually for each profession, and made a general recommendation regarding this issue and stated:

The Council believes this general approach to supervised acts more accurately reflects the reality that procedures to be delegated vary from profession to profession and may include subsets and variations of reserved acts and further, may be performed under a myriad of circumstances and conditions.

In its preliminary report on the scope of practice of medicine the Council also noted the following:

- *Although this term of reference refers to " " acts, it is intended to encompass any situation where someone other than the person to whom the reserved act has been granted performs that act. In other words, this term of reference refers to both delegation and supervision.*
- *This proposal is not intended to apply on a case-by-case basis. The requirement for approval of the governing body is meant to apply generally and not to individual cases, and would be satisfied by, for example, a general protocol in respect of delegation of reserved acts.*

This general position should be applied to all professions. The general position is largely a recognition that the a regulatory body is in the best place to determine when other health professionals can perform services under supervision, and thus a regulatory body should be charged with determining when delegation is appropriate in accordance with the principles set out above.

The Council wishes to emphasize that the issue of delegation arises only with respect to reserved acts.

Therefore the Council recommends that a provision be enacted which sets out the duties of a health professional and his or her regulatory college when delegating a reserved act. The provision should require the following:

- **The assigning health professional's governing body must provide assent to the proposed reserved act being performed by someone else;**
- **The reserved act to be assigned as well as the level of supervision must be clearly defined and circumscribed by the assigning health professional's governing body;**
- **Where the person to whom the act will be assigned is a member of a self-regulating health profession, his or her governing body must approve of the assigning of the reserved act;**
- **The instruction to perform the act must be made in writing either by way of a general written protocol or through a case-specific instruction;**
- **The assigning health professional must be satisfied that the individual who will be performing the act has the necessary skills and training to perform the act safely;**
- **The assigning health professional must ensure that the person who will be performing the act accepts the assignment.**

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D. RESERVED TITLES

Reserved titles are titles reserved exclusively to a health profession. Reserved titles afford a means for consumers to identify the different types of health care providers, to distinguish the qualified from the unqualified, and to differentiate those practitioners who are regulated from those who are not. Titles must adequately serve the public in describing the practitioner and the services being provided and must distinguish the practitioner from others performing services outside the jurisdiction of the college.

The titles protected for RPNs are set out in the *Registered Psychiatric Nurses Regulation* under the HPA:

Reserved title

3 No person other than a registrant may use the title "registered psychiatric nurse" or "licensed graduate psychiatric nurse".

The generic title "nurse" is also reserved to RPNs, pursuant to the *Nurses (Registered) Act*, RSBC 1996, c. 336.

Many respondents express general support for the proposal, including the BC Society of Occupational Therapists (BCSOT), the BC Association of Community Care (BCACC), the BC Medical Association (BCMA), the College of Psychologists of BC (CPBC), and the Union of Psychiatric Nurses (UPN).

Therefore, the Council recommends that the following titles be reserved for members of the profession:

- **Registered Psychiatric Nurse;**
- **R.P.N.;**
- **Licensed Graduate Psychiatric Nurse; and**
- **L.G.P.N.**

The Council recommends that the title "nurse" be reserved for registered psychiatric nurses, registered nurses, licensed practical nurses, and Christian Science nurses.

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E. OTHER ISSUES

Abolition of Separate Nursing Professions

The Council notes that various submissions propose that separate nursing categories be abolished by requiring LPNs to upgrade their education and qualify as RNs. Another submission proposes to abolish the profession of registered psychiatric nursing and yet another calls for the elimination of the category of licensed practical nursing. This issue is beyond the Council's mandate for this review and was not addressed by the Council.

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IV. RECOMMENDATIONS

1. The Council recommends the following scope of practice statement for registered psychiatric nurses:

The practice of nursing by registered psychiatric nurses is the provision of health care for the promotion, maintenance and restoration primarily of mental, emotional and developmental health, and of associated physical conditions by assessment of mental and physical health, planning and implementation of

interventions and co-ordination of health services.

2. The Council recommends the following reserved acts be granted to registered psychiatric nurses:

Performing the physically invasive or physically manipulative act of putting an instrument, hand or finger(s)

- i. into the external ear canal, up to the eardrum, but excluding cerumen management,
- ii. beyond the opening of the urethra,
- iii. beyond the labia majora, but excluding the insertion of intrauterine devices, or
- iv. beyond the anal verge.

3. The Council recommends that the following reserved acts be granted to registered psychiatric nurses to perform only if the act is ordered by a health practitioner who is authorized by legislation to perform the act:

- a. Performing the following physically invasive or physically manipulative acts:
 - i. procedures on tissue below the dermis, below the surface of a mucous membrane;
 - ii. administering a substance by injection or inhalation, irrigation, or instillation through enteral and parenteral means;
 - iii. putting an instrument, hand or finger(s)
 - a. beyond the point in the nasal passages, where they normally narrow,
 - b. beyond the pharynx, or
 - c. into an artificial opening into the body.
- b. Administering by any means a drug listed in Schedule I or II of the *Pharmacists, Pharmacy Operations and Drug Scheduling Act*.

4. The Council recommends that a provision be enacted which sets out the duties of a health professional and his or her regulatory college when delegating a reserved act. The provision should require the following:

- The assigning health professional's governing body must provide assent to the proposed reserved act being performed by someone else;
- The reserved act to be assigned as well as the level of supervision must be clearly defined and circumscribed by the assigning health professional's governing body;

- Where the person to whom the act will be assigned is a member of a self-regulating health profession, his or her governing body must approve of the assigning of the reserved act;
- The instruction to perform the act must be made in writing either by way of a general written protocol or through a case-specific instruction;
- The assigning health professional must be satisfied that the individual who will be performing the act has the necessary skills and training to perform the act safely;
- The assigning health professional must ensure that the person who will be performing the act accepts the assignment.

5. The Council recommends that the following titles be reserved for members of the profession:

- Registered Psychiatric Nurse;
- R.P.N.;
- Licensed Graduate Psychiatric Nurse; and
- L.G.P.N.

6. The Council recommends that the title "nurse" be reserved for registered psychiatric nurses, registered nurses, licensed practical nurses, and Christian Science nurses.

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APPENDIX "C" GLOSSARY AND ABBREVIATIONS OF NAMES

BC Association of Community Care	BCACC
BC College of Chiropractors	BCCC
BC Dietitians' and Nutritionists' Association	BCDNA
BC Medical Association	BCMA
BC Society of Occupational Therapists.	BCSOT
Central Vancouver Island Regional Health Board	CVIRHB
College of Massage Therapists of BC	CMTBC
College of Midwives of BC	CMBC
College of Physicians and Surgeons of BC	CPSBC

College of Psychologists of BC	CPBC
College of Registered Psychiatric Nurses of BC (formerly Registered Psychiatric Nurses Association of BC)	College
Greater Victoria Hospital Society	GVHS
Licensed Practical Nurses Association of BC	LPNABC
Ministry of Advanced Education, Training and Technology (formerly Ministry of Education, Skills and Training)	MAETT
Registered Nurses Association of BC	RNABC
Union of Psychiatric Nurses	UPN
Vancouver Community College	VCC

Last Revised: March 08, 2002

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Health Professions Council POST-HEARING UPDATE OF PRELIMINARY REPORT: REGISTERED PSYCHIATRIC NURSES

Irvine E. Epstein, Q.C., Chair
Arminée Kazanjian, Member
David MacAulay, Member

March 2001

This Post-Hearing Update should be read in conjunction with the [Preliminary Report](#) for the profession.

The Council issued its [Registered Psychiatric Nurses Scope of Practice Review \(Preliminary Report\)](#) in March 2000. The public hearing was held on 15 May 2000. The following are changes to the *Preliminary Report* which arose from the submissions made either at the public hearing or in subsequent written submissions.

I. SCOPE OF PRACTICE STATEMENT

The Council's *Preliminary Report* recommended that registered psychiatric nurses be granted the following scope of practice:

The practice of nursing by registered psychiatric nurses is the provision of health care for the promotion, maintenance and restoration primarily of mental, emotional and developmental health, and of associated physical conditions, by assessment of mental and physical health, planning and implementation of interventions and co-ordination of health services.

The Health Employers' Association of B. C. (HEABC) and the Registered Nurses Association of B. C. (RNABC) questioned the meaning of "developmental health." They queried whether it refers to health across the lifespan or persons with development challenges. The Council agrees with this concern and will remove this term from the scope of practice statement. The Council will add the term "palliation" as it is clear that it forms a large part of registered psychiatric nurses' practice. Therefore, the Council recommends the following scope of practice statement for registered psychiatric nurses:

The Health Professions Council recommends the following scope of practice for registered psychiatric nurses:

The practice of nursing by registered psychiatric nurses is the provision of health care for the promotion, maintenance, restoration and palliation, primarily of mental and emotional health and associated physical conditions, by assessment of mental and physical health, planning and implementation of interventions and co-ordination of health services.

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II. RESERVED ACTS

In its *Preliminary Report*, the Council recommended that registered psychiatric nurses be granted several reserved acts, some to be performed independently and some to be performed on the order of an authorized health professional:

The Council recommends the following reserved acts be granted to registered psychiatric nurses:

1. *Performing the physically invasive or physically manipulative act of putting an instrument, hand or finger(s)*
 - a. *into the external ear canal up to the eardrum but excluding cerumen management,*
 - b. *beyond the opening of the urethra,*
 - c. *beyond the labia major but excluding the insertion of intrauterine devices, or*
 - d. *beyond the anal verge.*

The Council recommends that the following reserved acts be granted to registered psychiatric nurses to perform only if the act is ordered by a health practitioner who is authorized by legislation to perform the act:

1. *Performing the following physically invasive or physically manipulative acts:*
 - a. *procedures on tissue below the dermis, below the surface of a mucous membrane;*
 - b. *administering a substance by injection or inhalation, irrigation, or instillation through enteral and parenteral means;*
 - c. *putting an instrument, hand or finger(s)*
 - i. *beyond the point in the nasal passages where they normally narrow,*
 - ii. *beyond the pharynx, or*
 - iii. *into an artificial opening into the body.*
2. *Administering by any means a drug listed in Schedule I or II of the Pharmacists, Pharmacy Operations and Drug Scheduling Act.*

The recommendations followed closely the Council's recommendations for reserved acts for registered nurses. While there is some difference in focus between the professions, the Council was generally satisfied that their training and education regarding the reserved acts was basically the same. The Council was also satisfied that both professions required and ought to be granted similar reserved acts. The B. C. Nurses' Union (BCNU) supported this position.

The one exception to this was for allergy challenge testing. The Council was not satisfied that registered psychiatric nurses had demonstrated the need, or the training and education necessary, to perform this reserved act. Therefore, with the exception of allergy challenge testing, the Council's reserved acts recommendation will be the same for registered nurses and registered psychiatric nurses. Since the post-hearing memo for registered nurses describes this issue in detail, it will not be repeated here.

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III. RESERVED TITLES

The Council's *Preliminary Report* recommended the following reserved titles for registered psychiatric nurses:

- *Registered Psychiatric Nurse,*
- *R.P.N.,*
- *Licensed Graduate Psychiatric Nurse, and*
- *L.G.P.N.*

The Council recommends that the title "nurse" be reserved for registered psychiatric nurses, registered nurses, licensed practical nurses and Christian Science nurses.

Although the title "Christian Science Nurse" appears in the current *Nurses (Registered) Act*, RSBC 1996, c. 335, the Council received no comment or submission on this title, nor did any of the nursing groups reviewed by the Council request this title. Therefore, the Council did not recommend that it be reserved.

The Health Professions Council recommends the following reserved titles for registered psychiatric nurses:

- **"Registered Psychiatric Nurse",**
- **"Licensed Graduate Psychiatric Nurse",**
- **"Nurse", and**
- **any abbreviation of those titles.**

Last Revised: March 08, 2002

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Health Professions Council Optometrists Scope of Practice Preliminary Report

Irvine E. Epstein, Q.C., Chair
Arminée Kazanjian, Member
David MacAulay, Member

April, 1999

This Preliminary Report should be read in conjunction with the [Post-Hearing Update](#) for the profession.

FOREWORD

This report is the result of the Health Professions Council's review of the scope of practice of optometry pursuant to the Terms of Reference from the Minister of Health and Minister Responsible for Seniors. Under the [Health Professions Act](#), the Health Professions Council is a six person advisory body appointed by the Government of British Columbia to make recommendations to the Minister of Health and Minister Responsible for Seniors about the regulation of health professions.

In this report the Health Professions Council examines how the existing scope of practice of optometry should be legislatively defined in order to reflect fairly and accurately the current state of practice and the public interest in the practice of optometry.

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EXECUTIVE SUMMARY

The Health Professions Council has conducted a review of the scope of practice of optometry.

The purpose of the review is to provide recommendations to the Minister of Health and Minister Responsible for Seniors regarding four matters: scope of practice statements, reserved acts, supervised acts, and reserved titles.

The Health Professions Council has conducted a detailed consultation process and its conclusions and recommendations regarding the four elements of the scope review are set out in this report.

1. The Council recommends the following scope of practice statement for optometry:

The practice of optometry is:

- (a) the assessment and diagnosis of the eye and vision system through the use of diagnostic drugs and instruments and devices, such as test lenses, test cards and trial lenses; and
- (b) the treatment and prevention of disorders of refraction, sensory and ocular motor disorders and dysfunctions of the eye and vision system primarily through the prescription and dispensing of ophthalmic devices.

2. The Council recommends the following reserved acts for registrants of the Board of Examiners in Optometry:

- making a diagnosis of a disorder of refraction, a sensory and ocular motor disorder or dysfunction of the eye and vision system as the cause of signs or symptoms of the individual; and
- performing a procedure on tissue in or below the surface of the cornea for the purpose of removing superficial foreign bodies from the eye.
- prescribing appliances or devices for vision conditions and fitting contact lenses.

3. The Council recommends

- that the titles "Optometrist", "Doctor of Optometry", "Dr. of Optometry", "Optometric Doctor", and "Optometric Dr." and any affix of those titles be reserved for registrants of the Board of Examiners in Optometry.

4. The Council recommends that the name of the regulatory body, the "Board of Examiners in Optometry", be changed to "College of Optometry of British Columbia".

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I. INTRODUCTION

A. THE NATURE OF THE REVIEW

This is the preliminary report of the review of the scope of practice of optometry by the Health Professions Council (the Council).

The review was conducted pursuant to Terms of Reference issued by the Minister of Health and Minister Responsible for Seniors in accordance with section 24, now section 25, of the [Health Professions Act](#) (the HPA).⁽¹⁾ The Terms of Reference direct the Council to review the scopes of practice of the recognized health professions, of which optometry is one.

The Terms of Reference, which are included as Appendix A to this report, indicate that there are four main elements to the scope of practice review:

- i. scope of practice statements which describe what the profession does, the methods it uses and the purpose for which it does it;
- ii. reserved acts which are those acts that present such a significant risk of harm that they should be performed only by professionals who are qualified to perform them;
- iii. supervised acts which are reserved acts, or aspects of reserved acts, which may be performed by persons supervised by health professionals; and
- iv. reserved titles which are titles that describe a profession's services and which are reserved exclusively for the health profession.

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B. THE PROCESS FOR THE REVIEW

The general process for the review provides for an initial meeting with the profession(s), submission of briefs by the regulatory body and professional association for each profession, a consultation process involving all health professions and interested parties regarding each professions' submission, drafting of a preliminary report, public hearings and a final report.

The Council met with representatives of the regulatory body for optometry, the Board of Examiners in Optometry (the Board) and with the membership association, the British Columbia Association of Optometrists (the BCAO) on November 10, 1994. Both bodies submitted their written briefs in January, 1995.

The submissions were then summarized and distributed in February, 1996 to interested groups and individuals including other regulated and unregulated health professions, teaching facilities and other provinces. Many responses were received. In 1998, both the Board and the BCAO were given a further opportunity to make submissions regarding the scope review, and further written submissions were made in late December, 1998 (BCAO) and early January, 1999 (the Board). The Council has carefully considered all of the information received in drafting this preliminary report.

The Council's scope of practice review process was delayed because of a court application filed by the BCAO against the Minister of Health and the Chair of the Council, alleging reasonable apprehension of bias on the part of the Chair. The application was dismissed in January, 1998 and the Minister of Health subsequently instructed the Council, on March 26, 1998 to proceed with its scope of practice review of optometry. An appeal launched by the BCAO is still outstanding; however the Board and the BCAO have both decided to participate willingly in the Council's process.

This report will be circulated to all health professions and other interested parties who participated in the Council's consultation process.

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C. THE REGULATION OF OPTOMETRY

The first provincial enactment was the *Optometry Act*, S.B.C. 1921, c. 48. It defined the practice of optometry and created the Board of Examiners as the regulatory body. Other provisions included a section prohibiting a person practising optometry from using the title "doctor" unless the person was a licensed medical practitioner. The first major amendments to the act were made by the *Optometry Act Amendment Act*, 1926-27, c. 51, when the Board of Examiners was given the power to make regulations concerning discipline, regulation of the practice, and the examination and admission of candidates to the study of the profession. This also marked the creation of the British Columbia Optometric Association.

Several amendments have since been made. Most notably, the *Health Statutes Amendment Act*, 1984, c. 19, provided for the use of the title "doctor" by optometrists, but only in conjunction with the terms "optometry" or "optometric", and the restriction of the use of the title "optometrist". Further amendments were made to provisions that were considered to be in conflict with the Charter in the *Charter of Rights Amendments Act*, 1985, c. 68. In 1986, under the *Miscellaneous Statutes Amendment Act (No.2)*, 1986, c. 16, the Association's name was changed to the British Columbia Association of Optometrists while the definition of "optometrist" was broadened. In 1989, optometrists were allowed to incorporate their professional practices. Finally, in 1993, by virtue of the *Health Professions Statutes Amendment Act*, S.B.C. 1993, c. 50, the Board of Examiners' duties and objects clause was set out, its investigation powers were enhanced and it was allowed, in appropriate circumstances, to suspend or impose limits on the practice of a member of the profession pending the completion of a hearing concerning the member's practice.

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D. VISION CARE PRACTITIONERS

To assist readers, the Council will provide a brief description of the three main types of practitioners providing vision care (2):

- Ophthalmologist: An ophthalmologist is a physician who specializes in the medical and surgical care of the eyes and visual system and in the prevention of eye disease and injury. The ophthalmologist is the medically trained specialist who can deliver total eye care: primary, secondary, and tertiary care services (i.e., vision services, contact lenses, eye examinations, medical eye care, and surgical eye care), diagnose general disease of the body and treat ocular manifestations of systemic diseases.
- Optometrist: An optometrist is a health service provider who is involved exclusively with vision problems. An optometrist examines the eyes and determines the presence of vision problems. An optometrist determines visual acuity, prescribes spectacles, contact lenses and eye exercises, and dispenses spectacles and contact lenses.
- Optician: An optician is a technician who makes, verifies and delivers lenses, frames and other specially fabricated optical devices and/or contact lenses to the intended wearer.

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E. GLOSSARY OF ACRONYMS

Throughout this report, the Council makes reference to the Board and the BCAO submissions and to the responses received during the consultation process. The Council has abbreviated its references to many of the groups that responded, and for ease of reference, has included the following glossary of abbreviations used:

The Board of Examiners in Optometry	the Board
The British Columbia Association of Optometry	the BCAO
Ad Hoc Committee for B.C. Orthoptists	AHCBCO
American Academy of Ophthalmology	AAO
The British Columbia College of Optics	BCCO
British Columbia Dietitians' and Nutritionists' Association	BCDNA
British Columbia Medical Association	BCMA
British Columbia Society of Eye Physicians and Surgeons	BCSEPS

Canadian Association of Pediatric Ophthalmologists	CAPO
Canadian Ophthalmological Society	COS
Canadian Orthoptic Council	COC
College of Dental Surgeons of British Columbia	CDSBC
College of Opticians of British Columbia	COBC
Department of Orthoptics and Ophthalmology, IWK-Grace Health Centre, Halifax	Grace Health Centre
Eye Care Centre, Department of Ophthalmology, Faculty of Medicine, University of British Columbia	ECCUBC
The Dispensing Opticians Association of British Columbia	DOABC
Ophthalmic Nurses Group of British Columbia	ONGBC
Opticians Association of Canada	OAC
Vision Council of Canada	Vision Council

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II. THE POLICY BACKGROUND

The main impetus for a scope of practice review was the Report of the British Columbia Royal Commission on Health Care and Costs (the Seaton Commission). The Seaton Commission stated that the existing legislation governing the health professions creates persistent jurisdictional disputes and a distinct lack of cooperation among the health professions, despite the fact that all health professional colleges have the same mandate - to protect the public from preventable harm.

The Seaton Commission stated that the primary reason for the jurisdictional disputes was the present regulatory system's reliance on exclusive scopes of practice. Under the exclusive scope of practice model, the various health professions have been granted an exclusive right to practice within a legislatively defined scope of practice. No one, other than a member in good standing of that profession, can perform acts within the profession's scope of practice unless they are granted an exemption.

The Commission concluded:

...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.

(Closer to Home, The Report of the Royal Commission on Health Care and Costs in British Columbia, Volume 2, 1991, p. D-33)

This recommendation is also consistent with legislative initiatives underway in Alberta. The Seaton Commission was not the first review body to suggest that the present legislative model of exclusive scopes of practice was inappropriate. Restricting professional monopolies (exclusive scopes of practice) was also recommended in an earlier study commissioned by the British Columbia Minister of Health. In discussing the conflicts which may arise between the professional college and the public interest, the issue of exclusive scopes of practice was raised:

It must be emphasized that any professional legislation which unduly restricts the scope of practice of skilled personnel may be contrary to the public interest in greater supply and accessibility of service through the development of team practice. Therefore, it is urged that: Professional legislation should not contain narrow restrictions or rigid definitions of scope of practice which are excessively exclusive; that measures should be taken (as indicated below) to reduce the area of interprofessional strain and conflict; and that no prosecutions for violations of scope of practice legislation should be undertaken without the prior consent of the appropriate public authority.

Insofar as may be possible with due regard for public safety, professional law should not place rigid restrictions on the scope of practice of allied health personnel, and greater flexibility should be encouraged in the allocation of roles between the health disciplines.

(Professor J.T. McLeod, "Public Regulation of the Professions" in Health Security for British Columbians, Special Report: Consumer Participation, Regulation of the Professions, and Decentralization (1974), the report of Richard D. Foulkes, B.A., M.D., F.A.P.H.A. to the Minister of Health, Province of British Columbia, Tome Three, p. 145)

Thus, the trend in regulatory policy for the health professions has been towards reducing exclusivity in order to enhance interdisciplinary practice, improve accessibility to health care services and increase consumer choice, while at the same time maintaining the fundamental objective of protecting the public.

These policy trends are clearly reflected in the Terms of Reference for the scope of practice review which provide the basis for a new regulatory framework for health professions in British Columbia. The core elements of the new framework are scope of practice statements and reserved acts.

Under the present system, scope of practice statements are exclusive. In the new system, scope statements will not be exclusive but professions may be granted reserved acts.

Reserved acts are those elements of a profession's scope of practice which present such a significant risk of harm that they should be reserved to a particular profession, or shared amongst particular professions. Thus, unlike the present system in which each profession is granted exclusivity within its entire defined scope of practice (subject to specified exceptions), only those acts which present a significant risk of harm will be reserved.

In short, the government has assigned the Council the task of creating a regulatory model based on broad, non-

exclusive scope of practice statements and narrowly defined reserved acts.

The government has the responsibility to ensure that those services which are accessible are safe and that the regulatory framework for the practice of health professions protects the public from incompetent, impaired, or unethical practitioners. At the same time, the regulatory framework should not entrench a paternalistic function for professions or reserve exclusive areas of practice simply to enhance professional status and control.

The new system of overlapping scopes of practice and narrow reserved acts removes barriers to interdisciplinary practice and offers greater choice and accessibility to the public. In the Council's view, the public interest is served by professional legislation which promotes quality in the delivery of health care services within safe parameters. Indeed, the Council's primary policy objective in conducting its review is achieving the optimum balance between safe practice and consumer choice.

With this in mind, the Council proposes to consider the practice of optometry having regard to the four elements of the scope review.

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III. DISCUSSION OF ISSUES

The main issues raised by this review can be discussed under the four elements listed above: scope of practice, reserved acts, supervised acts and reserved titles.

A. SCOPE OF PRACTICE STATEMENT

The scope statement **describes** what the profession does, the methods it uses, and the purpose for which it does it. Unlike the present legislative scheme, the statement itself does not grant an exclusive scope of practice. Nonetheless, the statement is important because: 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; and it informs the public about the services practitioners are qualified to perform. It is expected that the Council's recommendations will increase overlapping scopes of practice.

The Council believes that it is not necessary or useful to itemize every facet of a profession's scope of practice. Rather, a scope of practice definition should be sufficiently descriptive so that other health professions and members of the public alike can understand what the particular health professional does.

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1. Current Scope of Practice

The current scope of practice of optometry is set out in the definition of the practice of optometry in s.33 [16] of the [Optometrists Act](#).

Any one or a combination of the following practices constitutes the practice of optometry:

(a) investigation of the functions of the human eye by diagnostic drugs in accordance with the rules made under this Act and by test lenses, test cards, trial frames and other instruments or devices designed for that investigation; and

(b) prescription or adaptation of lenses, prisms or the use of orthoptic instruments of any kind to improve or correct the visual function, or to adapt the visual function to the requirements of a special occupation.

Schedule "A" to the Optometrists' Rules lists the drugs approved by the Board for diagnostic purposes. The most recent list of drugs available to the Council is attached as Appendix D.

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2. The British Columbia Association of Optometrists' Proposed Scope of Practice

The BCAO submits that the current scope of practice statement does not reflect the current education and training of optometrists, and proposes the following expanded scope of practice:

The practice of optometry is the examination, diagnosis, measurement and treatment of the oculo-visual status of the human eye; and includes, but is not limited to:

- *the examination of the human eye by any method, other than surgery, to diagnose, to treat, or to refer for consultation or treatment any abnormal condition of the eye or its adnexa;*
- *the employment of instruments, devices, test lenses, test cards or any refractive procedures, automated or otherwise, pharmaceutical agents and non-invasive procedures, intended for the investigating measuring, examining, treating, diagnosing or correcting visual defects or abnormal conditions of the human eye or its adnexa as may be authorized by the Board of Examiners in Optometry;*
- *the prescribing of lenses, devices containing lenses, prisms, contact lenses, orthoptics, vision training, pharmaceutical agents and prosthetic devices to correct, relieve, or treat defects or conditions of the human eye or its adnexa;*
- *the fitting and application of lenses, devices containing lenses, prisms, contact lenses, pharmaceutical agents and prosthetic devices intended to be placed directly upon or in contact with the tissues of the human eye or adnexa; and*
- *the prescription, supervision and management of regimes of therapy, for the improvement or monitoring of the visual health or function of patients.*

The proposed scope of practice represents a significant expansion in optometrists' current scope of practice. In particular, optometrists have requested that their scope be expanded to entitle them to "*diagnose any abnormal condition of the human eye*", "*treat abnormal conditions of the human eye*" and "*prescribe therapeutic*

pharmaceutical agents". The BCAO submits that the expansion would give optometrists legislative authority for treatment and management of anterior segment conditions, co-management of glaucoma with physicians, and the removal of superficial foreign bodies.

The BCAO's most recent submission (December 23, 1998) seems to suggest that the profession's scope of practice is even broader than this proposal, as it states that its scope "*would include, but is not necessarily limited to . . .*" and then sets out a list of 40 different types of services provided. The list includes "ultrasound testing", "treatment of infections and inflammations of the anterior segment (including the use of topical antibiotics, steroids, and all other required pharmaceutical agents)", and "treatment of ocular trauma - comanage if necessary". The BCAO also submits that "... *it is the profession itself that is best suited to determine the appropriate scope of practice based on current knowledge and standards of care*".

However, it is for the government, albeit in consultation with the professions, to determine the scope of practice. The Terms of Reference clearly direct the Council to recommend an appropriate scope of practice for a profession. If accepted, that recommendation would then be enshrined in legislation, as all scope statements currently are. In short, while it may be the profession's role, subject to government approval, to set and administer standards of practice, it cannot determine its own scope of practice. Ultimately, that is determined by the government.

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3. Summary of Submissions Regarding Proposed Scope of Practice

a) Other Jurisdictions

Several other provinces provided information about the scope of practice of optometry.

New Brunswick Health and Community Services provided the Council with the New Brunswick definition of the practice of optometry:

The performance of services usually rendered by an optometrist including the measurement and assessment of vision using such drugs for such purposes as are prescribed by the bylaws, the prescribing and dispensing of ophthalmic appliances or other aids, and prescribing and providing orthoptics for the relief or correction of any visual or muscular error or defect of the eye.

Northwest Territories Health and Social Services enclosed a copy of the *Optometry Act, RSNWT 1988, c.0-3*, which contains the following definition of the practice of optometry:

Practice of optometry means the employment of means other than drugs and surgery for the measurement of the refractive or muscular condition of the eye and the prescribing or supplying of lenses, prisms, or spectacles for the relief or correction of any visual or muscular defect of the eye.

No changes are presently being considered to that legislation.

The Ontario Ministry of Health refers to section 3 of the *Ontario Optometry Act, SO 1991, c.35*, which outlines

optometrists scope of practice as follows:

The practice of optometry is the assessment of the eye and vision system and the diagnosis, treatment, and prevention of disorders of refraction, sensory and ocular motor disorders and disfunctions of the eye and vision system and prescribed diseases.

Currently, there are no prescribed diseases in the regulations under the *Optometry Act*, though that issue is presently under consideration.

The Office des professions du Québec refers to section 16 of the *Optometrists Act* in Québec which states:

The practice of optometry is an act which, except the use of medication, deals with vision and is related to examination or functional analysis of the eyes and assessment of visual disorders, as well as orthoptics, prescription, fitting, adjustment, sale, and replacement of ophthalmic lenses.

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b) Supportive Submissions

Only four submissions express agreement with the proposed expanded definition of the scope of practice of optometry. The Pacific University College of Optometry located in the state of Oregon, expresses complete agreement with the profession's proposal but without any detail. It does, however, provide an attachment which outlines the education and training of optometry students in the areas of practice proposed by the BCAO, including diagnosis and treatment of eye disease, and the use of therapeutic pharmaceutical substances. The School of Optometry, Faculty of Science, University of Waterloo expresses general support for all elements of the optometrists' submission and states that its program includes education in all of the proposed areas of expansion. The Licensed Practical Nurses Association simply supports the proposal without comment. The British Columbia Dieticians' and Nutritionists' Association (BCDNA) generally supports the optometrists' submission but questions the proposal to use therapeutic drugs.

The remainder of the approximately 45 submissions criticize various aspects of the profession's proposal.

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c) Non-Supportive Submissions

(1) Treatment of Eye Disease

The proposal to treat eye disease, along with the related request to use therapeutic pharmaceutical substances, elicited the most comment.

The BCAO submits that optometrists are qualified to diagnose and treat eye disease. Its submission does not appear limited to any specific disease though in parts of its submission it refers to "common eye disease". The

BCAO also states:

The professional training of the optometry student is similar to that of the medical, dental and podiatric student. The optometric curriculum includes training in human anatomy, neuroanatomy, ocular anatomy, human physiology, biochemistry, microbiology, pharmacology (both general and ocular), general and ocular pathology, diagnosis and treatment of ocular disease, ocular motility, physiology and geometric optics, with internship/externship programs.

It is important to note that treatment of eye disease has traditionally not been a part of the scope of practice of optometry in British Columbia.

The BCAO states that, " . . . allowing optometrists to treat the conditions they now routinely diagnose is a logical, progressive move", and that "education and training of the optometrist" has evolved to a point that primary care treatment of eye disease is within their scope of practice academically, but not legally. It further submits that allowing them to treat eye disease is in the public interest as it would eliminate the need for referrals to other health care professionals, avoid delay in treatment, and address the needs of BC's rural population which, it submits, is presently underserviced.

The Board submits:

To achieve the goal of expanded scope of practice the Board would require some changes to the Act and Rules. The definition of the practice of optometry must be amended, as it was when diagnostic drugs were added. References to "drugs for diagnostic purposes" should be amended to "drugs".

. . .

When the definition change has been made, the Board will determine by policy statement which classes of ocular diseases may be treated by optometrists and also under which circumstances. The Board also will determine which classifications of drugs may be used and which routes of administration. The individual practitioner should be free to select the particular pharmaceutical agent, so long as it falls within a particular classification.

The Dispensing Opticians Association of British Columbia (DOABC) and the Opticians Association of Canada (OAC) believe that treatment of eye disease requires training and education in the systemic effects of drugs and disease treatment on the individual. Both groups believe current optometric training is not sufficient. They state that treatment of eye disease requires training similar to that of physicians as disease involves the entire human body and can have serious systemic effects on the client. Both groups are very concerned about giving the optometrists the discretion to determine which eye diseases they can treat. They state that if such an expansion is contemplated, the Council should follow the position taken by the Ontario Health Professions Regulatory Advisory Council (the HPRAC) that a list of prescribed diseases must be specific rather than general and that optometrists must list, on a case by case basis, why they are qualified to treat diseases.

The Canadian Association of Pediatric Ophthalmologists (CAPO) is concerned about the treatment of eye disease proposal, specifically with respect to the proposal that scope of practice decisions be made by way of policy statement. In its view this is far too vague, and potentially dangerous. It states:

Optometrists are skilled in refraction. They are not medical doctors. They have no credentials in the treatment of ocular conditions which have in many cases systemic causes.

The British Columbia Medical Association (BCMA) also has serious concerns about the optometrists' proposal. It states:

Optometrists are trained to deal with optical errors of the eye, to fit glasses and contact lenses, to detect medical eye problems and refer such problems to the appropriate physician. They are not trained in the prescription and monitoring of drugs, many of which have the potential for serious side effects, nor are they trained to diagnose those medical conditions that are often associated with eye disease. The claim that optometrists possess a level of training similar to that of family practitioners and ophthalmologists constitutes a misrepresentation of the practice of optometry to the public.

The British Columbia Society of Eye Physicians and Surgeons (BCSEPS) believes that this proposal is essentially a request that optometrists be given the legislated right to practice medicine. The BCSEPS states that such a wide expansion has not been permitted in any other jurisdiction in Canada. With respect to the diagnosis and treatment of eye disease, the BCSEPS states that misdiagnosis and mismanagement of eye diseases such as glaucoma, iritis and diabetic retinopathy can lead to irreversible vision loss and even blindness. The BCSEPS also states that optometrists are trained to detect abnormalities during an eye examination but not to diagnose the cause of the abnormality.

The Canadian Ophthalmological Society (COS) believes that optometrists should be limited to investigations of the functions of the human eye as opposed to the diagnosis and treatment of diseases of the eye. It believes that optometrists are not trained to provide medical diagnoses, perform medical procedures, or prescribe medications which could be harmful to the patient. It states that at the present time, only physicians are properly qualified to diagnose and treat eye disease. The COS notes that the proposed scope of practice, which affords discretion to the Board to determine which therapeutic pharmaceutical agents may be used and which eye diseases may be treated, not only significantly expands their scope but also lacks specificity about how they will establish their scope, and any limits or restrictions on their scope.

The COS also states that in treating primary eye disease it is important to realize that many of these so called primary problems are not problems in isolation, but are manifestation of diseases that affect the whole body. For example, recurrent eye infections occur frequently in diabetics, scaling of the eye lids is part of Parkinson's disease, viral infections of the eye can be a sign of herpes or systemic adeno viruses causing sore throats and ears, and dry eyes are often part of rheumatoid arthritis. Indeed, it states that primary eye disease is in fact really a misnomer because in a great majority of cases the signs and symptoms seen in the eyes must be viewed in the context of the health of the entire body for the individual to be properly treated.

The Ad Hoc Committee for B.C. Orthoptists (AHCBCO) expresses concern regarding the proposal for treatment and management of eye disease. It believes that only the ophthalmology fellowship and residency program provides the skills necessary to ensure the safe performance of this service.

The American Academy of Ophthalmology (AAO) questions the generality of the optometrists' submission, and particularly the proposal that the Board be entitled to determine which eye diseases optometrists may treat by way of policy statement. They strongly believe that optometrists must provide specific details of the diseases and procedures they wish to employ. It states that a similar problem has arisen in the US in that many optometric statutes contain language which is unspecific and does not clearly delineate the terms or limitations on the scope of practice.

Several other submissions, such as those of the College of Dental Surgeons of British Columbia (CDSBC), the Department of Ophthalmology, University of Alberta and the Eye Care Centre, Department of Ophthalmology,

Faculty of Medicine, University of British Columbia (ECCUBC) make similar submissions.

In short there was appreciable opposition to the profession's proposal regarding treatment of eye disease.

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(2) Prosthetic Services

The BCAO's proposal that prescribing and dispensing of prosthetic devices be included within its scope of practice elicited some criticism, most of it from individuals who are involved in the provision of services related to artificial eyes.

Eriksons Custom Made Artificial Eyes states that including ocular prosthetics as part of optometry or opticianry, particularly as exclusive practice areas, would be a serious disservice to the citizens of British Columbia as it would prohibit ocularists from performing their services.

Marie Allen, an ocularist, expresses surprise that the optometrists are requesting exclusive rights regarding prosthetics. She does not believe that optometrists currently fit and fabricate custom prostheses, nor does she believe that optometrists' training contains any information on either the fitting or the fabrication of ocular prostheses. In short, she indicates that she does not want to be displaced from her profession by a group of individuals who are less knowledgeable in this field and would produce substandard results.

Raymond Allen, also an ocularist, expresses a similar concern about the optometrists' proposal regarding prosthetic devices for the eye.

The Eye Care Centre, Department of Ophthalmology, Faculty of Medicine, University of British Columbia (ECCUBC) expresses a concern that the optometrists' proposal regarding fitting and application of prosthetic devices will have a detrimental impact on the practice of ocularists. ECCUBC states that ocularists, not optometrists, provide the vast majority of prosthetic devices in this province. Finally, ECCUBC states that optometrists are not trained and educated to provide such services.

The President of the Canadian Ophthalmological Society (COS) submits that optometrists are not trained and educated to fit custom prostheses.

The Vision Council of Canada (Vision Council), a non-profit association which represents the retail optical industry, also submits that the prescribing of prosthetic devices is currently not regulated, and that optometry's current legislation makes no mention of prescribing prosthetic devices.

These submissions were made in response to the BCAO's original submission which proposed that optometrists be granted this act, as part of their scope of practice. The submissions seem to be based on the assumption that scope of practice statements are exclusive, and that optometrists should not be the only profession providing these services. However, as the Council has already noted, scope of practice statements are not exclusive, but rather descriptive. This should alleviate some of the concerns expressed.

Nevertheless, some of the submissions indicate that optometrists are not qualified to perform such services, and therefore they ought not fall within the scope of practice of optometry. The Council notes that the provision of

"prosthetic devices" is not set out in the current scope of practice of optometry, nor have the Board or the BCAO provided information in this regard. Without further information, the Council is not prepared to include provision of prosthetic services within the scope of practice of optometry.

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(3) Additional Criticisms

Vision Council made a lengthy submission expressing considerable concern about the scope of practice definition proposed by the optometrists. Vision Council questions the use of the wording "*fitting and application of lenses, devices containing lenses, prisms, contact lenses, pharmaceutical agents and prosthetic devices*". In Vision Council's view this language is too broad and ambiguous. It questions how devices containing lenses would be defined and states that if this phrase is intended to mean frames, then its inclusion is highly inappropriate and an unwarranted incursion into the opticianry scope of practice.

Further, Vision Council believes that the scope of practice statement should refer to dispensing or selling of ophthalmic devices. Vision Council states that nowhere in their submission do the optometrists use the word "dispensing", and it emphasizes that optometrists are in the commercial business of selling eyewear. The Council agrees that dispensing and selling constitutes a significant part of optometric practice, and reference to it ought to be included in the definition of scope of practice.

Many other respondents submitted that the proposed expanded definition of the scope of practice of optometry "infringes" on the practice of other professions. Some of the concerns raised appear to be based on a misunderstanding that, in the new regulatory model, scope of practice statements will continue to be exclusive. The Council emphasizes that, in the new regulatory system described above, a scope statement is not exclusive; it is only descriptive. Further, it is expected that the scope of practice review process will result in more overlapping scopes of practice. Thus, a profession will not be prevented from performing an act simply because it also falls within another profession's scope of practice.

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4. Conclusions Regarding Scope of Practice

The [Criteria and Guidelines](#) for the Council's scope of practice review are attached as Schedule A to the Council's Terms of Reference. Under scope of practice, the Council is directed to answer the following question:

*How should the existing scope of practice for the health profession be legislatively defined in order to reflect fairly and accurately the **current** state of practice in that field of health care and reflect the public interest in the practice of the profession? [Emphasis added.]*

- *The current definition may require expansion and updating to reflect academic/scientific advancements in the practice of the profession and in related professions.*
- *A concise legislative definition of the tasks and services appropriately delivered by registrants is*

required. This should include any limits on the scope of practice that may be necessary for public protection and may involve limits on a class or classes of registrants who have different skills and abilities than other registrants.

- *An aspect of scope of practice may be shared between two or more discrete health professions.*

The Council appreciates that the current **legislative** definition may not accurately reflect the **actual** practice of the profession, and will consider expansions of current legislative scope as long as they fall with the current actual practice. Thus, the Council's review is limited to determining services which **currently** fall within the profession's scope of practice.

The Council has reviewed the BCAO's proposal and supporting information, as well as the responses to consultation and, for several reasons, cannot accept the profession's proposal.

As indicated in the Terms of Reference, the scope of practice statement is intended to be a **concise** description of what the profession does - it is not intended to be an exhaustive list of all services performed by practitioners. The profession itself acknowledges this in its most recent submission. In the Council's view the proposal by the profession is too long and detailed.

Based on the information reviewed during its investigation, the Council is not prepared to expand optometrists' scope of practice to include an unlimited right to treat and diagnose any abnormal conditions of the human eye or to use therapeutic pharmaceutical substances.

The primary problem with the proposal is that it grants the Board of Examiners in Optometry the power to redefine the scope of practice of optometry on an ongoing basis. It is important to remember that treatment of eye disease is not currently within the scope of practice of optometry, and this request, as acknowledged by the BCAO, is for a substantial increase in the profession's scope of practice. Because of this, the Council is troubled by the lack of specificity in the proposal. Although glaucoma was referred to, the profession does not specifically describe the diseases, or types of diseases, that optometrists are trained and educated to treat, other than implying that the Board will simply determine, by policy statement, which diseases optometrists can treat.

A further example of the lack of specificity of the proposal is contained in the BCAO's most recent submission. It states:

Today, all 50 states in the U.S. have passed legislation to authorize doctors of optometry to use and/or prescribe therapeutic pharmaceutical agents (TPA's) for the treatment and management of eye disease. In Canada, Yukon is the most recent jurisdiction to join Alberta, Saskatchewan and New Brunswick in authorizing TPA utilization by optometrists.

However, virtually all of these jurisdictions, and certainly all of the Canadian jurisdictions, place limitations on treatment of eye disease by optometrists. These limitations include the types of diseases that may be treated, as well as specific requirements for further education and training and additional examinations. Although the BCAO makes brief reference to additional training, no attempt is made to describe the specific diseases they propose to treat, and how the training relates to such diseases.

The breadth of the profession's proposal is also underscored by the Board's request that it determine, by policy statement, which eye diseases may be treated and how they should be treated. This is tantamount to requesting full treatment rights with regard to any disease which may manifest itself through the eyes. The Council has received little evidence to support such a far reaching request, and indeed has received much opposition to the

proposal.

The Council accepts the detailed submission of those opposed to the optometrists' proposal to diagnose and treat eye disease.

Therefore, the Council recommends the following scope of practice statement for optometry:

The practice of optometry is:

(a) the assessment and diagnosis of the eye and vision system through the use of diagnostic drugs and instruments and devices, such as test lenses, test cards and trial lenses; and

(b) the treatment and prevention of disorders of refraction, sensory and ocular motor disorders and disfunctions of the eye and vision system primarily through the prescription and dispensing of ophthalmic devices.

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B. RESERVED ACTS

The rationale underlying the granting of reserved acts is to protect the public by limiting provision of those particularly dangerous acts to members of specific professions who are qualified to perform them. Only those acts which present a significant risk of harm will be reserved.

The Council has developed a list of reserved acts which is included in its [Shared Scope of Practice Model Working Paper](#) (the *Working Paper*). The list (see Appendix B) was discussed at length in the *Working Paper* which was widely distributed amongst the professions for consultation. The Council appreciates that at the time of the BCAO's submission, the Council had not yet developed its list of reserved acts.

In its initial submission, the BCAO proposed the following reserved acts:

- treatment services involving ocular therapeutic pharmaceutical agents should be restricted to physicians and optometrists;
- diagnostic and treatment services involving vision therapy and orthoptics should be restricted to optometrists, physicians and orthoptists acting under the direction of an optometrist or ophthalmologist; and
- treatment services involving ophthalmic lenses and contact lenses should be restricted to optometrists, ophthalmologists and licensed opticians.

Although none of the specific proposals of the BCAO fall within the Council's list, a review of its application and subsequent submissions indicates that it is clearly requesting various of the reserved acts including "diagnosis", "prescription and administration of drugs", "prescribing appliances or devices for vision conditions" as well as

the invasive act of putting an instrument, hand or finger(s) beyond the surface of the cornea. The Council will deal with the BCAO's proposals within the framework of the reserved acts list.

At the outset though the Council notes that virtually all of the respondents criticized the initial reserved acts proposal as being too broad particularly in light of the use of terms such as "treatment services". Respondents felt that such terms were virtually unlimited in scope and had the potential to reserve both harmful and unharful services to optometrists. For example, the DOABC and the OAC believe that the reserved acts proposed by the profession, instead of being precisely worded descriptions of acts that present a significant risk of harm, are loosely worded and ambiguous in their meaning. The Council emphasizes, however, that its list includes only those services presenting a significant risk of harm, and such acts as "treatment services" are not reserved acts.

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1. Making a Diagnosis

The Council's reserved act #1 is as follows:

Making a diagnosis identifying a disease, disorder or condition as the cause of signs or symptoms of the individual.

The BCAO has proposed that optometrists be granted the right to diagnose any abnormal condition of the human eye. Indeed, the BCAO submits that optometrists have been diagnosing ocular diseases and recognizing systemic conditions for years. The BCAO also provided information regarding training and education in this area, such as curricula from schools of optometry and descriptions of clinical practice programs.

The Council is satisfied that optometrists diagnose disorders of refraction, sensory and ocular motor disorders and disfunctions of the eye and visions system, and has included this as part of its recommendation regarding the scope of practice statement at page 21, above.

However, an issue remains regarding diagnosis of eye disease. Although the Council has previously rejected the profession's proposal that it treat eye disease, this issue remains outstanding as the profession suggests that it diagnoses such diseases for the purposes of referral to physicians.

On this issue, the Canadian Ophthalmological Society states that when considering the present scope of practice as it pertains to primary eye disease, it is important to be clear that optometrists do not diagnose and treat eye disease. It states:

*The present scope of practice for optometry centres on vision care and does not require the **DIAGNOSIS** of any abnormality detected while assessing the eye. As an example, hemorrhages may be seen on the retina or lining of the eye, but it is not the responsibility of the optometrist to determine whether these hemorrhages are due to:*

- diabetes
- AIDS

- *leukemia*
- *hypertension*

That is the responsibility of the secondary caregiver. The responsibility of the optometrist is to detect if the abnormality is present. [Emphasis in original.]

They assess the eye for abnormalities and, if these are found, they refer the problem for diagnosis and treatment by a physician, including family physicians. The COS is of the opinion that optometrists do not have training comparable to physicians and that the practice of diagnosis and use of therapeutic drugs are not within their scope of practice.

The Council agrees with this submission, and is of the view that the process of recognizing an abnormality for the purposes of referral does not constitute diagnosis. The process described by optometrists is more appropriately characterized as assessment of conditions, rather than diagnosis of disease.

Therefore, the Council recommends that registrants of the Board of Examiners in Optometry be granted the reserved act of "making a diagnosis of a disorder of refraction, a sensory and ocular motor disorder or dysfunction of the eye and vision system as the cause of signs or symptoms of the individual".

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2. Prescribing Drugs

The Council's reserved act #5 is as follows:

Prescribing, compounding, dispensing or administering by any means a drug listed in Schedule I or II of the [Pharmacists, Pharmacy Operations and Drug Scheduling Act](#).

For the purposes of this reserved act, the following definitions shall apply:

"prescribing": the ordering of a drug.

"compounding": mixing ingredients, at least one of which is a drug.

"dispensing": preparing or filling a prescription for drugs.

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a) Therapeutic Drugs

The profession proposes that optometrists be entitled to use and prescribe therapeutic pharmaceutical agents (TPAs). The BCAO provided a list of categories of TPAs which, it submits, optometrists are trained to use (attached as Appendix C). Clearly, this is directly related to the profession's request to treat eye disease. Since the Council has rejected the proposal, it is not necessary to deal with this issue.

However, many respondents commented specifically on the use of TPAs, and these responses supported the Council's conclusion that treatment of eye disease does not fall within the scope of practice of optometry. Moreover, it is important to note that the Board submitted it would determine, by policy statement, which classifications of drugs may be used and how they would be administered.

The Dispensing Opticians Association of British Columbia (DOABC) and the Opticians Association of Canada (OAC) express concern about the proposal that optometrist be entitled to provide "*treatment services involving therapeutic pharmaceutical agents*". The DOABC and OAC note that the proposal on therapeutic drugs constitutes an enormous expansion of the existing scope and that optometrists' training regarding the effects of drugs falls well short of ophthalmologists' training. The DOABC and OAC are also very concerned about the wording in the proposal which extends discretion to the optometrists to determine which therapeutic drugs they can treat by way of policy statements.

The College of Dental Surgeons of British Columbia (CDSBC) states that anyone using such agents should be fully educated with regard to the agents, their interactions, and all ramifications of their use.

The British Columbia Society of Eye Physicians and Surgeons (BCSEPS) notes that many of the commonly used drugs to treat eye disorders, such as glaucoma, have very serious side effects. It indicates that the treatment of eye disease requires an understanding of total body systems and that optometrists do not have the supervised clinical experience necessary for an adequate understanding of the relationship between eye disease and systemic disease. The BCSEPS also states that although optometrists have clinical training, it deals almost exclusively with problems of refraction, not disease and optometrists have virtually no clinical training in the pharmaceutical treatment of total body disease. In short, it does not believe that optometrists are qualified to prescribe therapeutic drugs.

The Canadian Ophthalmological Society (COS) has serious concerns about some of the drugs listed in the optometrists' proposal. In particular, the drugs numbered 6, 10, 13, and 16 are used to treat glaucoma which is a serious eye disease and is not appropriate for optometrists to treat. In addition, it questions whether optometrists have the appropriate training to deal with the significant side effects associated with several of the drugs listed.

The American Academy of Ophthalmology (AAO) states that the list of drugs proposed by the optometrists includes diagnostic and therapeutic drugs. It believes that a listing of the permitted therapeutics and/or the eye conditions that may be treated would offer more complete guidelines and protection for the public. The AAO notes that in the United States many states impose restrictions on the use of several of the drugs listed in the appendix to the optometric proposal. In short, the AAO questions the lack of specifics regarding the therapeutic drugs which optometrists may use.

The British Columbia Dieticians' and Nutritionists' Association (BCDNA) has some concern regarding the use of therapeutic drugs and recommends clarification about how and what the drugs are used for. The Canadian Association of Pediatric Ophthalmologists (CAPO) expresses similar general concerns about the therapeutic drugs proposal.

The Ophthalmic Nurses Group of British Columbia (ONGBC) does not support expanding the scope of practice

in optometry to include prescribing drugs as it believes medical doctors are adequately trained to perform this function and optometrists are not. Likewise, the BCMA has serious concerns about the optometrists' proposal. It does not feel that optometrists should be included in the group that may use therapeutic pharmaceutical agents.

Prince Edward Island Department of Health and Social Services included in its submission a copy of the PEI legislation. It notes that when its Act was created, it included a feature that would have allowed drugs only in accordance with provisions for training and conditions of uses, and enactment of regulations which would have required consultation with the College of Physicians and Surgeons of BC and government approval. There was some confusion, however, and the references to drugs were taken out of the Act with the unusual result that the statute contains no reference to drugs. As a result, it is not against the law for optometrists to use drugs. Optometrists in PEI fairly commonly use diagnostic drugs. However, the regulatory body has decided that it does not want optometrists using therapeutic drugs and has placed a prohibition in the standards of practice.

After reviewing these submissions, the Council reiterates its view that it is not necessary, nor is it in the public interest to grant optometrists the right to use or prescribe therapeutic pharmaceutical agents.

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b) Drugs for Diagnostic Purposes

The optometrists are currently entitled to use the diagnostic drugs listed in the rules under the [Optometrists Act](#) (Appendix D).

The Council has not conducted a detailed review of this list. However, several drugs falling within the list are also within Schedule I or II of the [Pharmacists, Pharmacy Operations and Drug Scheduling Act](#), and thus are subject to the Council's list of reserved acts. For example, "topical anaesthetics" and "mydriatics" would certainly include Schedule I or II substances. Under the new regulatory model, optometrists will not be required to list all diagnostic drugs used in practice. However, they would be required to list the specific diagnostic drugs which would fall within the Council's list. Although the Council is willing to grant the profession the reserved act of "*prescribing, compounding, dispensing or administering by any means a drug listed in Schedule I or II of the Pharmacists, Pharmacy Operations and Drug Scheduling Act*", it would only be for diagnostic purposes and only to the extent the item falls within Schedule I or II. Thus, the Council is of the view that a more detailed list of diagnostic drugs which fall within Schedule I or II must be provided by the profession before the Council can make a formal recommendation.

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3. Invasive Acts

The Council's reserved act list sets out several invasive acts which include the act of "*performing a procedure on tissue in or below the surface of the cornea*".

The BCAO submits that optometrists are trained and educated to remove superficial foreign bodies from the eye. Very few submissions were received with respect to this portion of the proposal, and none objected to the

proposal. The BCSEPS states only that patients with ocular foreign bodies are already well served by family physicians and emergency room physicians; however, they state nothing about optometrists' training and education in this area.

The Council is satisfied that this act falls within the scope of practice of optometry.

Therefore the Council recommends that registrants of the Board of Examiners be granted the reserved act of "performing a procedure on tissue in or below the surface of the cornea for the purpose of removing superficial foreign bodies from the eye".

Finally, on the issue of reserved acts, in its most recent submission the Board makes reference to the use of laser being approved in one U.S. state. Such a procedure would quite likely fall within the Council's reserved act #4, "*applying or ordering the application of a hazardous form of energy*". However, as the profession made no specific proposal, the Council has not considered this issue.

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4. Prescribing Devices for Vision Conditions

The Council's reserved act #6 states:

Prescribing appliances or devices for vision, hearing or dental conditions; dispensing such prescribed appliances or devices for dental conditions; fitting such appliances or devices for dental conditions, or fitting contact lenses.

In reviewing the existing legislation, and the materials provided, there can be no doubt that optometrists prescribe devices for vision problems and fit contact lenses.

Therefore, the Council recommends that registrants of the Board of Examiners in Optometry be granted the reserved act of "prescribing appliances or devices for vision conditions and fitting contact lenses".

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C. SUPERVISED ACTS

In previous scope of practice reports, the Council has set out its position that the regulatory college of a profession is best placed to determine whether, and under what conditions, a reserved act may be performed under the supervision of a registrant.

In its report of on the [scope of practice of medicine](#) the Council stated:

The Council recommends that a provision be enacted which sets out the duties of a health professional and his or her regulatory college when delegating a reserved act. The provision should require the following:

- *The assigning health professional's governing body must provide assent to the proposed reserved act being performed by someone else;*
- *The reserved act to be assigned as well as the level of supervision must be clearly defined and circumscribed by the assigning health professional's governing body;*
- *Where the person to whom the act will be assigned is a member of a self-regulating health profession, his or her governing body must approve of the assigning of the reserved act;*
- *The instruction to perform the act must be made in writing either by way of a general written protocol or through a case-specific instruction;*
- *The assigning health professional must be satisfied that the individual who will be performing the act has the necessary skills and training to perform the act safely;*
- *The assigning health professional must ensure that the person who will be performing the act accepts the assignment.*

The Council believes this general approach to supervised acts more accurately reflects the reality that procedures to be delegated vary from profession to profession and may include subsets and variations of reserved acts and further, may be performed under a myriad of circumstances and conditions.

Three issues related to supervision arose during this investigation.

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1. Optometric Assistants

The BCAO made no specific submissions regarding whether any of the reserved acts can be performed under supervision. However, it did make general comments about optometric assistants. Optometric assistants perform various pre- and post-test screening procedures and specific testing aimed at health data collection. These procedures are investigational procedures of a technical nature including depth perception screening, colour vision screening, visual field testing, autokeratometry, contact lens insertion and removal, non-contact tonometry, and various automated computer-assisted procedures. None of these acts appear on the Council's list of reserved acts, and therefore would not fall within the Council's general proposal regarding supervision.

2. Contact Lenses

Another issue concerning supervision was the discussion of supervision of contact lens fitting. The College of

Opticians of British Columbia (COBC) submitted:

It was agreed by Optometrists, Ophthalmologists and Opticians during discussion on the Opticians' scope of practice that the fitting of contact lenses should not be a supervised activity in order to ensure that the public is protected. Our position has not changed and we maintain that this activity MUST NOT be supervised under Optometrists.

There is already a licensed group of opticians, who have demonstrated a minimum level of competency through examination. These opticians are required to adhere to the Regulations and Bylaws of the College of Opticians with regard to continuing education, quality assurance, code of ethics, inquiry professional standards and discipline. The public will not be protected if we permit unlicensed individuals to perform activities to which regulations are in place within another Regulatory body.

Thus, the COBC submits that optometrists ought not to be permitted to delegate the reserved act of contact lens fitting. Vision Council submits that optometrists ought to be subject to the same rules as opticians, which are restrictive in regard to delegation of this act. The Council simply repeats its position that the issue of whether an act can be performed under supervision and under what conditions is best left to the regulatory body of the profession.

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3. Orthoptists

Orthoptists are para-medical professionals who work in multi-disciplinary teams involved in the provision of eye care to the public. For the most part, they work in hospitals and ophthalmologists' offices. Generally, they work under the supervision of an ophthalmologist.

Several groups either representing or consisting of orthoptists objected to that portion of the BCAO's proposal where it states optometrists supervise orthoptist, in some circumstances.

The Department of Ophthalmology at St. Paul's Hospital states that orthoptists are certified by the Canadian Orthoptic Council and are required to practice under the supervision of a physician, ophthalmologist, or neuro-ophthalmologist. Orthoptists are not allowed to practice under the supervision of an optometrist. Therefore, to suggest that orthoptists work under the supervision of an optometrist is inappropriate.

The Department of Orthoptics and Ophthalmology, IKW-Grace Health Centre, Halifax (Grace Health Centre), states that the proposed scope of practice includes all of the skills orthoptists use except for the use of pharmaceutical agents which orthoptists use only under the supervision of an ophthalmologist. Therefore, various of the skills referred to by the optometrists should not be legislated to be performed only by optometrists or physicians to the exclusion of orthoptist. Grace Health Centre also notes that orthoptist cannot work under an optometrist as a result of their certification. The orthoptist can only work with a physician, ophthalmologist, or neuro-ophthalmologist. Grace Health Centre also expresses concern that the proposal regarding treatment services involving ophthalmic lenses and contact lenses would effect the practice of orthoptics.

The AHCBCO states that the current scope of practice, which states that certain practices including the use of orthoptic instruments, which are included in the current scope of practice of optometry are also performed by

orthoptists. The AHCBCO also notes that orthoptists use pharmaceutical agents only under the direct supervision of a physician and they are concerned that non-physicians would be given license to prescribe drugs, many of which have serious side effects.

The Council accepts these submissions and notes that orthoptists need have no concern as if they do not work under the supervision of an optometrist and thus would not be covered by any provisions regarding supervision which may be established by the Board of Examiners.

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D. RESERVED TITLES

Reserved titles are titles reserved exclusively to a health profession. Reserved titles afford a means for consumers to identify the different types of health care providers, to distinguish the qualified from the unqualified, and to differentiate those practitioners who are regulated from those who are not. Titles must adequately serve the public in describing the practitioner and the services being provided and must distinguish the practitioner from others performing services outside the jurisdiction of the college.

Section 31 of the current [Optometrists Act](#) provides as follows:

Use of titles>

31 (1)

An optometrist holding a valid license under this Act, who holds the academic qualification of Doctor of Optometry granted by a university for a course of studies accepted by the boards as qualification for registration and licensing under this Act, may display or make use of the title "doctor" or the abbreviation "Dr.", but only as "Doctor of Optometry", "Dr. of Optometry", "Optometry Doctor" or "Optometry Dr.".

Also, section 35(3) of the current [Optometrists Act](#) provides that no person, except a registrant, may use the title "optometrist" or any other title, name or description implying that he or she is entitled to practise optometry.

The BCAO proposes that in addition to the currently protected titles, optometrists be granted the exclusive right to use the following titles:

"Optometric Physician" and "O.D."

The BCMA suggests that the term "Doctor of Optometry" be used so as to make it clear that optometrists are not medical doctors. The Canadian Ophthalmological Society (COS) believes that the Council should be very careful about allowing titles which further blur the line between medical doctors and optometrists. Similarly, the British Columbia Society of Eye Physicians and Surgeons (BCSEPS) believes that the public and even some paramedical personnel are not aware that optometrists are not medical doctors and therefore suggest that the prefix "Dr." always be followed by the term "optometry". Ontario Ministry of Health states that in Ontario

optometrists are allowed to refer to themselves as "Doctor".

The British Columbia College of Optics (BCCO), a private educational institution, states that the title "optometrist" should be deleted from the list of reserved titles since many members of the general public still confuse the terms "optician" and "optometrist". The BCCO states that assuming an expansion of optometry scope of practice to include therapeutic pharmaceutical agents, the term "optometric doctor" may be more appropriate.

The American Academy of Ophthalmology (AAO) indicates that the use of the titles "optometrist" and "O.D." are appropriate. However, the AAO noted that there is an effort on the part of optometrists in the United States to identify themselves as physicians by using the term "Optometric Physician". The AAO believes this is a problem as many patients cannot readily differentiate between an ophthalmologist and an optometrist. The Council agrees, and is of the view that granting optometrists the title "physician" would not assist the public in determining what the optometric profession does.

A member of the University of British Columbia Department of Ophthalmology expressed concern about the reservation of the use of the title "O.D.". Although currently not practicing, this individual has earned his optometry degree and feels he is entitled to use the designation, "O.D.". The Council agrees that academic or educational designations should not be reserved.

The Council is satisfied that the current titles serve the public adequately and that there is no need to expand the titles currently reserved to members of the profession.

Therefore, the Council recommends:

- that the titles "Optometrist", "Doctor of Optometry", "Dr. of Optometry", "Optometric Doctor", and "Optometric Dr." and any affix of those titles be reserved for registrants of the Board of Examiners in Optometry.**

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E. OTHER ISSUES

1. Prescription Issues

This is a significant issue for the Dispensing Opticians Association of British Columbia (DOABC) and the Opticians Association of Canada (OAC). They believe that the new legislation must include language to ensure that a consumer is given a prescription on the completion of an eye examination. Another issue regarding prescriptions is the difference in optometrists' and opticians' understanding of the term prescription. Apparently, optometrists believe that prescription may include a specific brand name while opticians believe that a prescription is simply the written record of the ophthalmic lens necessary to correct refractive error. The DOABC and the OAC submit that this term must be defined clearly in the new legislation, and that the current definition in the Optician's Regulation is appropriate. The regulation states:

"prescription" means

- (a) the written record or the power of a lens to correct the refractive error of an eye, and
- (b) reading add, prisms, back vertex distance and contraindications; . . .

The Council is of the view that these issues are an inter-professional dispute and do not fall within its mandate for the scope of practice review. The issue must be worked out amongst the professions or failing that, perhaps by the government through legislative initiative. However, the Council has previously discussed prescription issues in its report on the "Recommendations on the Designation of Opticianry" issued in December 1992. The Council made several recommendations which are repeated here:

7. *It should be mandatory for optometrists and ophthalmologists to deliver prescriptions for both eyeglasses and contact lenses to their patients.*
8. *Prescriptions issued by an optometrist or ophthalmologist should not indicate in any way that only a person qualified to issue a prescription is qualified to fill it, but may direct the patient to return to the prescriber if problems are encountered.*
9. *Unless a specific contra-indication is included in a prescription, it should not contain any reference or prohibition against mathematically converting it from a prescription for eyeglasses to a prescription for contact lenses.*

The Council reiterates these comments. The Opticianry Report also contains supporting discussions regarding these recommendations.

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2. The Name of the Regulatory Body

In British Columbia, the name of the body responsible for regulating optometry is the "Board of Examiners in Optometry". Generally speaking, it is customary within the health professions to refer to the regulatory body as the "College", while the professional body is identified as the "Association". This is the practice in British Columbia, and most other Canadian jurisdictions. In the Council's view, this practice greatly assists the public in determining the respective roles of the two bodies.

Therefore, the Council recommends that the name of the regulatory body, the "Board of Examiners in Optometry", be changed to "College of Optometry of British Columbia".

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3. Various Other Issues

Several respondents raised other issues which do not fall within the Council's mandate for the scope of practice review. These include prohibitions in the [Optometrists Act](#) about associations with opticians, the practice of simple sight testing by trained refracting opticians, and frame selection being dictated by the prescriber. None of these issues were addressed by the Council.

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IV. RECOMMENDATIONS

1. The Council recommends the following scope of practice statement for optometry:

The practice of optometry is:

- (a) the assessment and diagnosis of the eye and vision system through the use of diagnostic drugs and instruments and devices, such as test lenses, test cards and trial lenses; and
- (b) the treatment and prevention of disorders of refraction, sensory and ocular motor disorders and disfunctions of the eye and vision system primarily through the prescription and dispensing of ophthalmic devices.

2. The Council recommends the following reserved acts for registrants of the Board of Examiners in Optometry:

- making a diagnosis of a disorder of refraction, a sensory and ocular motor disorder or dysfunction of the eye and vision system as the cause of signs or symptoms of the individual; and
- performing a procedure on tissue in or below the surface of the cornea for the purpose of removing superficial foreign bodies from the eye.
- prescribing appliances or devices for vision conditions and fitting contact lenses.

3. The Council recommends

- that the titles "Optometrist", "Doctor of Optometry", "Dr. of Optometry", "Optometric Doctor", and "Optometric Dr." and any affix of those titles be reserved for registrants of the Board of Examiners in Optometry.

4. The Council recommends that the name of the regulatory body, the "Board of Examiners in Optometry", be changed to "College of Optometry of British Columbia".

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Footnotes:

1. During the early drafting of this Report statute references were based on RSBC 1979 and Amendments. For ease of reference, the older provisions of the revised statutes 1979 are indicated in brackets next to the current citations. The current versions refer to the [Health Professions Act](#), RSBC 1996, c. 183 and the [Optometrists Act](#), RSBC 1996, c. 342.

2. American Academy of Ophthalmology, *Glossary of Terms*, revised and approved by the Board of Trustees in June 1993.

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Health Professions Council POST-HEARING UPDATE OF PRELIMINARY REPORT: OPTOMETRISTS

Arminée Kazanjian, Member

David MacAulay, Member

Brenda McBain, Member

March 2001

This Post-Hearing Update should be read in conjunction with the [Preliminary Report](#) for the profession.

The Council issued its *Optometrists Scope of Practice Review (Preliminary Report)* in April 1999. The public hearing was held on 24 January 2000. The following are changes to the *Preliminary Report* which arose from the submissions made either at the public hearing or in subsequent written submissions.

I. SCOPE OF PRACTICE

In the *Preliminary Report*, the Council recommended the following scope of practice for optometrists:

The practice of optometry is:

- a. *the assessment and diagnosis of the eye and vision system through the use of diagnostic drugs and instruments and devices, such as test lenses, test cards and trial lenses; and*
- b. *the treatment and prevention of disorders of refraction, sensory and ocular motor disorders and dysfunctions of the eye and vision system primarily through the prescription and dispensing of ophthalmic devices.*

In the *Preliminary Report*, the Council discussed the issues of eye disease and the use of therapeutic pharmaceutical agents (TPAs) by optometrists, and concluded that they should not be allowed to treat and diagnose abnormal conditions of the human eye or to use TPAs. The Council's conclusion was based largely on the profession's extremely broad request. Both the B.C. Association of Optometrists (BCAO) and the Board of Examiners in Optometry requested treatment of eye disease and use of pharmaceuticals without limitation.

At the public hearing, the profession made a more specific proposal which was followed up in writing after the hearing. In its submission of 19 February 2000 the BCAO proposed that optometrists be granted a formulary of

drug categories approved by regulation which would include the right to use the following restricted pharmaceutical agents:

- i. *mydriatics*;
- ii. *cycloplegics*;
- iii. *miotics*;
- iv. *non-steroidal, anti-allergy medications*;
- v. *non-steroidal, anti-inflammatory medications*;
- vi. *steroids*;
- vii. *anti-infective medications*; and
- viii. *in a consultative, co-management arrangement with an ophthalmologist who is licensed to practice in Canada, anti-glaucoma medications*.

The BCAO also suggested changes to the scope of practice statement which would follow from granting the use of therapeutic pharmaceutical agents.

TPA use by optometrists in Canada is permitted in Alberta, New Brunswick, Saskatchewan, the Yukon Territory, Nova Scotia and Quebec. Quebec has amended the *Optometry Act*, RSQ, c.O-7, to allow TPA privileges to optometrists. However, the regulations, which will spell out TPA use in greater detail and which require government approval, have yet to be enacted. It is important to note that all jurisdictions provide parameters for optometrists' ability to use TPA. For example, Nova Scotia requires, among others things, 40 hours of clinical training. Saskatchewan does not allow use of anti-glaucoma agents. There are 47 different states in the U.S. that allow TPA use and each state attempts to balance consumer choice with public safety. Virtually all U.S. jurisdictions contain restrictions on use of TPA, and many require additional training and education.

After reviewing the detailed information from other jurisdictions and considering the more specific and limited proposal from the BCAO, the Council is prepared to recommend that optometrists be permitted to treat eye disease and use some therapeutic pharmaceutical agents. This recommendation requires some modifications to the scope of practice statement, and the Council therefore recommends the following scope of practice statement for optometry:

The Health Professions Council recommends the following scope of practice for optometrists:

The practice of optometry is the assessment of the eye and vision system through the use of diagnostic drugs and instruments and devices, such as test lenses, test cards and trial lenses; and the treatment and prevention of disorders of refraction, sensory and ocular motor disorders, and diseases and disorders of the eye and structures directly related to the vision system through the prescription and dispensing of ophthalmic devices and therapeutic pharmaceutical agents prescribed by regulation.

The Council has determined, as a general matter, that scope of practice statements should not contain or attempt to list the reserved acts granted to a profession. Accordingly, the Council has removed the term "diagnosis" from the scope of practice statement.

There is no doubt, however, that optometrists may perform diagnosis as that reserved act has been granted to them.

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II. RESERVED ACTS

In the *Preliminary Report*, the Council recommended the following reserved acts for optometrists:

1. *Making a diagnosis of a disorder of refraction, a sensory and ocular motor disorder or dysfunction of the eye and vision system as the cause of signs or symptoms of the individual;*
2. *Performing a procedure on tissue in or below the surface of the cornea for the purpose of removing superficial foreign bodies from the eye;*
3. *Prescribing appliances or devices for vision conditions and fitting contact lenses.*

Granting optometrists the use of therapeutic pharmaceutical agents also requires modifications to the reserved act granted to the profession.

First, the act of diagnosis as granted to optometrists should be modified so that it reads:

The Health Professions Council recommends the following reserved act for optometrists:

1. ***Making a diagnosis of a disorder of refraction, a sensory and ocular motor disorder, disease or dysfunction of the eye and structures directly related to the vision system as the cause of signs or symptoms of the individual.***

Second, optometrists should be granted the following reserved act:

The Health Professions Council recommends the following reserved act for optometrists:

5(a) Prescribing, dispensing or administering a drug prescribed by regulation.

For the purposes of this reserved act, the following definitions shall apply:

"prescribing": the ordering of a drug.

"dispensing": preparing or filling a prescription for drugs.

The Council emphasizes that its recommendation regarding use of therapeutic pharmaceuticals is conditional on the passing of a regulation to address this issue.



A. Contents of Proposed Regulation for use of Therapeutic Pharmaceutical Agents

The regulation through which optometrists are granted the use of therapeutic pharmaceutical substances is a key part of this recommendation and, at a minimum, must contain the following elements:

1. A listing of drug categories

The regulation should include the categories of drugs approved for use by optometrists. The Council recommends that this list contain the following topical therapeutic pharmaceutical medications:

- i. mydriatics;
- ii. cycloplegics;
- iii. miotics;
- iv. non-steroidal, anti-allergy medications;
- v. non-steroidal, anti-inflammatory medications;
- vi. corticosteroids; and
- vii. anti-infective medications.

The regulation should also refer to the categories of diagnostic drugs used by optometrists. It is expected that for both diagnostic and therapeutic drugs, a more specific list of drugs falling within the categories described in the regulation will be created by the regulatory body for optometry and enacted through bylaws.

The Council has not granted the optometrists' request for use of anti-glaucoma medications because it is not satisfied that their education and training is sufficient in this area. While we support co-management of such diseases with physicians, the serious systemic implications of the medications used in treating this condition are, in our view, beyond the present scope of practice of optometry.

2. Training and education requirements

Virtually all jurisdictions which have approved optometrists' use of therapeutic pharmaceutical substances require some form of specialized training and education. For example, the Bylaws of the Saskatchewan Association of Optometrists which were approved in December 1997 contain the following:

4.15 The Board of Examiners shall review, develop, administer and recommend to Council the educational standards and examinations required for members to be eligible for a diagnostic pharmaceutical agents certificate or a therapeutic pharmaceutical agents certificate.

10.3 The Registrar may issue a Diagnostic Pharmaceutical Agents Certificate to a member who provides satisfactory evidence that the member:

- a. *has graduated subsequent to the year 1979 from either the University of Montreal or the University of Waterloo Schools of Optometry with full credit for a course in pharmacology; or*
- b. *has graduated subsequent to the year 1979 from a school or college of Optometry with full credit for a course in pharmacology judged by the Board of Examiners to be the equivalent to the course presented*

at either the University of Montreal or the University of Waterloo Schools of Optometry; or

- c. *has completed a course in pharmacology approved by the Board of Examiners and passed the examinations prescribed by the Board of Examiners.*

In our view, the proposed regulation in B.C. ought to contain similar requirements for further education, a training program and examination.

The provinces of Alberta, New Brunswick, Saskatchewan and the Yukon have similar regulations, and they may serve as models for a similar regulation in B.C.

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3. Requirement to notify treating physician

The regulation should also contain a requirement that the optometrist notify the patient's primary care provider any time a therapeutic pharmaceutical substance is administered or prescribed.

The Health Professions Council recommends that the regulation through which optometrists are granted the use of therapeutic pharmaceutical agents must contain at a minimum the following elements:

- **a listing of specific drug categories of therapeutic pharmaceutical agents which optometrists may use;**
- **a certification program including training and education requirements, and an examination; and**
- **a requirement to notify the treating physician any time a therapeutic pharmaceutical agent is administered or prescribed.**

B. Prosthetic Devices

At the hearing, two ocularists discussed the issue of fabricating artificial eyes. They were concerned that they would be prevented from performing this service. The reserved acts list does not include fabricating artificial eyes. To the extent that this service raises a risk of harm, the Council is satisfied that the likelihood of untrained persons practising in this field is small and is addressed through the highly specialised nature of the practice.

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Health Professions Council Pharmacists Scope of Practice Preliminary Report

Irvine E. Epstein, Q.C., Chair
Arminée Kazanjian, Member
David MacAulay, Member

April 2000

This Preliminary Report should be read in conjunction with the [Post-Hearing Update](#) for the profession.

FOREWORD

This report is the result of the Health Professions Council's review of the scope of practice of pharmacy pursuant to the [Terms of Reference](#) from the Minister of Health and Minister Responsible for Seniors. Under the [Health Professions Act](#), the Health Professions Council is a six-person advisory body appointed by the Government of British Columbia to make recommendations to the Minister of Health and Minister Responsible for Seniors about the regulation of health professions.

In this report the Health Professions Council examines how the existing scope of practice of pharmacy should be legislatively defined in order to reflect fairly and accurately the current state of practice and the public interest in the practice of pharmacy.

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The Health Professions Council has conducted a review of the scope of practice of pharmacy.

The purpose of the review is to provide recommendations to the Minister of Health and Minister Responsible for Seniors regarding four matters: scope of practice statements, reserved acts, supervised acts, and reserved titles.

The Health Professions Council has conducted a detailed consultation process and its recommendations regarding the four elements of the scope review are as follows:

1. The Council recommends the following scope of practice statement for pharmacists:

The practice of pharmacy is the compounding, dispensing and sale of drugs monitoring drug therapy and advising on therapeutic values, contents and hazards of drugs and devices and identification, assessment and recommendations to prevent or resolve drug related problems.

2. The Council recommends that compounding or dispensing a drug listed in Schedule I or II of the *Pharmacists, Pharmacy, Operations and Drug Scheduling Act* be granted to members of the College of Pharmacists. For the purposes of this reserved act, the following definitions shall apply:

"compounding": mixing ingredients, at least one of which is a drug.

"dispensing": preparing or filling a prescription for drugs.

3. The Council recommends that a provision be enacted which deals with general principles regarding delegation of reserved acts. The provision would apply generally, not to individual cases. It should require the following:

- The assigning health professional's governing body must provide assent to the proposed reserved act being performed by someone else
- The reserved act to be assigned as well as the level of supervision must be clearly defined and circumscribed by the assigning health professional's governing body
- Where the person to whom the act will be assigned is a member of a self-regulated health profession, his or her governing body must approve of the assignment

- The instruction to perform the act must be made in writing either by way of a general written protocol or through a case-specific instruction
 - The assigning health professional must be satisfied that the individual who will be performing the act has the necessary skills and training to perform the act safely
 - The assigning health professional must ensure that the person who will be performing the act accepts the assignment.
4. The Council recommends the following titles or abbreviations thereof be reserved for members of the College of Pharmacists of BC:
- Apothecary
 - Druggist
 - Pharmacist and
 - Pharmaceutical Chemist.

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I. INTRODUCTION

A. THE NATURE OF THE REVIEW

This is the preliminary report of the review of the scope of practice of pharmacy by the Health Professions Council (Council).

The review was conducted pursuant to [Terms of Reference](#) issued by the Minister of Health and Minister Responsible for Seniors in accordance with section 25 of the [Health Professions Act \(HPA\)](#). The [Terms of Reference](#) direct the Council to review the scopes of practice of the recognized health professions, of which pharmacy is one.

The *Terms of Reference*, which are included as [Appendix A](#) to this report, indicate that there are four main elements to the scope of practice review:

- i. scope of practice statements which describe what the profession does, the methods it uses and the purpose for which it does it
- ii. reserved acts which are those acts that present such a significant risk of harm that they should be performed only by professionals who are qualified to perform them
- iii. supervised acts which are reserved acts, or aspects of reserved acts, which may be performed by persons supervised by health professionals and

- iv. reserved titles which are titles that describe a profession's services and which are reserved exclusively for the health profession.

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B. THE PROCESS FOR THE REVIEW

The general process for the review provides for an initial meeting with the profession(s), submission of briefs by the regulatory body and professional association for each profession, a consultation process involving all health professions and interested parties regarding each professions' submission, drafting of a preliminary report, public hearings and a final report.

The Council met with representatives of the College of Pharmacists of BC (College) early in 1995. In June 1995 the College submitted its scope of practice brief. This was the subject of consultation in 1996. The College submitted an Addendum in 1999 which was the subject of a second consultation process. This report contains the Council's preliminary findings regarding both the original brief and the 1999 Addendum.

This report will be circulated to all health professions and other interested parties who participated in the Council's consultation process. A public hearing is scheduled on June 6, 2000, after which a final report will be issued. Persons or organizations who have made written responses to either the original consultation letters or to this report will be invited to speak at the hearing.

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C. THE REGULATION OF PHARMACY

The first provincial enactment was the *Pharmacy Act*, SBC 1891, c. 33. It established the Pharmaceutical Association of British Columbia with a Board of Examiners to examine candidates. It provided a list of drugs (schedules) to place restrictions on the sale of certain drugs, and enabled the Board of Examiners to dispense with examination of candidates under certain circumstances. It also empowered the council of the Association to make bylaws. The *Pharmacy Act*, RSBC 1903-4, c.5, made it unlawful to practise without a certificate anywhere in the province. In 1921 the *Pharmacy Act Amendment Act*, RSBC 1921, c. 50, required the presence of a licensed pharmacist in every pharmacy, but permitted certified clerks to be left temporarily in charge. The *Pharmacy Act Amendment Act*, RSBC 1923, c.55 revised the provision regarding the council's power to make bylaws.

The *Pharmacy Act*, RSBC 1935, c. 56, repealed and replaced the earlier *Pharmacy Act*, RSBC 1924, c. 193. It provided a list of prohibitions, including prohibited use of the titles "pharmacist", "druggist", "pharmaceutical chemist", etc. unless registered under the Act. It also introduced a new provision dealing with cancellation of licenses, and with appeals from a cancellation to the Supreme Court. The *Pharmacy Act Amendment Act*, RSBC 1946, c. 58, permitted the council to suspend a licence pending a hearing by the council, and permitted it to make bylaws and regulations regarding the qualifications for registration as pharmacy students, the period of practical training required, the discipline of registered students, fees to be paid on reinstatement, the striking off the register or suspension of any member for non-payment of fees, etc. It also provided new criteria for medical

practitioners to meet in order to be registered. Finally, it required the presence of a licensed pharmacist at all times when a pharmacy is open, thereby no longer permitting certified clerks to be left in charge.

The *Pharmacy Act Amendment Act*, RSBC 1951, c. 61, revised, among others, the definition of "pharmacy" and "drug". It also recognized the full-time Faculty of Pharmacy at UBC. It permitted the executive committee of the council to recommend to the Lieutenant-Governor in Council changes in the schedule of drugs. The *Pharmacy Act Amendment Act*, RSBC 1957, c. 47, amended the definition of "pharmacy" to authorize the Minister to bring within the scope of the Act those hospitals large enough to have a dispensary run by a qualified pharmacist and to exclude the small hospitals. The *Pharmacy Act Amendment Act*, RSBC 1960, c. 42, amended the definition of "restricted drugs" to make reference to Schedule F of the *Food and Drugs Act of Canada*. The definition of "drug" was changed under the *Pharmacy Act Amendment Act*, RSBC 1964, c. 38, to that used in the *Food and Drugs Act*.

The *Pharmacy Act*, RSBC 1974, c. 62, repealed and replaced the *Pharmacy Act*, RSBC 1960, c. 282. It revised the definition section, constituted the College of Pharmacists of BC, and provided that the council of the Association is to administer the College. It also amended the provision regarding prohibited acts and regarding restrictions on sale of drugs of Schedule A. The act was renamed the *Pharmacists Act*, RSBC 1979, c. 326.

The *Pharmacists, Pharmacy, Operations and Drug Scheduling Act*, SBC 1993, c. 62 replaced the 1979 *Pharmacists Act*. It established the powers of the College of Pharmacists including registration, standards of practice, discipline, and bylaw and rule-making power. The Act also included provisions relating to medicated animal feeds and veterinary drugs.

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II. THE POLICY BACKGROUND

The main impetus for a scope of practice review was the *Report of the British Columbia Royal Commission on Health Care and Costs* (the Seaton Commission). The Seaton Commission stated that the existing legislation governing the health professions creates persistent jurisdictional disputes and a distinct lack of co-operation among the health professions, despite the fact that all health professional colleges have the same mandate - to protect the public from preventable harm.

The Seaton Commission stated that the primary reason for the jurisdictional disputes was the present regulatory system's reliance on exclusive scopes of practice. Under the exclusive scope of practice model, the various health professions have been granted an exclusive right to practice within a legislatively defined scope of practice. No one, other than a member in good standing of that profession, can perform acts within the profession's scope of practice unless they are granted an exemption.

The Commission concluded:

...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.

(Closer to Home, The Report of the Royal Commission on Health Care and Costs in British

Columbia, Volume 2, 1991, p. D-33)

This recommendation is also consistent with legislative initiatives underway in Alberta.

The Seaton Commission was not the first review body to suggest that the present legislative model of exclusive scopes of practice was inappropriate. Restricting professional monopolies (exclusive scopes of practice) was also recommended in an earlier study commissioned by the British Columbia Minister of Health. In discussing the conflicts which may arise between the professional college and the public interest, the issue of exclusive scopes of practice was raised:

It must be emphasized that any professional legislation which unduly restricts the scope of practice of skilled personnel may be contrary to the public interest in greater supply and accessibility of service through the development of team practice. Therefore, it is urged that: Professional legislation should not contain narrow restrictions or rigid definitions of scope of practice which are excessively exclusive that measures should be taken (as indicated below) to reduce the area of interprofessional strain and conflict and that no prosecutions for violations of scope of practice legislation should be undertaken without the prior consent of the appropriate public authority.

Insofar as may be possible with due regard for public safety, professional law should not place rigid restrictions on the scope of practice of allied health personnel, and greater flexibility should be encouraged in the allocation of roles between the health disciplines.

(Professor J.T. McLeod, *Public Regulation of the Professions in Health Security for British Columbians, Special Report: Consumer Participation, Regulation of the Professions, and Decentralization* (1974), the report of Richard D. Foulkes, B.A., M.D., F.A.P.H.A. to the Minister of Health, Province of British Columbia, Tome Three, p.145)

Thus, the trend in regulatory policy for the health professions has been towards reducing exclusivity in order to enhance interdisciplinary practice, improve accessibility to health care services and increase consumer choice, while at the same time maintaining the fundamental objective of protecting the public.

These policy trends are clearly reflected in the [Terms of Reference](#) for the scope of practice review which provide the basis for a new regulatory framework for health professions in British Columbia. The core elements of the new framework are scope of practice statements and reserved acts.

Under the present system, scope of practice statements are exclusive. In the new system, scope statements will not be exclusive but professions may be granted reserved acts.

Reserved acts are those elements of a profession's scope of practice which present such a significant risk of harm that they should be reserved to a particular profession, or shared amongst particular professions. Thus, unlike the present system in which each profession is granted exclusivity within its entire defined scope of practice (subject to specified exceptions), only those acts which present a significant risk of harm will be reserved.

In short, the government has assigned the Council the task of creating a regulatory model based on broad, non-exclusive scope of practice statements and narrowly defined reserved acts.

The government has the responsibility to ensure that those services which are accessible are safe and that the regulatory framework for the practice of health professions protects the public from incompetent, impaired, or unethical practitioners. At the same time, the regulatory framework should not entrench a paternalistic function for professions or reserve exclusive areas of practice simply to enhance professional status and control.

The new system of overlapping scopes of practice and narrow reserved acts removes barriers to interdisciplinary practice and offers greater choice and accessibility to the public. In the Council's view, the public interest is served by professional legislation which promotes quality in the delivery of health care services within safe parameters. Indeed, the Council's primary policy objective in conducting its review is achieving the optimum balance between safe practice and consumer choice.

With this in mind, the Council proposes to consider the practice of pharmacy having regard to the four elements of the scope review.

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III. DISCUSSION OF ISSUES

The main issues raised by this review are the four elements listed above: scope of practice, reserved acts, supervised acts and reserved titles.

A. SCOPE OF PRACTICE

The scope statement **describes** what the profession does, the methods it uses, and the purpose for which it does it. Unlike the present legislative scheme, the statement itself does not grant an exclusive scope of practice. Nonetheless, the statement is important because: 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 and it informs the public about the services practitioners are qualified to perform. It is expected that the Council's recommendations will increase overlapping scopes of practice.

The current scope of practice of pharmacists is defined by the *[Pharmacists, Pharmacy, Operations and Drug Scheduling Act](#)*, RSBC 1996, c. 62 (PPODSA) as the practice and responsibility for:

- a. *interpretation and evaluation of prescriptions,*
- b. *compounding, dispensing and added labelling of drugs and devices,*
- c. *monitoring drug therapy,*
- d. *identification, assessment and recommendations necessary to resolve or prevent drug related problems in patients,*
- e. *advising persons of the therapeutic values, content and hazards of drugs and devices,*

- f. *safe storage of drugs and devices,*
- g. *maintenance of proper records, including patient records, for drugs and devices,*
- h. *services, duties and transactions necessary to the management, operation and control of a pharmacy or to provide pharmacy services in a hospital, facility or care centre, and*
- i. *sale of drugs by pharmacists.*

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1. Scope of Practice in Other Provinces

In Ontario, pharmacists are regulated under the *Regulated Health Professions Act*, SO 1991, c. 18, and the *Pharmacy Act*, SO 1991, c. 36. The scope of practice is defined in section 3 of the *Pharmacy Act* as follows:

The practice of pharmacy is the custody, compounding and dispensing of drugs, the provision of non-prescription drugs, health care aids and devices and the provision of information related to drug use.

Bill 22, or the *Health Professions Act* of Alberta was assented to in May 1999 and is currently awaiting proclamation. Section 3 of Schedule 19 of the Act defines the scope of practice:

In their practice, pharmacists promote health and prevent and treat diseases, dysfunction and disorders through proper drug therapy and non-drug decisions and, in relation to that, do one or more of the following:

- a. *assist and advise clients, patients and other health care providers by contributing unique drug and non-drug therapy knowledge on drug and non-drug selection and use,*
- b. *monitor responses and outcomes to drug therapy,*
- c. *compound, prepare and dispense drugs,*
- d. *provide non-prescription drugs, blood products, parenteral nutrition, health care aids and devices,*
- e. *supervise and manage drug distribution systems to maintain public safety and drug system security,*
- f. *educate clients, patients and regulated members of the Alberta College of Pharmacists and of other colleges in matters described in this section,*
- g. *conduct or collaborate in drug-related research,*

- h. *conduct or administer drug and other health-related programs, and*
 - i. *provide restricted activities authorized by the regulations.*

According to information provided by the Alberta Pharmaceutical Association (AphA), there are currently no restricted activities for pharmacists in Alberta. Restricted activities will be the subject of regulations to be proposed and reviewed sometime in the year 2001 or 2002.

The Manitoba *Pharmaceutical Act*, CCSM, c. P60, defines pharmacists' scope of practice as follows:

Practice of pharmacy means

- a. *responsibility for preparing, distributing and controlling drugs in a pharmacy,*
- b. *compounding a prescription,*
- c. *dispensing a drug,*
- d. *selling a drug by retail,*
- e. *operating a pharmacy insofar as the operation relates to the practice of pharmacy.*

In Quebec, section 17 of the *Pharmacy Act*, RSQ, c. P-10, gives the following scope of practice statement:

Every act having as its object the preparation or selling, by prescription or not, of a medication or poison constitutes the practice of pharmacy.

The practice of pharmacy includes the communication of information on the prescribed use or, failing a prescription, on the recognized use of medications or poisons, and the making of a record for each person to whom a pharmacist delivers medication or poison on prescription and the pharmacological study of such record.

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2. Proposed Scope of Practice

In its initial 1995 brief to the Council the College proposed the addition of the following three points to the current legislative scope of practice definition, to reflect current and emerging areas of patient-focused pharmacy care:

- 1. *performing physical assessment relating to the initiation or monitoring of drug therapy*
- 2. *obtaining diagnostic or analytic test results in accordance with previously approved written guidelines or protocols*

3. *initiating or modifying medication therapy in accordance with previously approved written guidelines or protocols.*

The College is asking that these three activities be explicitly stated in the scope of practice statement, which would expand the scope of practice of pharmacists. As well, these encompass acts or activities which form part of certain of the Council's list of reserved acts, specifically reserved acts #1 (diagnosis) and #5 (prescription and administration of a drug listed in Schedule I or II of the PPODSA). The College made a further submission in September 1999 regarding specific reserved acts.

The requests by the College for physical assessments related to initiation or monitoring of drug therapy, for use of diagnostic test results, and for initiating or modifying medication therapy were the subject of much comment in the initial consultation process conducted in 1996. Those original responses will be summarized here, but because these 1995 requests are closely related to the more specific requests for reserved acts outlined in the College's subsequent 1999 brief to the Council, they will be subject to further analysis in the reserved acts section of this report.

The Faculty of Pharmaceutical Sciences at UBC believes the proposed scope of practice statement is a good reflection of the activities that constitute pharmacy practice in BC. It adds that the convenient and relatively wide access that the public has to pharmacists in BC puts pharmacists in a unique position to provide efficient primary care services including general health information, medication education materials, consultation on self-medication products, regular monitoring of prescribed drugs, and referrals to other health professionals. This has been described by the profession as "pharmaceutical care" and the undergraduate curriculum has been moulded to prepare graduates for a patient-centred practice.

The Faculty adds that the three additional points proposed by the College reflect similar legislative initiatives that have taken place in North America.

A number of respondents make generally supportive comments about the College's scope of practice submission. The College is supported by the Ontario College of Pharmacists, the BC Naturopathic Association (BCNA), and the Faculty of Pharmaceutical Sciences at UBC. The Registered Nurses Association of BC (RNABC) has no concerns with the proposed scope of practice and clarifies that its position is only in regard to the relationship between the proposed scope of practice of pharmacists and the scope of practice of registered nurses. The Licensed Practical Nurses Association of BC (LPNABC) foresees no problem with the College's proposed scope of practice. The College of Licensed Practical Nurses of BC (CLPNBC) is concerned about medication counselling and that licensed practical nurses should be able to provide general medication information.

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a. performing physical assessment relating to the initiation or monitoring of drug therapy

The use of "assessment" has been discussed by the Council in previous reports and in its [Shared Scope of Practice Model Working Paper](#) (*Working Paper*). The Council recognizes that every health professional who works directly with patients makes some type of "assessment" of the patient. The Council has distinguished "assessment", which is not a reserved act, from "diagnosis" which is described in reserved act #1:

Essentially, diagnosis is the identification of the cause of signs or symptoms. Assessment is a process of observation and evaluation of the physical status or progress of a patient, which may involve observation of symptoms, but does not include naming or identifying a disease, disorder, or condition as the cause of these symptoms.

With respect to physical assessments the Faculty of Pharmaceutical Sciences at UBC states that pharmacists have always been required to use some physical assessment skills in observing and interviewing a patient. It states that the pharmacy curriculum does not devote much time to physical assessment and would require changes if the proposed scope of practice is approved.

Others who responded to the consultation process pointed out that pharmacists do not currently possess physical assessment skills or training.

The BC Medical Association (BCMA) states that whatever physical assessment skills are taught to pharmacy students cannot compare to the medical doctors' pathophysiological approach. The BCMA finds the concept of pharmacists performing physical examinations and then prescribing medications most alarming.

The College of Physicians and Surgeons (CPSBC) strongly supports the submission by the BC Medical Association. It also states that it has very real concerns about the proposed expansion of scope of practice. The CPSBC does not believe that pharmacists have the education and practical experience to undertake physical assessments in a community pharmacy setting. It clarifies however that the context of pharmacy practice in hospitals is quite different.

The BC Society of Medical Laboratory Science (BCSMLS, formerly the BC Society of Medical Technologists) asks what type of physical assessments would be performed by pharmacists. It also asks who will train the pharmacists and whether current fiscal limitations on pharmacy education allow for retraining of pharmacists. Further, the BCSMLS inquires about review programs on pharmacists' expertise in physical assessments, and whether the physical assessment performed by a pharmacist is sufficiently comprehensive to ensure safety in the initiation of drug therapy. Finally, the BCSMLS asks what qualifies as an "institutional setting" for the performance of physical assessments by pharmacists.

The Registered Psychiatric Nurses Association of BC (RPNABC) states that not all pharmacists are competent to perform "*physical assessments relating to the initiation or monitoring of drug therapy*". The RPNABC adds that while the College recognizes that not all pharmacists are competent to perform physical assessments, it should be reflected in the wording for the proposed scope of practice.

The Health Association of BC (HABC, formerly the British Columbia Health Association) does not support "*performing physical assessment relating to the initiation or monitoring of drug therapy*" because of potential stress that patients experience due to a number of different practitioners performing physical assessments. It also states that there is a lack of convincing need for such an expansion to the scope of practice.

The Nova Scotia Department of Health (NSDOH) states that the term "*physical assessment*" should be defined. It also suggests that this act be performed in accordance with previously approved written guidelines or protocols. NSDOH also states that two elements of the proposed scope of practice (performing physical assessments... and administering medications...) are not competencies required at licensure.

New Brunswick Health and Community Services (NBHCS) states that "*physical assessment*" is very broad and needs to be clarified. It further states that in New Brunswick, hospital pharmacists and occasionally, community pharmacists have access to and use tests results for monitoring purposes, and that pharmacists working in

institutional settings do modification therapy in accordance with protocols approved by the multidisciplinary Pharmacy and Therapeutics' Committee and the Medical Advisory Committee. It states that pharmacists' role in these areas have proven to be a valuable asset in the delivery of quality and cost-effective patient care. Finally, NBHCS adds that the process by which the guidelines or protocols are approved be clearly defined and accepted by all relevant health care professions.

The Council has not reserved the assessment process for any health profession. As stated in the Council's *Working Paper*:

The Council believes it important to distinguish between diagnosis and assessment....

... all health care practitioners assess a client's progress and response to services rendered....

...In the Council's view, it is the identification of a disease, disorder or condition as the cause of signs or symptoms of the individual which should be a reserved act, and the process of assessment should continue to be in the public domain. Both regulated and unregulated practitioners would be free to perform assessments during the course of providing health care services, subject always to the proposed general risk of harm clause.

"Physical assessment", in the context of the College's submission, would need to be further defined if it is to be considered for inclusion in the scope of practice statement.

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b. obtaining diagnostic or analytic test results in accordance with previously approved written guidelines or protocols

The College has requested that "*obtaining diagnostic and analytic test results*" be specifically included in pharmacists' scope of practice. The ability to order and interpret diagnostic testing is an integral part of the reserved act of "diagnosis". The Council has not specifically mentioned ordering and interpreting diagnostic tests as a reserved act. However, in the Council's report on the *Recommendations on the Designation of Medical Laboratory Technology*, it made the following comments in concluding that Medical Laboratory Technologists met the criteria for designation as a health profession under the HPA. At page 13 of the Council's report *Recommendations on the Designation of Medical Laboratory Technology* it stated:

The process of diagnosis frequently requires the use of a number of diagnostic tools, including the results of laboratory testing. Quality-control is an essential part of laboratory testing. The applicant submits, and was supported by testimony from the DAP of the CPSBC, among others, that, without quality-control, laboratory data can be erroneously reported, creating the risk of misdiagnosis. However, it is the responsibility of the diagnostician to consider all of the information available from and about the patient, including the results of laboratory testing, and assess the reliability of the test results in light of all the other information available in order to make a diagnosis...

The Council clearly found that isolated laboratory data were not reliable for diagnostic and treatment purposes unless that data could be assessed along with other diagnostic signs and symptoms by a practitioner trained and educated to make a diagnosis.

The Council further stated:

...In its submission, the applicant raised a concern about quality-control in point-of-care testing. The Council notes that as technology becomes more accessible, patients are increasingly able to self-monitor using point-of-care testing. Creating a reserved act for quality-control will not eliminate point-of-care testing or the need for patients to consult their health-care providers for diagnosis and treatment. The accuracy of test results generated outside diagnostic laboratory facilities must be assessed by the practitioner in the ongoing management of the patient's treatment process.

The Diagnostic Accreditation Program (DAP) of the College of Physicians and Surgeons of BC (CPSBC) made the following comments with regard to the College's request to obtain diagnostic or analytic test results and performing screening/monitoring procedures:

In all laboratory testing, from obtaining the specimen from the patient to reporting the results, there are multiple possible mechanisms which may produce erroneous results. Factors such as adequate patient identification, specimen labeling, appropriate samples, patient preparation, appropriate specimen containers and tube, and instrument calibration and operation, must be controlled in minute detail to avoid errors. Even reagents used in the performance of instrument testing must be tested from batch lot to batch lot, and the performance of the instrument must be compared to other instruments performing the same test...

...Patient testing in hospital may also be conducted with small portable instruments such as those the pharmacists are proposing to use. Such testing is euphemistically called "Point of Care" or "Near Patient" Testing.

The laboratory selects these instruments, the experts in the laboratory set up the quality control and testing procedures, and the laboratory monitors the ongoing performance of the quality control...Point of Care Testing involves the laboratory delegation of the performance of tests to medical personnel who are not trained and certified technologists. Such delegation requires a formal program of training, documentation of the training, and updates as methodology or instrumentation changes.

Records of quality control and maintenance procedures, regularly monitored by the laboratory, are also required. The Diagnostic Accreditation Program and other experts in laboratory medicine have found these procedures critical to maintaining the appropriate quality of reported results from such devices. Further the laboratory assistants to whom this training is usually given are included in the College of Technologists, an application recently approved by the Health Professions Council. Nurses, also regulated as a profession, are the other candidates for training in Point of Care Testing.

This situation is quite different from a pharmacy practice, in which a pharmacist would delegate the testing, likely to a pharmacy assistant or other personnel. The whole mechanism of expert direction, technologist expertise, and documented training would be lacking. This does not serve the public well...When staff are inadequately trained, and ongoing supervision and control is not exercised over the performance of testing, even these "simple" instruments have had significant problems and errors which are of a magnitude to influence clinical decision making. The DAP Guideline for Point of Care Testing is appended for your perusal. Specialist physicians

(pathologists) are constantly engaged in fielding inquiries about the results and interpretations of common laboratory tests from doctors, nurses, and other health care professionals. On the basis of this experience, pathologists would support the view that pharmacists simply do not have the expertise to interpret the usual abnormalities of even the most common laboratory test in today's complex medical environment.

The BCSMLS submits its official position statement regarding Point-of-Care Laboratory Testing as well as the position statement of the Canadian Society for Medical Laboratory Science (CSMLS). Both the CSMLS and the BCSMLS endorse point-of-care testing where it enhances patient care and is under the supervision of qualified medical laboratory technologists. The BCSMLS adds:

..the following criteria should be met:

1. Maintenance, calibration and quality control of instruments must be under the supervision of certified Medical Laboratory Technologists wherever testing is performed.

2. Where procedures are already in place for testing to be performed by staff other than certified Medical Laboratory Technologists, Technologists must remain responsible for interpretation of quality control, maintenance, training and continuing education on these instruments.

The apparent simplicity of the instrumentation must not suggest that little or no technical expertise is needed to ensure accurate results.

The College's 1995 submission was unclear with regard to the use of diagnostic and analytic test results by pharmacists and inclusion of this in their scope of practice. It has requested "obtaining diagnostic or analytic test results in accordance with previously approved written guidelines or protocols". Given its submission as a whole, which refers to use of these results, including point-of-care testing and the ability to initiate and monitor medication therapy, it is likely that what the College requested does not fall within pharmacists' current scope of practice.

In its submission the BC Association of Laboratory Physicians (BCALP), medical doctors with specialty certification in laboratory medicine, comment with regard to pharmacists obtaining diagnostic or analytic test results:

The activities included under this heading involve the practice of medical laboratory technology and the practice of medicine. The delivery of these services involves the performance of two reserved acts:

1) Making a diagnosis, identifying a disease, disorder or condition as the cause of signs or symptoms of the individual

2) Performing the following physically invasive or physically manipulative acts:

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

Although the applicant's summary might suggest that the pharmacists only propose to perform

test procedures, the explanatory text shows that they do not intend to limit themselves to test performance. Phrases like "to offer a diagnosis", determine if they have iron deficiency anemia offer definitive advice (about iron deficiency anemia) to the patient indicate they intend to diagnose and treat health conditions.

The Council concurs with the submission of the BCALP. Diagnosis is the foundation upon which all of the other reserved acts rest. Other reserved acts either flow from diagnosis as treatment or assist in establishing a diagnosis. Use of diagnostic test results is not supported by evidence of pharmacists' education and training as practitioners with the ability to diagnose. It may represent advanced pharmaceutical practice, in certain limited circumstances, or it may refer to a delegated medical act, under the category supervised (or delegated) acts. In either case, it falls outside of pharmacists' general scope of practice and would not be appropriate for inclusion in a scope statement which is intended to assist the public and other health professionals in understanding what the profession is trained to do.

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c. initiating or modifying medication therapy in accordance with previously approved written guidelines or protocols

This specific request more properly falls within the reserved acts section of this report and will be discussed there.

3. Conclusion

The Council believes that it is not necessary or useful to itemize every facet of a profession's scope of practice. Rather, a scope of practice definition should be sufficiently descriptive so that other health professions and members of the public alike can understand what the particular health professional does.

The Council carefully reviewed the 1995 brief, the 1999 addendum, the current scope of practice of pharmacy in other provinces, and the responses to the consultation process. The 1999 addendum was largely a request for expanded practice and reserved acts related to prescription and administration of drugs. Prescription and administration of drugs will be dealt with in the reserved acts section of the report. The Council recognizes pharmacists' role in advising and monitoring drug therapy in conjunction with the more traditional function of compounding, dispensing and sale of drugs and related devices.

Therefore, the Council recommends the following scope of practice for pharmacists:

The practice of pharmacy is the compounding, dispensing and sale of drugs monitoring drug therapy and advising on therapeutic values, contents and hazards of drugs and devices and identification, assessment and recommendations to prevent or resolve drug related problems.

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B. RESERVED ACTS

The rationale underlying the granting of reserved acts is to protect the public by limiting provision of those particularly dangerous acts to members of specific professions who are qualified to perform them. Only those acts which present a significant risk of harm will be reserved. The Council developed a list of reserved acts, and included it in a report it issued in July 1998, the [Shared Scope of Practice Model Working Paper](#) (*Working Paper*). As a result of the responses and consultation process the list has been revised from time to time. The current list is attached as Appendix B.

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1. 1995 Proposal for Reserved Acts

The Council emphasizes there are no exclusively reserved acts. Each profession which requests any reserved act is considered individually on its own merits and without regard to whether any other profession has been granted the same reserved act. In its 1995 submission, the College proposed the following four functions to be reserved for pharmacy with "joint exclusivity" with other specified professions.

- *dispensing all prescription medications*
- *distributing all limited-access medications (nonprescription medication products which must be sold from the Dispensary Area of licensed pharmacies)*
- *providing nonspecific and patient-specific drug information and medication counselling*
- *developing and implementing medication therapy policies, drug utilization review programs, and prescribing guidelines.*

The first two of the College's requests for reserved acts (*dispensing all prescription medications* and *distributing all limited-access medications*) fall within the Council's reserved act #5:*Prescribing, compounding, dispensing or administering by any means a drug listed in Schedule I or II of the [Pharmacists, Pharmacy, Operations and Drug Scheduling Act](#)*. These two reserved acts are currently within pharmacists' scope of practice and the Council agrees that they should be granted non-exclusively to pharmacists.

The third and fourth proposed reserved acts do not appear to carry a significant risk of harm, nor has the College provided evidence or documentation to indicate such risk. While these activities are properly included in pharmacists' scope of practice, there is no need to include such activities in the reserved acts list.

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2. 1999 (Addendum) Proposal for Reserved Acts

In its addendum of September 7, 1999, the College requests three additional reserved acts which are detailed below. The College states that the profession of pharmacy continues to experience major shifts in its focus moving from a product-oriented practice to a patient care practice. The focus on direct patient care is reflected in the College's *Framework of Professional Practice* which replaces the *Statement of Competencies* referred to in the College's 1995 submission. The College states that the *Framework of Professional Practice* describes the roles, functions and activities performed by competent pharmacists.

The College proposes the following three reserved acts for pharmacists:

1. *Administering medications, including parenteral, intradermal, subcutaneous, intramuscular and intravenous injections.*
2. *Performing screening and monitoring procedures using pharmacy-based laboratory tests, including the associated quality control functions, and interpreting and communicating the results.*
3. *Selecting, recommending and initiating the drug therapy, dose and route of administration when a qualified practitioner has made a diagnosis.*

The College also states that pharmacists can serve the public by advocating and providing immunization in programs such as the following which is included in the College's proposed reserved act 1:

Promoting pharmacist-coordinated pneumonia and/or influenza vaccination programs in community pharmacies and other ambulatory care settings.

Providing pharmacy-based immunizations for international travel.

Using influenza vaccination programs as an opportunity for conducting prospective, comprehensive immunization screening.

As supporting rationale for its position, the College cites Pharmaceutical Care as a means of clarifying and expanding the pharmacists' role in the health care system of the next century. The 1995 submission uses a definition of Pharmaceutical Care from Hepler and Strand as follows:

Pharmaceutical Care is the responsible provision of drug therapy for the purpose of achieving definite outcomes that improve a patient's quality of life. These outcomes are (1) cure of a disease, (2) elimination / reduction of a patient's symptomatology, (3) arresting or slowing of a disease process, or (4) preventing a disease or symptomatology.

Pharmaceutical care involves the process through which a pharmacist co-operates with a patient and other professional in designing, implementing, and monitoring a therapeutic plan that will produce specific therapeutic outcomes for the patient. This in turn involves three major functions: (1) identifying potential and actual drug-related problems, (2) resolving actual drug-related problems, and (3) preventing potential drug-related problems.

61b1103} InfoTip=Stores your documents, graphics, and other files. e's 1999 brief quotes a 1997 statement from the World Health Organization (WHO), in conjunction with the International Pharmaceutical Federation,

which acknowledged that:

Pharmacists all over the world are the most numerous and easily accessible health outlets for the general public. Trained in public health questions, with long experience of entering into dialogue with and providing education and information to the general public, pharmacists are well placed to participate in health education and prevention campaigns.

As health professionals, they are in permanent contact with decision-makers in the epidemiological, diagnostic and therapeutic fields they participate in the actual treatment and follow-up on patients, and they make a major contribution to the collection, analysis and communication of health data.

The College of Physicians and Surgeons of BC (CPSBC) responds to the College as follows:

*The International Pharmaceutical Federation statement, notwithstanding its publication in association with the WHO, makes dubious claims that are not supported by strong, clear evidence. It is very doubtful whether "**pharmacists all over the world** are the **most numerous and most easily accessible health care outlets**". It is also very doubtful whether "they are in **permanent contact** with decision makers in the epidemiological, diagnostic and therapeutic fields". Furthermore, because pharmacists may "**participate** in the actual treatment and follow up on patients" and may **contribute** to the "collection, analysis and communication of health data", it does not follow that the proposed expansions of scope of practice are justified .*

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a. Administering Medications

With respect to administering medications, the College states that pharmacists are well positioned to take on the new role of administering medications because their knowledge of pharmacology and therapeutics and their ability to identify and resolve drug-related problems are an integral part of their training, standards and practice. The College further states that pharmacists routinely anticipate adverse drug reactions and monitor the outcomes of medication therapy.

The College states that currently 31 pharmacy regulatory boards in the United States have granted pharmacists the authority to administer medications and/or immunizations through their definition of the terms "practice of pharmacy" or "dispense". The College argues that with certain modifications to the existing PharmaNet system, pharmacists could maintain immunization profiles within the current patient record.

The College also argues that pharmacists can play a key role in other types of medication administration such as the administration of parenteral nutrition solutions.

The College states that pharmacists who offer medication administration programs will comply with current accepted guidelines and recommendations recognized by health care providers involved with medication administration. Pharmacists will also follow algorithms for the medication administration, including obtaining a patient history and consulting with previous medical providers.

Comments of respondents to the consultation process regarding this reserved act will be consolidated at page 25 with comments on "selecting, recommending and initiating drug therapy", as they overlap significantly.

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b. Performing Screening and Monitoring Procedures

With respect to *performing screening and monitoring procedures*, the College states that since pharmacists are "closest to home", they have the potential to serve as the source of useful screening and monitoring programs, which could offer long-term benefits to patients and the health care system. The College states it is prepared to ensure that pharmacists evaluate the accuracy and reliability of any tests and testing equipment used in the process of monitoring their patients. It then cites the following examples of screening and monitoring procedures:

- Blood pressure screening and monitoring.
- Cholesterol measurement.
- Blood glucose testing.
- Pregnancy testing.
- Hemoglobin assessment.
- Other services such as PSA marker tests (for prostate cancer), H.pylori tests and osteoporosis marker tests.

The College emphasizes the need for a team approach composed of physicians, pharmacists and patients. Physicians need to be informed of results while pharmacists need to ensure that patients are provided with copies of self-care monitoring measures and are encouraged to seek medical evaluation when appropriate.

The Manitoba Pharmaceutical Association (MPA) states that the proposed examples of screening and monitoring procedures are consistent with guidelines established in Manitoba. However, the MPA argues that the pharmacist must have additional training to perform and interpret results, or have trained personnel on site. It states that if follow-up and referral is not included in the listed screening procedures it will not amount to enhanced patient care.

The BC Association of Laboratory Physicians (BCALP) states:

The application provides some specific instances where public harm might result. The section on hemoglobin assessment was particularly worrisome. There are many causes of low hemoglobin, of which iron deficiency is but one. The approach outlined by the pharmacists is dangerous as it could delay appropriate investigation and treatment of the cause of the anemia (e.g. occult malignancy, bleeding ulcer). Serious treatable conditions may well be masked by supplemental iron therapy precluding early diagnosis and cure of potentially life threatening lesions. Iron deficiency in males of any age and postmenopausal females warrants investigation for blood loss, which usually arises from the gastrointestinal tract and may be the first sign of a malignant tumor or ulcer. In addition, the comment about hemoglobin assessment shows little insight into

the nature of iron deficiency. Body depletion of iron stores occurs before anemia develops. Many Canadian women or children may have symptomatic iron deficiency without anemia. The pharmacist who uses the hemoglobin level to determine the need for iron supplementation could very well cause harm. Another concerning example is that of cholesterol testing. As cholesterol is but one risk factor for atherosclerosis, a high-risk patient who receives a good cholesterol reading at a pharmacy may falsely conclude that their atherosclerosis risk is low.

The College of Physicians and Surgeons of BC (CPSBC) states that the performance of pharmacy based laboratory tests for screening and monitoring purposes is not advisable and not in the public interest.

The CPSBC also has a concern with the limited ability of pharmacists to interpret test results that often require consideration of multiple factors, by a physician, to properly evaluate their significance. It states that pharmacists are not qualified to fully interpret the medical significance of results. The CPSBC then makes specific comments about the listed examples:

- Blood pressure measurements: The CPSBC states the pharmacists' ability to make an accurate reading is not sufficient to competently interpret possible medical significance of a particular reading or give appropriate advice. Advice and evaluation of this measurement requires medical confirmation.
- Cholesterol measurement: The CPSBC states that as a "stand alone" test, cholesterol measurement is doubtful.
- Blood glucose monitoring: The CPSBC states this is best done by the patients themselves but sees no reason why pharmacist cannot assist those who do not have the capability to test themselves,
- Pregnancy: The CPSBC states that most women prefer to do this themselves but again, sees no reason why a pharmacist cannot assist.
- Hemoglobin assessment: The CPSBC reiterates its comment on the limited ability of pharmacists to appraise the significance of results.
- Other services: The CPSBC states that PSA marker tests alone carry the risk of false reassurance that H.pylor tests are only a minor part of the total diagnostic work-up of patients and that the evaluation of osteoporosis is complex and controversial and beyond pharmacists' capabilities.

In sum, the CPSBC states that the tests by themselves are inadequate and interpretation and advice by a pharmacist are insufficient. Additionally, it states that there could be increased costs to the public as issues of conflict of interest need to be addressed. Specifically, pharmacists stand to profit from the sale of products they prescribe or recommend on the basis of the tests they carry out themselves.

The Council has commented in this report at pages 13 to 17 about the use of diagnostic or analytic test results and physical assessment. The submissions have indicated that the use of laboratory data, performance of tests and physical assessment by means of blood pressure and other monitoring procedures are not currently included in the education and training of pharmacists. The Council has concluded at page 17 that all of these tests are adjunct to the reserved act of diagnosis which pharmacists are not trained to perform.

c. Selecting, Recommending and Initiating Drug Therapy

Finally, with respect to *selecting, recommending and initiating drug therapy*, the College refers to its 1995 submission and its proposal to "recognize the initiation and modification of drug therapy in accordance with previously approved written guidelines or protocols". The College states that it has since been determined that the authority for this activity exists in the current legislation in section 31(2)(b) of the *PPODSA*. The full section provides as follows:

Terms of a prescription

31 (1) A registrant must not dispense a prescription drug or device in any manner or in a quantity that is not authorized in the prescription unless the change is permitted by subsection (2) or section 30.

(2) A registrant may dispense a drug or device contrary to the terms of a prescription

- a. *if the prescription quantity of the drug or device does not conform to available package sizes,*
- b. *if it is within the specifications established under a therapeutic interchange program or protocol approved by the governing body of a hospital or by the council,*
- c. *if it within the specifications established under a protocol intended to optimize the therapeutic outcome of treatment with the prescribed drug or device that has been approved by the council, or*
- d. *if the variance is permitted for professional reasons described in the bylaws.*

The College states that section 31(2)(b) provides for the authority to establish collaborative drug therapy agreements which are signed by the relevant practitioners (physicians, dentists) and by pharmacists. These collaborative agreements will give pharmacists authority to do things such as initiating drug therapy. The agreements will usually include a mechanism for reporting back to the practitioner.

The College states its Council has recently approved the first collaborative drug therapy protocol, and other pharmacists are being encouraged to consider using the existing authority to enhance their ability to provide service to patients and assistance to other health professionals.

The Council questions the College's interpretation of section 31(2)(b) as granting pharmacists the authority to prescribe or administer drugs. Section 31(2) refers to dispensing. According to information provided to the Council as a result of the consultation process, pharmacists are not trained and educated to prescribe or administer drugs by any means.

The College further states that the BC Minister's Health Advisory Council on Women's Health, the BC Women's Hospital and Health Care Centre, and the Society of Obstetricians and Gynecologists of Canada contacted the College to discuss women's access to emergency contraception. The College states that some organizations specifically requested that the College implement a process whereby women could obtain emergency

contraception directly from pharmacists without a physician's prescription. This prompted the College to seek amendments to the *PPODSA* that would allow independent prescribing of drugs listed in a schedule regulation to the *PPODSA*. The College therefore proposes that the Council recommend appropriate changes to the definition of the practice of pharmacy.

In conclusion, the College states that its Council would need to develop guidelines and procedures to address the expanded clinical functions of pharmacists so that adequate supervision can be maintained. This development of standards of patient care will involve representatives from the professions which currently possess independent prescribing authority. Finally, the College states that pharmacists will need to know their scope of practice that specific training in the new function areas will be required as well as adequate legal definition and realistic standards of practice, in order to assess the performance of individual practitioners.

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3. Second Consultation Process

Upon receipt of the College's additional proposal for reserved acts, the Council conducted a second consultation process, in the fall of 1999. Several respondents support the proposals. Those supporting include Dr. Reginald E. Smith, Clinical Pharmacist, who suggests that the College establish a certifying process where advanced training is recognized and required for wider drug prescribing privileges.

Others support the proposals with some qualifications. The Alberta Pharmaceutical Association (APhA) generally supports the College's proposals and commented that the APhA council has recently approved a competency-based program for pharmacists administering parenteral medications and also guidelines for pharmacists involved in sale of and counselling about point-of-care testing products. APhA is also concerned about the lack of discussion of sexually transmitted diseases and AIDS when BC pharmacists dispense post-coital contraception and encourages BC pharmacists to address this issue.

The Manitoba Pharmaceutical Association (MPA) supports the proposals but states that a pharmacist's ability to administer the listed forms of injections vary greatly with the individual pharmacist. The MPA suggests to separate this proposed addition into two categories: invasive and non-invasive administration. Pharmacists who want to perform invasive administration would require additional training and knowledge to perform the function and also to manage any emergent critical patient response. The MPA agrees that pharmacists' accessibility is a key component to overall patient care.

The MPA points out that there has been a trend to move certain prescription items to non-prescription status by the federal government. Once a medication is non-prescription, many governments and third party payers de-list the medication as a product covered under the "drug program". The MPA states this tends to devalue the medication and the pharmacists' involvement in treatment plans and does not necessarily accomplish decreased care costs. The patient will still attend the practitioner's office and challenge the prescriber to issue an order for "something covered". The MPA states that it is therefore important to recognize the role of the pharmacist.

The majority of responses to the College's 1999 proposal for reserved acts comment on the lack of evidence of education and training of pharmacists to perform those reserved acts, with the exception of dispensing prescription medications. Respondents in this category include the College of Physicians and Surgeons of BC (CPSBC), the Diagnostic Accreditation Program (DAP), the BC Medical Association (BCMA), the Registered

Nurses Association of BC (RNABC), the BC Society of Laboratory Science (BCSL), Manitoba Health and the Nova Scotia Department of Health (NSDOH). The latter points out:

...two elements of the proposed additions to the scope of practice require competencies not specified in the National Association of Pharmacy Regulatory Authority's Professional Competencies for Canadian Pharmacists at Entry to Practice . They are:

- Performing physical assessment relating to the initiation or monitoring of drug therapy (proposed in January 1996) and*
- Administering medication, including parenteral, intradermal, subcutaneous, intramuscular and intravenous injections (proposed in September 1999).*

The CPSBC is strongly opposed to expansion of the pharmacist's role in selecting, recommending and initiating drug therapy by way of proposed amendments to the PPODSA. The CPSBC argues that while it supported the issue of emergency contraception by allowing pharmacists to dispense the medication without prescription, it does not justify the quantum leap to permitting the College to unilaterally add other drugs to an independent prescribing schedule. The CPSBC states:

- Pharmacists should not be permitted to independently administer medications by injections as this would significantly increase risk to the public as pharmacists are not qualified to deal with serious potentially fatal reactions that not uncommonly occur. If pharmacists are allowed to administer medications by injections, there should be very clear definition of what they can and cannot administer without prior approval of a physician.
- Any immunization activity by pharmacists should only be under the direction of the public health officer.
- Intravenous administration of "nutrition solutions" in a home-care setting should be under the direction and supervision of a physician with the assistance of a home-care nurse. The CPSBC does not believe pharmacists have the practical training and experience to achieve the minimum level of competence that should be considered necessary in the public interest.

The BC Medical Association (BCMA) states there is no evidence that patient health care would be enhanced by the administration of medications by pharmacists. It contends that the goal of assuring continuity of care is unlikely to be achieved by introducing a further health care professional. It also argues that administering medications through the listed forms of injections has been part of the training of nurses and physicians, but not that of pharmacists.

The BCMA further states that concerns have been raised regarding pharmacists' ability and education to respond appropriately to an adverse drug reaction. Also, it is unclear if pharmacists will develop treatment rooms on the premises of drug stores, and whether facilities would be available for the patients to recover after administration of the medication. The BCMA questions the claim of easy accessibility of pharmacists if they were to administer medication in separate rooms. The BCMA raises other concerns such as liability, insurance and the on-call availability of a pharmacist to deal with the sequelae of his/her ministrations.

While the College has used the term "*in accordance with preapproved protocols and procedures*", it appears

that the College is requesting a type of independent practice, unsupervised by other health practitioners. There has been no evidence of formal training or certification for advanced practice in these reserved acts. Nor is there any evidence of an objective measure of competency for pharmacists who would perform these reserved acts. The Ph.D. program at UBC includes advanced competencies in some of the areas requested by the College, however there appears to be no certification or competency monitoring in place for evaluating the continuing competency of these graduates. In addition, it appears that the College is advocating that all of its members would be qualified to practice these reserved acts in community pharmacies.

The College has submitted its *Framework of Professional Practice (FPP)* which describes the roles, functions and activities performed by competent pharmacists. The FPP links to the *Professional Competencies for Canadian Pharmacists at Entry to Practice*. This *Professional Competencies* document has been adopted by ten Canadian pharmacy regulatory organizations. The College states that the FPP is the foundation document for all entry-level and continuing competency assessment activities administered by the College.

The College also submitted its plans for developing a C.A.R.E. (Continuing Assessment, Reflection and Enhancement) Program which was anticipated to replace and expand the Quality Assurance (QA) Program. The primary focus of the C.A.R.E program appeared to be toward developing a self-assessment tool for pharmacists to monitor their own practices and to report back to the College. Unfortunately, the College has not provided any follow up on this initial information provided to the Council in 1996 when the C.A.R.E. program was in the planning stages.

The College has indicated that there are advanced practitioners of pharmacy in certain clinical and hospital pharmacies in Canada. As well, in the U.S. there are advanced pharmacy practitioners who diagnose, prescribe and administer medications.

Professional pharmacist organizations in Canada have supported this concept. The Faculty of Pharmaceutical Sciences supports expanded practice and Pharmaceutical Care and is willing to expand the curriculum to provide education and training in the advanced practice areas.

If the College is requesting that pharmacists be delegated reserved acts from physicians or other health professionals who are granted THOSE reserved acts, that would fall under the supervised (or delegated) acts principles. At least three respondents supported this position: The Nova Scotia Department of Health (NSDOH), the Health Association of BC (HABC), and the College of Physicians and Surgeons of Manitoba (CPSM).

However, if the College is requesting that a form of advanced pharmacy practitioner be allowed to independently initiate and perform those reserved acts, there must be evidence of uniform training beyond the basic pharmacy curriculum, as well as objective evidence of competency which is formally assessed, established and accepted by the College as well as the profession of pharmacy, including uniform standards of practice, none of which have been provided to the Council.

Without evidence of an existing program to assure continuing competency for those practitioners who are already practising in an expanded role within certain institutions, the Council cannot recommend granting reserved acts to pharmacists on the assumption that formal competency assurance and training programs will be developed at some future time.

4. Conclusion

The supervised acts principles will apply until such time as independent practice of pharmacists in this area is developed to the point where there is sufficient uniform education, training, and competency monitoring to ensure public safety. Physicians may continue to delegate reserved acts pursuant to established protocols in the limited circumstances where it would be appropriate for pharmacists to perform the reserved acts requested: initiation, administration, or modification of drug therapy.

The Council has concluded that the following reserved act is currently within the documented competency of members of the College.

Therefore, the Council recommends that compounding or dispensing a drug listed in Schedule I or II of the *Pharmacists, Pharmacy, Operations and Drug Scheduling Act* be granted to members of the College of Pharmacists. For the purposes of this reserved act, the following definitions shall apply:

"compounding": mixing ingredients, at least one of which is a drug.

"Dispensing": preparing or filling a prescription for drugs.

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C. SUPERVISED ACTS

The Criteria and Guidelines attached to the [Terms of Reference](#) state that although reserved acts may only be performed by professions to whom they have been specifically granted, it may be appropriate for other persons to perform them or aspects of them, under the supervision of members of those professions. The Criteria and Guidelines also indicate that where Council is satisfied that a reserved act may be performed under supervision it may recommend training and qualification requirements, limitations regarding where the act may be performed and the degree of supervision required.

The College proposes no change to the current regulations which allow pharmacists to supervise pharmacy technicians to perform the preparatory and distributive functions of dispensing pharmaceuticals.

Therefore, the Council recommends that a provision be enacted which deals with general principles regarding delegation of reserved acts. The provision would apply generally, not to individual cases. It should require the following:

- The assigning health professional's governing body must provide assent to the proposed reserved act being performed by someone else
- The reserved act to be assigned as well as the level of supervision must be clearly defined and circumscribed by the assigning health professional's governing body
- Where the person to whom the act will be assigned is a member of a self-regulated health profession, his or her governing body must approve of the assignment
- The instruction to perform the act must be made in writing either by way of a general written protocol or through a case-specific instruction
- The assigning health professional must be satisfied that the individual who will be performing the act has the necessary skills and training to perform the act safely
- The assigning health professional must ensure that the person who will be performing the act accepts the assignment.

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D. RESERVED TITLES

Reserved titles are titles reserved exclusively to a health profession. Reserved titles afford a means for consumers to identify the different types of health care providers, to distinguish the qualified from the unqualified, and to differentiate those practitioners who are regulated from those who are not. Titles must adequately serve the public in describing the practitioner and the services being provided and must distinguish the practitioner from others performing services outside the jurisdiction of the college.

The College proposes no change to section 21(1)(d) of the *PPODSA* which reserves the following titles for use by pharmacists:

- Chemist
- Pharmaceutical chemist
- Druggist
- Apothecary
- Pharmacist

- R.Ph.
- R.Pharm.

Most respondents did not question the titles currently reserved for pharmacists with the exception of the title "chemist". A number of respondents including the College of Physicians and Surgeons (CPSBC), the BC Society of Medical Technologists (BCSMT) and New Brunswick Health and Community Services felt that "chemist" was misleading and restrictive, since there are other professional groups that use this title.

The BCSMT suggests using "chemist" only in conjunction with "pharmaceutical".

In Ontario, the following titles and any abbreviation or variation thereof are reserved:

- apothecary
- druggist
- pharmacist
- pharmaceutical chemist

The Council accepts that reservation of the title "chemist" may be misleading to the public.

Therefore, the Council recommends the following titles or abbreviations thereof be reserved for members of the College of Pharmacists of BC:

- **Apothecary**
- **Druggist**
- **Pharmacist** and
- **Pharmaceutical Chemist.**

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IV. RECOMMENDATIONS

1. The Council recommends the following scope of practice statement for pharmacists:

The practice of pharmacy is the compounding, dispensing and sale of drugs monitoring drug therapy and advising on therapeutic values, contents and hazards of drugs and devices and identification, assessment and recommendations to prevent or resolve drug related problems.

2. The Council recommends that compounding or dispensing a drug listed in Schedule I or II of the [Pharmacists, Pharmacy, Operations and Drug Scheduling Act](#) be granted to members of the College of Pharmacists. For the purposes of this reserved act, the following definitions shall apply:

"compounding": mixing ingredients, at least one of which is a drug.

"dispensing": preparing or filling a prescription for drugs.

3. The Council recommends that a provision be enacted which deals with general principles regarding delegation of reserved acts. The provision would apply generally, not to individual cases. It should require the following:

- The assigning health professional's governing body must provide assent to the proposed reserved act being performed by someone else
- The reserved act to be assigned as well as the level of supervision must be clearly defined and circumscribed by the assigning health professional's governing body
- Where the person to whom the act will be assigned is a member of a self-regulated health profession, his or her governing body must approve of the assignment
- The instruction to perform the act must be made in writing either by way of a general written protocol or through a case-specific instruction
- The assigning health professional must be satisfied that the individual who will be performing the act has the necessary skills and training to perform the act safely
- The assigning health professional must ensure that the person who will be performing the act accepts the assignment.

4. The Council recommends the following titles or abbreviations thereof be reserved for members of the College of Pharmacists of BC:

- Apothecary
- Druggist
- Pharmacist and
- Pharmaceutical Chemist.

Last Revised: March 08, 2002

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Health Professions Council POST-HEARING UPDATE OF PRELIMINARY REPORT: PHARMACISTS

Irvine E. Epstein, Q.C., Chair
Arminée Kazanjian, Member
David MacAulay, Member

March 2001

This Post-Hearing Update should be read in conjunction with the [Preliminary Report](#) for the profession.

The Council issued its *Pharmacists Scope of Practice (Preliminary Report)* in March 2000. The public hearing was held on 6 June 2000. The following are further comments on the *Preliminary Report* which arose from the submissions made either at the public hearing or in subsequent written submissions.

I. SCOPE OF PRACTICE:

The Council in its *Preliminary Report* recommended the following scope of practice for pharmacists:

The practice of pharmacy is the compounding, dispensing and sale of drugs; monitoring drug therapy and advising on therapeutic values, contents and hazards of drugs and devices; and identification, assessment and recommendations to prevent or resolve drug related problems.

The B.C. Pharmaceutical Association argued that "physical assessment" must be included in the scope of practice statement. Blood pressure monitoring, bone density scanning and blood glucose monitoring were given as examples.

The inclusion of "physical assessment" implies an expanded scope of practice which has been addressed by the Council in its *Preliminary Report*.

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II. RESERVED ACTS

The Council in its *Preliminary Report* recommended the following reserved acts for pharmacists:

Compounding or dispensing a drug listed in Schedule I or II of the Pharmacists, Pharmacy Operations and Drug Scheduling Act. For the purposes of this reserved act, the following definitions shall apply:

"compounding": mixing ingredients, at least one of which is a drug.

"dispensing": preparing or filling a prescription for drugs.

The College of Pharmacists of British Columbia (the College) had requested a number of reserved acts including administration of drugs by parenteral, intradermal and subcutaneous routes. At the public hearing, a representative of the UBC faculty of pharmacy conceded that "the technique itself is part of the skill set, but the actual administration of the drug is something we would have to add to the program". By "technique" the speaker indicated he meant: rate of administration, reconstitution of the drug, route recommended and precautions.

The College also requested that it members be allowed to perform "screening and monitoring procedures such as blood pressure screening, cholesterol measurement, blood glucose testing, pregnancy testing, hemoglobin assessment, PSA marker tests, osteoporosis marker tests." Some of these require procedures below the dermis. The Council has commented in its *Preliminary Report* that these appear to be part of diagnosis for which pharmacists are not currently trained. Allowing pharmacists to utilize these tests was strongly opposed by the College of Physicians and Surgeons of British Columbia, among others. The Manitoba Pharmaceutical Association stated that these would require advanced training to perform and interpret results. The Manitoba Pharmaceutical Association also said that if referral and follow-up is not included, patient care would not be enhanced.

The College also requested that "selecting, recommending and initiating drug therapy" be a reserved act. This is, in essence, prescribing, and was noted to be such in one of the articles submitted at the hearing by a Pharm. D graduate of UBC, Dr. Reginald Smith. The Council also received a post-hearing submission from Sonja Rinzema, RN, MN, that pharmacists who have advanced training and who meet certain standards can manage anti-coagulant services and other chronic disease states, such as diabetes. Dr. Smith indicated at the public hearing that he also interprets EKG results and changes pharmacotherapy based upon his findings. He states that if a patient's condition changes, the patient is referred to the MD. If not, Dr. Smith manages. This is only after the patient has been diagnosed or treatment has commenced by a medical doctor.

Dr. Smith submitted studies and protocols which are in place in the U.S. Veterans Administration (VA) for such programs. It should be noted that the VA has implemented general guidelines for medication prescribing only for certain advanced practitioners such as clinical nurse specialists and clinical pharmacy specialists (Masters or Pharm. D. graduates, pharmacists who have completed an accredited residency, specialty board certified pharmacists or pharmacists with equivalent experience). He indicated that there are national practice guidelines for specific disease states and protocols which he follows. He did indicate that protocols are not in place for all types of patients and he was concerned that hospital based protocols might not apply in the community. He states that it is important that advanced practice pharmacists have access to laboratory data for pharmaceutical management. He says advanced practice pharmacists also administer intravenous and subcutaneous medications.

All of the additional reserved acts proposed by pharmacists are related to an expansion of the scope of

practice. For community based pharmacists, there is a notable lack of training in the reserved acts requested. Information provided to the Council indicates that where these types of pharmaceutical interventions by pharmacists exist they are always protocol driven.

In the *Preliminary Report*, the Council made the following observation:

While the College has used the term "in accordance with preapproved protocols and procedures", it appears that the College is requesting a type of independent practice, unsupervised by other health practitioners. There has been no evidence of formal training or certification for advanced practice in these reserved acts. Nor is there any evidence of an objective measure of competency for pharmacists who would perform these reserved acts. The Pharm. D. program at UBC includes advanced competencies in some of the areas requested by the College; however, there appears to be no certification or competency monitoring in place for evaluating the continuing competency of these graduates. In addition, it appears that the College is advocating that all of its members would be qualified to practice these reserved acts in community pharmacies.

The Council has carefully considered the College requests for an expanded scope of practice for its members. The Council has not been presented with sufficient evidence to recommend that prescription, diagnosis, and monitoring and adjustment of medications, including physical assessment and access to selected laboratory testing, be granted to any of the members of the College at this time. These are all advanced competencies involving reserved acts and should only be performed by practitioners who have clearly documented advanced training and for whom the College has established credentialling and monitoring procedures. Those advanced practitioners, such as Dr. Smith, may represent an emerging new category of registrant of the College. However, until such time as the College has satisfied its duties under its current legislation to protect the public by adopting credentialling and monitoring procedures, the advanced practices these practitioners employ, which include reserved acts, should be covered by the delegation protocols recommended by the Council in its *Final Report on the Scope of Practice Review*.

Without evidence that the College has appropriate certification procedures to assess and monitor the competencies required, even with evidence that there are educational programs available, the Council cannot at this time recommend such an expanded scope of practice.

The Council notes that in October 2000 an order of the Lieutenant Governor in Council amended the *Pharmacists, Pharmacy Operations and Drug Scheduling Act* to include pharmacists within the definition of "practitioner" "... only for the purposes of prescribing the following drugs for use for emergency contraception." The Council has not considered nor made any recommendation with regard to the actions of the Lieutenant-Governor in Council.

The Council recognizes the limited purposes for this amendment. The Council considered the special circumstances which precipitated this revision and does not feel it affects the Council's scope of practice review process or recommendations.

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Health Professions Council Physical Therapists Scope of Practice Preliminary Report

Irvine E. Epstein, Q.C., Chair
Arminée Kazanjian, Member
David MacAulay, Member

January 1998

This Preliminary Report should be read in conjunction with the [Post-Hearing Update](#) for the profession.

FOREWORD

This report is the result of the Health Professions Council's review of the scope of practice of physical therapy pursuant to the [Terms of Reference](#) from the Minister of Health and Minister Responsible for Seniors. Under the [Health Professions Act](#), the Health Professions Council is a six person advisory body appointed by the Government of British Columbia to make recommendations to the Minister of Health and Minister Responsible for Seniors about the regulation of the health professions.

In this report the Health Professions Council examined how the existing scope of practice of physical therapy should be legislatively defined in order to reflect fairly and accurately the current state of practice and the public interest in the practice of physical therapy.

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EXECUTIVE SUMMARY

The Health Professions Council has conducted a review of the scope of practice of physical therapy.

The purpose of the review is to provide recommendations to the Minister of Health and Minister Responsible for Seniors regarding four matters: scope of practice statements, reserved acts, supervised acts, and reserved titles.

The Health Professions Council has conducted a detailed consultation process and its conclusions and recommendations regarding the four elements of the scope review are set out in this report.

1. The Council recommends the following scope of practice statement for members of the College of Physical Therapists of B.C.:

The practice of physical therapy is the assessment and treatment of the neuromusculoskeletal 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.

2. The Council recommends the following reserved acts be granted to members of the College of Physical Therapists of B.C.:

- 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 neuromusculoskeletal systems 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 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 in the nasal passages where they normally narrow, beyond the pharynx, or into an artificial opening into the body for the purpose of bronchotracheal 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](#).

3. The Council recommends that a provision be enacted which sets out the duties of a health professional and his or her regulatory college when delegating a reserved act. The provision should require the following:

- The assigning health professional's governing body must provide assent to the proposed reserved act being performed by someone else;
- The reserved act to be assigned as well as the level of supervision must be clearly defined and circumscribed by the assigning health professional's governing body;
- Where the person to whom the act will be assigned is a member of a self-regulating health profession, his or her governing body must approve of the assigning of the reserved act;
- The instruction to perform the act must be made in writing either by way of a general written protocol or through a case-specific instruction;
- The assigning health professional must be satisfied that the individual who will be performing the act has the necessary skills and training to perform the act safely;
- The assigning health professional must ensure that the person who will be performing the act accepts the assignment.

4. The Council recommends that the titles "physiotherapist" and "physical therapist" be reserved for members of the College of Physical Therapists of B.C.

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I. INTRODUCTION

A. THE NATURE OF THE REVIEW

This is the preliminary report of the review of the scope of practice of physical therapy by the Health Professions Council (the Council).

The review was conducted pursuant to [Terms of Reference](#) issued by the Minister of Health and Minister Responsible for Seniors in accordance with section 25 [24]⁽¹⁾ [Citations throughout the text refer to RSBC 1996 provisions. The citations in brackets and in italics refer to older provisions.] of the [Health Professions Act](#) (the HPA). The [Terms of Reference](#) direct the Council to review the scopes of practice of the recognized health professions, of which physical therapy is one.

The *Terms of Reference*, which are included as [Appendix A](#) to this report, indicate that there are four main elements to the scope of practice review:

- I. scope of practice statements which describe what the profession does, the methods it uses and the

purpose for which it does it;

- II. reserved acts which are those acts that present such a significant risk of harm that they should be performed only by professionals who are qualified to perform them;
- III. supervised acts which are reserved acts, or aspects of reserved acts, which may be performed by persons supervised by health professionals; and
- IV. reserved titles which are titles that describe a profession's services and which are reserved exclusively for the health profession.

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B. THE PROCESS FOR THE REVIEW

The general process for the review provides for an initial meeting with the profession, submission of briefs by the regulatory body and professional association for each profession, a consultation process involving all health professions and interested parties regarding each professions' submission, drafting of a preliminary report, public hearings and a final report.

The Council met with representatives of the College of Physical Therapists of B.C. (the College), the Physiotherapy Association of B.C., and the B.C. Association of Physiotherapists in Private Practice in December 1994. On August 23, 1995 the College submitted a scope of practice brief prepared in consultation with the two associations. No other briefs were submitted on behalf of the physical therapy profession. The brief was then summarized and distributed to interested groups and individuals including other regulated and unregulated health professions, educational institutions and other provinces.

Respondents to this consultation process focused on a number of issues which the Council felt warranted further investigation. In September 1996, the Council requested the College to clarify several issues which were highlighted during the consultation process. The College responded on January 2, 1997.

On May 19, 1998, the College submitted revisions to its initial scope of practice brief originally presented to the Council in 1995. The revisions were based upon the Council's *Shared Scope of Practice Model Working Paper* (the *Working Paper*) which was issued in January 1998.

This preliminary report will be circulated to all health professions and other interested parties who participated in the Council's consultation process.

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C. THE REGULATION OF PHYSICAL THERAPY

Physical therapists (then known as physiotherapists) were initially governed under one act with massage therapists (formerly massage practitioners). The first provincial enactment was the *Physiotherapists and Massage Practitioners Act*, S.B.C. 1946, c. 59. It created the Association of Physiotherapists and Massage Practitioners of British Columbia, the regulatory body, as well as the Board of Physiotherapists and Massage

Practitioners. The first enactment defined physiotherapy and massage and restricted the use of the following reserved titles: chartered physiotherapists, physiotherapists, massage practitioner, and masseur.

In 1954, the *Physiotherapists and Massage Practitioners Amendment Act*, 1954, c.32, provided for several amendments. The Board of Physiotherapists and Massage Practitioners was renamed the Council of Physiotherapists and Massage Practitioners, and was given the power to make regulations respecting applications, cancellations, suspensions, and reinstatement of members. The definition of "registered physiotherapist" was altered and gave registered physiotherapists and masseurs the exclusive right to practise their respective fields. Further, the Council was given authority to approve all schools teaching physiotherapy and massage. The *Physiotherapists and Massage Practitioners Amendment Act*, 1957, c.48 made it illegal for a hospital employee, other than a registered physiotherapist or massage practitioner, to provide massage of any kind for patients. An amendment was made to exempt from the prohibition certain hospitals, particularly those which are too small to employ a physiotherapist or massage practitioner.

In 1972, the *Physiotherapists and Massage Practitioners Act*, 1972, c. 42, eliminated the reference to the *Trade-School Regulation Act* and the teaching of physiotherapy as well as the requirement that standards of education of the Canadian Physiotherapy Association apply under the Act. In 1979, the statute was renamed the *Physiotherapists Act*, R.S.B.C. 1979, c.327.

In 1987, the *Health Statutes Amendment Act*, 1987, c. 55, revised educational and training qualifications for registration as a registered physiotherapist to include training as a remedial gymnast. While the act repealed the power of the Lieutenant Governor in Council to make regulations prescribing educational qualifications and requirements for temporary registration, it permitted the Minister to request an amendment to a rule. The *Health Professions Amendment Act*, 1989, c.29, allowed the Association of Physiotherapists and Massage Practitioners to authorize physiotherapists or massage practitioners to incorporate their practices. A separate register for physiotherapists and remedial gymnasts was established and the limitations on the practice of physiotherapy were revised. Subsequently, the *Health Professions Statutes Amendment Act*, 1993, c. 50, set out the duties and objects for the regulatory body. It mandated public representation in the Association while enhancing the Association's investigatory and suspension powers.

Finally, the *Health Professions Statutes Amendment Act*, 1994, c. 42, repealed the *Physiotherapists Act*, R.S.B.C. 1979, c. 327, as the College of Physical Therapists and the College of Massage Therapists were designated under the HPA in December, 1994. The designation was pursuant to the Lieutenant Governor in Council's power to designate a health profession under section 12 [12] of the HPA without directing the Council to conduct an investigation. Under the HPA> two separate colleges were established: the College of Physical Therapists of British Columbia and the College of Massage Therapists of British Columbia.

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II. THE POLICY BACKGROUND

The main impetus for a scope of practice review was the Report of the British Columbia Royal Commission on Health Care and Costs (the Seaton Commission). The Seaton Commission stated that the existing legislation governing the health professions creates persistent jurisdictional disputes and a distinct lack of cooperation among the health professions, despite the fact that all health professional colleges have the same mandate - to protect the public from preventable harm.

The Seaton Commission stated that the primary reason for the jurisdictional disputes was the present regulatory system's reliance on exclusive scopes of practice. Under the exclusive scope of practice model, the various health professions have been granted an exclusive right to practice within a legislatively defined scope of practice. No one, other than a member in good standing of that profession, can perform acts within the profession's scope of practice unless they are granted an exemption.

The Commission concluded:

...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.

(Closer to Home, The Report of the Royal Commission on Health Care and Costs in British Columbia, Volume 2, 1991, p. D-33)

This recommendation is also consistent with legislative initiatives underway in Alberta. The Seaton Commission was not the first review body to suggest that the present legislative model of exclusive scopes of practice was inappropriate. Restricting professional monopolies (exclusive scopes of practice) was also recommended in an earlier study commissioned by the British Columbia Minister of Health. In discussing the conflicts which may arise between the professional college and the public interest, the issue of exclusive scopes of practice was raised:

It must be emphasized that any professional legislation which unduly restricts the scope of practice of skilled personnel may be contrary to the public interest in greater supply and accessibility of service through the development of team practice. Therefore, it is urged that: Professional legislation should not contain narrow restrictions or rigid definitions of scope of practice which are excessively exclusive; that measures should be taken (as indicated below) to reduce the area of interprofessional strain and conflict; and that no prosecutions for violations of scope of practice legislation should be undertaken without the prior consent of the appropriate public authority.

Insofar as may be possible with due regard for public safety, professional law should not place rigid restrictions on the scope of practice of allied health personnel, and greater flexibility should be encouraged in the allocation of roles between the health disciplines.

(Professor J.T. McLeod, "Public Regulation of the Professions" in Health Security for British Columbians, Special Report: Consumer Participation, Regulation of the Professions, and Decentralization (1974), the report of Richard D. Foulkes, B.A., M.D., F.A.P.H.A. to the Minister of Health, Province of British Columbia, Tome Three, p. 145)

Thus, the trend in regulatory policy for the health professions has been towards reducing exclusivity in order to enhance interdisciplinary practice, improve accessibility to health care services and increase consumer choice, while at the same time maintaining the fundamental objective of protecting the public.

These policy trends are clearly reflected in the [Terms of Reference](#) for the scope of practice review which provide the basis for a new regulatory framework for health professions in British Columbia. The core elements of the new framework are scope of practice statements and reserved acts.

Under the present system, scope of practice statements are exclusive. In the new system, scope statements will not be exclusive but professions may be granted reserved acts.

Reserved acts are those elements of a profession's scope of practice which present such a significant risk of harm that they should be reserved to a particular profession, or shared amongst particular professions. Thus, unlike the present system in which each profession is granted exclusivity within its entire defined scope of practice (subject to specified exceptions), only those acts which present a significant risk of harm will be reserved.

In short, the government has assigned the Council the task of creating a regulatory model based on broad, non-exclusive scope of practice statements and narrowly defined reserved acts.

The government has the responsibility to ensure that those services which are accessible are safe and that the regulatory framework for the practice of health professions protects the public from incompetent, impaired, or unethical practitioners. At the same time, the regulatory framework should not entrench a paternalistic function for professions or reserve exclusive areas of practice simply to enhance professional status and control.

The new system of overlapping scopes of practice and narrow reserved acts removes barriers to interdisciplinary practice and offers greater choice and accessibility to the public. In the Council's view, the public interest is served by professional legislation which promotes quality in the delivery of health care services within safe parameters. Indeed, the Council's primary policy objective in conducting its review is achieving the optimum balance between safe practice and consumer choice.

With this in mind, the Council proposes to consider the practice of physical therapy having regard to the four elements of the scope review.

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III. DISCUSSION OF ISSUES

The main issues raised by this review are the four elements listed above: scope of practice, reserved acts, supervised acts and reserved titles.

A. SCOPE OF PRACTICE STATEMENT

The scope statement describes what the profession does, the methods it uses, and the purpose for which it does it. Unlike the present legislative scheme, the statement itself does not grant an exclusive scope of practice. Nonetheless, the statement is important because: 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; and it informs the public about the services practitioners are qualified to perform. It is expected that the Council's recommendations will increase overlapping scopes of practice.

It is the Council's view that it is not necessary nor useful to exhaustively itemize every facet of a profession's services to the public within the scope of practice statement. Rather, a scope of practice definition should be a broad and general statement which is sufficiently descriptive that other health professions and members of the public alike can understand what the particular health profession does.

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1. Current Scope of Practice and Scope of Practice Proposed by the College of Physical Therapists of B.C.

The current scope of practice of physical therapy is set out in the *Physical Therapist Regulation* (the *Regulation*) under the *HPA*:

"physical therapy" means the treatment of the human body by physical or mechanical means, by manipulation, massage, exercise, the application of bandages, hydrotherapy and medical electricity, for the therapeutic purpose of maintaining or restoring function that has been impaired by injury or disease.

In its initial brief to the Council in 1995, the College submitted a revised scope statement which the College described as broadly defined to ensure that it will remain applicable as physical therapy practice evolves to meet the needs of consumers. The submission stated that the proposed changes to the scope of practice for physical therapists are based on the current and imminent changes in the following four areas:

- *Changing practice patterns and a changing workforce;*
- *Changes in the health care system;*
- *Protection of the public; and*
- *Changes to the education of physiotherapists.*

The College proposed the following scope of practice definition:

practice of physical therapy/physiotherapy means the application of professional physical therapy knowledge, skills, attitudes and judgment by a physical therapist to obtain, regain or maintain optimal health and functional performance. Physical therapy is practiced throughout the spectrum of health care. Integral to the practice of physical therapy are the areas of health promotion, injury and disability prevention, research, teaching and health services management.

Physical therapy practice includes, but is not limited to:

- *assessment of neuromusculoskeletal and cardiorespiratory systems and establishment of a physical therapy diagnosis,*
- *development, progression, implementation and evaluation of therapeutic exercise programs,*
- *education of client, caregivers, students and other health service providers,*
- *manual therapy treatment techniques such as massage, proprioceptive neuromuscular facilitation, muscle energy techniques,*

- *joint mobilization and manipulation,*
- *pain relief including acupuncture,*
- *administration of physical therapy related medications,*
- *prescription, manufacture, modification and application of braces, splints, taping, mobility aids or seating equipment,*
- *hydrotherapy, electrotherapy and use of mechanical, radiant or thermal energy*
- *ergonomic evaluation, modification, education and counselling.*

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2. Summary of Responses

The proposed scope of practice was circulated broadly by the Council for comment as part of a consultation process. Several respondents to the consultation commented that the proposed scope of practice statement was too broad and extended into areas of health, fitness and exercise, for which physical therapists have no consistent standardized specialized training. The B.C. Association of Kinesiologists (BCAK), B.C. Recreation and Parks Association (BCRPA) and Human Factors Association (HFA) recommended limiting the scope to maintenance and restoration of function that has been impaired by injury or disease or to therapeutic exercise for symptomatic populations. Their rationale appears to be that their practice areas of fitness and exercise overlap with those aspects of physical therapy practice. Their rationale did not involve any other analysis to justify limiting the scope of physical therapy practice. The British Columbia Medical Association (BCMA) commented that physical therapy is not practised throughout the spectrum of health care, notable exceptions being psychiatry and pharmacotherapy.

The Council wishes to emphasize that the scope statement is not exclusive, only descriptive. Further, it is expected that the scope of practice review process will result in more overlapping scopes of practice. To the extent that a broad scope of practice statement might encompass acts which carry a significant risk of harm, the reserved acts system will deal with that issue.

The Association of Physical Therapists of Manitoba agreed with the scope statement, but wondered if "*pain relief including acupuncture*" limits the use of acupuncture and cited the Canadian Physiotherapy Association position to include the use of acupuncture to "*normalize physiological functions*".

One respondent, the School of Physical Education, University of Victoria, questioned whether physical therapists are trained in cardiovascular assessment techniques as part of their academic preparation.

Both the BCMA and the British Columbia Association of Podiatrists (BCAP) were concerned with the proposed provision relating to "*the prescription, manufacture, modification and application of braces, splints, taping, mobility aids or seating equipment*". Both associations were concerned that this may involve prescription from either a medical doctor or a podiatrist. The BCAP was concerned that there was no definition of "*braces, splints*

"or mobility aids" and opposed allowing physical therapists to prescribe and manufacture braces, splints, or mobility aids which alter the biomechanics of the foot ("orthotics") as the physiotherapist may not have the necessary training to prescribe such devices. The BCAP submitted that physical therapists should fabricate certain types of braces, splints or mobility aids which affect the biomechanics of the foot only upon prescription by a podiatrist or physician, and only after adequate training in proper fabrication and under the supervision of a podiatrist.

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3. Revised Proposal Submitted by the College of Physical Therapists of B.C.

After reviewing the responses to the consultation process regarding the proposed scope of practice statement, the Council wrote to the College requesting that the scope statement be revised. The Council's specific concerns were that the statement as proposed did not meet the *Terms of Reference* and policy guidelines which direct that it "describe what the profession does, the methods it uses, and the purpose for which it does it". The Council suggested that the College reword its scope statement to meet the *Terms of Reference* and policy guidelines.

On January 2, 1997, the College submitted the following revised scope of practice statement:

*The practice of physical therapy is the use by a physical therapist of specific knowledge, skills and professional judgment to assess an individual's physical abilities, establish a physical therapy diagnosis, and provide treatment and education to promote mobility and health, relieve or manage pain and develop, restore, maintain or enhance optimal functional performance.**

**Functional performance refers to the ability of an individual to safely and effectively perform, those physical activities required to fulfil the roles and responsibilities in daily life.*

Physical Therapy practice includes, but is not limited to:

- *assessment of neuromusculoskeletal and cardiorespiratory systems and establishment of a physical therapy diagnosis,*
- *development, progression, implementation and evaluation of therapeutic exercise programs,*
- *education of client, caregivers, students and other health service providers,*
- *manual therapy treatment techniques such as massage, proprioceptive neuromuscular facilitation, muscle energy techniques, joint mobilization and manipulation,*
- *pain relief and management including acupuncture,*
- *administration of physical therapy related medications,*
- *prescription, manufacture, modification and application of braces, splints, taping, mobility aids or*

seating equipment,

- *hydrotherapy, electrotherapy* and use of mechanical, radiant or thermal energy,*

***"electrotherapy" means the application of all modalities derived from the electromagnetic spectrum and ultrasound into the body for therapeutic purposes.*

- *ergonomic evaluation, modification and education,*
- *counselling re: movement dysfunction and physical limitation, and*
- *research.*

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4. Conclusion

The Council has reviewed this second scope of practice statement and found that the first paragraph contains a description of intent as well as general categories of techniques utilized to achieve the intended result. The *Terms of Reference* require a concise description of the scope of practice. The Council has adopted the essential elements of the College's proposal in its recommendation regarding the scope of practice statement. By making a broad statement regarding techniques, the public and the other health professions will have sufficient information to define physical therapy within a broad therapeutic context. Physical therapy will not be limited to narrowly stated techniques which would constrain growth and development of the profession within its own scope of practice parameters.

A list of specific techniques such as those submitted in the second part of the revised scope statement is not generally included in a scope of practice statement. Any of these acts or activities listed which comprise reserved acts will be dealt with in the next section of this preliminary report. If the activity is not within a reserved act, it can be performed by any health professional so long as it is within their defined scope of practice.

The Council recommends the following scope of practice statement for members of the College of Physical Therapists of B.C.:

The practice of physical therapy is the assessment and treatment of the neuromusculoskeletal 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.

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B. RESERVED ACTS

The rationale underlying the granting of reserved acts is to protect the public by limiting provision of those particularly dangerous acts to members of specific professions who are qualified to perform them. Only those acts which present a significant risk of harm will be reserved.

The Council has developed a [list of reserved acts \(Appendix B\)](#) which is set out in its [Working Paper](#). The [Working Paper](#) was, in large part, a result of the Council's review of information provided by the various professions during the scope of practice consultation process. The Council understands that each profession's scope of practice brief was formulated without the benefit of a proposed reserved acts list and has considered this when reviewing proposals submitted in the profession's original brief.

The Council wishes to emphasize that its recommendations will likely provide for the sharing of many of the reserved acts. Thus, in conducting its review of any of the reserved acts of a profession, the Council is not necessarily deciding which acts would be reserved exclusively to that profession. It is possible and indeed likely that acts reserved to a profession will also be reserved to other professions. However, each profession must perform its reserved acts only within its defined scope of practice. Each profession is being given the opportunity to describe which of the reserved acts its members are qualified to perform and therefore should be reserved to members of that profession.

As noted on page 8, the current definition of the scope of practice of physical therapy is contained in the Physical Therapists Regulation. Section 5(1) of that Regulation states that this broadly framed scope also constitutes the reserved acts for physical therapists. Section 5(1) reads:

Subject to section 14 of the Act, no person other than a registrant may practise physical therapy.

Section 14 of the *HPA* reads in part:

. . . nothing in this Act, the regulations or the bylaws prohibits a person from

- A. *practising a profession, discipline or other occupation in accordance with this or another Act, or*
- B. *providing or giving first aid or temporary assistance to another person in case of emergency if that aid or assistance is given without gain or reward or hope of gain or reward.*

The combined effect of section 5(1) of the current Physical Therapists Regulation and section 14 of the *HPA* essentially reserves the entire scope of physical therapy practice exclusively to physical therapists or other regulated health professionals whose scope of practice encompasses such activities without regard to whether these activities are reserved acts or not. In contrast, the *Terms of Reference* clearly state that the rationale underlying the granting of reserved acts is to protect the public by restricting performance of acts which present a significant risk of harm to members of specific professions who are qualified to perform them. The entire thrust of the scope review process, as set out in the [Working Paper](#), is to restrict only those activities which carry a significant risk of harm.

In response to the [Working Paper](#), the College submitted further requests for reserved acts on May 19, 1998. Because the 1995 submission was the subject of a broad consultation process, this report will discuss the relevant results of that consultation process as well as the newly requested reserved acts received in May, 1998.

In its 1995 brief, the College proposed that its members receive two categories of reserved acts. The Council recognizes that the 1995 brief was submitted without benefit of the Council's 1998 [Working Paper](#). Several of the College's 1995 requests for reserved acts clearly do not fit within the reserved acts outlined in the [Working Paper](#). They are:

- *discharge from physiotherapy services*
- *therapeutic exercise prescription*
- *discharge planning and case management*
- *ergonomic assessment, modification, education and counselling*

The remaining reserved acts requested in 1995 are listed below and will be dealt with in conjunction with those requested in the College's May 1998 letter.

Category 1: The College's proposal for acts reserved exclusively to registrants of the College:

- *physical therapy assessment/diagnosis*
- *administration of physical therapy related medications through iontophoresis.*

Category 2: The College's proposal for reserved acts to be shared with other professions:

- *administration of physical therapy related medications*
- *joint mobilization and high velocity manipulation*
- *acupuncture*
- *equipment prescription*
- *bronchotracheal suctioning*
- *electrotherapy*

The Council will be considering these proposals in the context of its Reserved Acts List.

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1. Diagnosis

The following comments were received in response to the College's proposed reserved act of physical therapy assessment/diagnosis.

Both the BCMA and the BCAP objected to the reservation of this act to physical therapists to the exclusion of medical doctors and podiatrists. There are several groups of doctors who have expertise in this area and thus overlap in function with physical therapists.

The BCAP objected to reserving this area exclusively to physical therapists because of physical therapists' limitation in training in foot disorders.

The College addendum to its brief entitled "Physical Therapy and the Prescription of Therapeutic Exercise" addresses this issue at page 7:

One danger of prescribing exercise treatment without adequate assessment and monitoring is that of missed diagnosis of systemic or medical conditions that could potentially harm the client.

Physiotherapists act as primary health care providers in B.C., as in other parts of Canada, and most of the United States . . . Independent practice requires that the physical therapist be able to evaluate a client complaint knowledgeably and determine whether the client has signs and symptoms of a systemic disease or a medical condition that should be evaluated by a more appropriate health care provider . . . Direct access has been the wake up call for our profession regarding medical screening responsibilities. Yet, we have always had this responsibility and for decades have incorporated a screening component into our examination scheme . . . Physical therapists' responsibilities include appropriate communications with, and referral to, other health care providers. Inherent in the physical therapy skills of assessment and treatment of movement dysfunction is the skill set of screening for subjective symptoms and observed signs that suggest the need for referral for other medical screening.

A small number of respondents to the consultation process questioned the training of physical therapists in the area of assessment, particularly the area of cardiorespiratory assessment. The Council is not able to determine the adequacy of educational preparation of physical therapists for the assessment techniques in question. However the Council has no concerns about the minimum standards of educational preparation of physical therapists, in light of the long history of physical therapy as a self-regulating profession with a great deal of experience in assessing qualifications for entry to practice and academic accreditation.

Under section 19 [18] of the *HPA*, the issue of competency to practice is the responsibility of the College. The minimum standards of good practice of any profession would require the individual practitioner to practice safely and within their scope of practice as educated and trained. This would include, for any health professional, an assessment of the patient to determine whether professional intervention would be beneficial, should be modified in a particular situation to avoid harm to the patient, or indeed whether referral to another health profession is indicated in lieu of undertaking any treatment.

Assessment must be an integral and fundamental part of every health professional's practice. Assessment refers to the first step in how physical therapists practice their profession. Evaluation includes history taking and assessment (not diagnosis) for the purpose of initiation and modification of treatment. Use of the term "*diagnosis*" can become problematic if used interchangeably with "*assessment*".

In its January 2, 1997 submission the College clarified the nature of physical therapy diagnosis:

*Physical therapists do not diagnose disease. When physical therapists use the term *diagnosis* they mean the determination of the cause of a client's presenting subjective symptoms and objective signs*

relating to movement dysfunction and functional limitations. An assessment or evaluation is the process by which the information is gathered . . .

This process of establishing a physical therapy diagnosis is integral to the practice of physical therapy. Without it, the physical therapist is unable to establish treatment and educational programs to address a client's needs . . .

"This process may be similar to the 'classic' medical diagnostic process in that the goal frequently is to pinpoint a cause of - or a contributing factor to - a patients' problem in order to direct treatment; however, a major difference between a diagnosis by a PT and a diagnosis by a physician is in what's being looked to as a 'cause.'" (Fosnaught, M., "A Critical Look at Diagnosis", PT Magazine Vol.50: Sept. 1996, p.49)

In the same letter, the College has set out several categories of harm and a rating scale to quantify the seriousness of the consequences if the task or responsibility is not performed properly. With regard to physical therapy diagnosis, the College states:

Misdiagnosis at a minimum results in prolonging the resolution of the client's problem. If a misdiagnosis results in inappropriate treatment in clients with a medical condition, it could result in injury or death. (For example, if a physical therapist was to misdiagnose a client presenting with calf pain as being of a musculoskeletal origin rather than a deep vein thrombosis, the client could go on to develop pulmonary embolism - which could result in death.)

The College comments that while there are no compiled statistical reports that discuss the prevalence of these types of injuries, individual case studies that document these injuries are found in professional journals, reports of insurance settlements and in individual patient files.

On May 19, 1998, the College submitted a further elaboration on the issue of reserved acts for members of the College, as a response to the Council's [Working Paper](#). In relation to the Council's reserved act, "*making a diagnosis identifying a disease, disorder or condition as the cause of signs or symptoms of an individual*", the College states:

Physical Therapists are primary care practitioners and must make a physical therapy diagnosis in order to appropriately treat or refer a client.

In the [Working Paper](#), the Council describes "assessment" as a process of observation and evaluation of the physical status or progress of a patient, which may involve observation of symptoms, but does not include naming or identifying a disease, disorder, or condition as the cause of these symptoms.

The Council recognizes that members of the public may access a physical therapist without a referral from a medical doctor. However, what the College defines as "*physical therapy diagnosis*" is, in the Council's terminology, "*assessment*" as defined in the [Working Paper](#).

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2. Physically Invasive or Physically Manipulative Acts

a) Procedures on Tissue Below the Dermis

Acupuncture: In its May 1998 letter to the Council, the College requested acupuncture under the reserved act, "procedures on tissue below the dermis". The College comments that "[P]hysical Therapists utilize acupuncture . . . within their practices."

The Council received several comments during the consultation process regarding physical therapists' use of acupuncture. The British Columbia Naturopathic Association (BCNA) commented that the College submission does not detail the educational requirements and standards for physical therapists willing to perform acupuncture. The BCNA's view is that these should be clearly stated and ideally, agreed to by both registered acupuncturists and naturopaths in the province. The Registered Nurses Association of B.C. (the RNABC) wonders whether acupuncture includes acupressure. The British Columbia College of Acupuncturists (BCCA) comments that acupuncture is not within the scope of practice of physical therapists and should not be a reserved act for them because their training is inadequate, according to the BCCA. The Association of Physical Therapists of Manitoba agreed with the scope statement, but wondered if "*pain relief including acupuncture*" limits the use of acupuncture and cited the Canadian Physiotherapy Association position to include the use of acupuncture to "*normalize physiological functions*".

The Council was concerned about the range of acupuncture services provided by physical therapists. In September 1996, the Council wrote to the College and asked specifically "*Is the use of acupuncture limited to pain relief?*" The College responded in a December 1996 letter:

There are approximately 100 physical therapists in B.C. who utilize acupuncture within their practices. Acupuncture is used primarily to relieve or decrease pain, but may also be used as an adjunct in treating clients with musculoskeletal, cardiorespiratory and neurological conditions to obtain maximum functional performance (for example to reduce spasticity, or aid in the treatment of urinary incontinence). In Canada, physical therapists have been using acupuncture since the early 1980's.

The College submits that the level of training in acupuncture for physicians and for physical therapists is identical. The College includes a brochure for a seminar sponsored by the Acupuncture Foundation of Canada Institute (AFCI) which consists of 9 days of instruction after which a physiotherapist, physician or dentist may challenge the examination for certification in acupuncture treatment.

The College of Acupuncturists of B.C. (CABC) submitted that:

*One of the tenets of public protection is that a health profession should clearly define the **limitations of its practice**. Limitations in training require limitation in practice. If a physiotherapist wishes to make a traditional Chinese diagnosis and utilize acupuncture accordingly, they should also be a registrant of the College of Acupuncturists . . . The applicant's Addendum 4-Summary of Post Graduate Education Programs describes a basic three week-end course. A description of the training program includes the treatment of various conditions such as **dermatological** and **psychiatric** disorders. Other courses offered include a three day training "teaching the basic fundamental theories of traditional acupuncture which allow one to make a traditional Chinese diagnosis."*

The examples as shown above illustrate the potential for the inappropriate use of acupuncture by a physical therapist.

The CABC objects to granting the reserved act, acupuncture, to physical therapists, however, their objections, in

the Council's view, are objections on the basis of scope of practice. The Council emphasizes that a reserved act can be shared among several health professions. However, it can only be performed by a member of a health profession practising within that profession's scope of practice.

The Council was interested in the use of acupuncture by other health practitioners and requested information from the College of Physicians and Surgeons of B.C. (the CPSBC). The CPSBC submitted its policy with regard to use of acupuncture. It reads in part:

As a result of experience and evaluation of world literature, acupuncture is considered to have a valid role in the management of patients with selected pain syndromes . . . On the basis of present knowledge it does not have a curative effect on the fundamental disease process.

In the opinion of the College, physicians who wish to administer acupuncture should:

- 1. Have a special knowledge of the problems of chronic pain as it pertains to accurate diagnosis of the cause, evaluation, assessment and possible alternative management approaches.*

...

- 6. Be aware that the advocated use of acupuncture in other than pain problems has not been fully assessed.*

The CPSBC requires satisfactory completion of the three levels of courses offered by the AFCI or the University of Alberta Programme on Medical Acupuncture. The College requires the completion of AFCI examinations or the certificate program in Medical Acupuncture of the University of Alberta. The College submitted the AFCI curriculum which indicates that the AFCI level 1 curriculum includes training in "anatomical acupuncture" and a one hour introduction to classical traditional Chinese medicine ("TCM") acupuncture. AFCI confirms that there is currently no examination offered in classical TCM acupuncture.

The Council is in receipt of the College of Physical Therapists Policies and Procedures, re: Acupuncture Treatment, May 1996, which indicates:

Acupuncture, using needles, is within the scope of physical therapy practice when utilized in the treatment of neuromusculoskeletal or cardiorespiratory dysfunction to prevent or modify the perception of pain or to normalize physiological functions, including pain control.

The use of the reserved act of acupuncture by physical therapists or by any regulated health professional is confined to use within the profession's scope of practice. The College has not requested the reserved act of "TCM diagnosis" nor has the College provided any evidence of training sufficient to utilize TCM diagnosis. However, the Council has never been presented with evidence of an independent risk of harm in the use of acupuncture therapy without a proper TCM diagnosis. While the Council recognizes the considerable difference in philosophical approach between the use of acupuncture in TCM and its use in a western medicine context, including its use by physical therapists, the Council must emphasize the limitations imposed by the shared scope/reserved acts system.

Acupuncture is one of the primary TCM therapies and when used by a TCM practitioner it is based upon a TCM diagnosis and is used within the scope of practice of TCM. However, the therapeutic benefits of acupuncture have come to be recognized by western medicine and when utilized in a western context, acupuncture is based

upon an allopathic (western) medical diagnosis. Acupuncture has been found to be particularly useful in management of pain, according to both the CPSBC and the College.

The Council recognized the risk of harm inherent in acupuncture when it recommended the designation of the College of Acupuncturists and recommended granting its members the reserved act of "*inserting acupuncture needles below the dermis*". The Council considers that it is in the public interest to grant reserved acts to those professions which have adequate advanced practice certification programs in place and whose regulatory body has determined that these advanced practitioners have been adequately trained to apply such reserved techniques. Under section 19 [18] of the *HPA*> it is the duty of a health profession's regulatory body to ensure that its members practice within their scope of practice according to recognized standards and maintain competency. Regulatory bodies have the duty to protect the public from untrained and incompetent practitioners, whether it be at an entrance to practice level, or at a level of advanced practice. The College has demonstrated that physical therapists' have in place an advanced certification program for acupuncture.

The Council recommends that the reserved act of performing procedures below the dermis for purposes of acupuncture for the management of pain and/or normalization of physiological functioning of the cardiorespiratory and neuromusculoskeletal systems be granted to members of the College of Physical Therapists of B.C.

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b) Reducing a Dislocation of a Joint

In its May 1998 letter to the Council, the College requested the following additional reserved act which had not been referred to in its 1995 brief:

2(b): Setting or casting a fracture of a bone or reducing a dislocation of a joint;

Physical Therapists working in the sports injury arena are called upon to relocate a joint at the scene of a sporting event (for example a shoulder dislocation).

The College did not submit documentation or information about core training or advanced certification of physical therapists with regard to this reserved act. Nothing was submitted to support granting this act to members of the College, other than the College's request that this act be reserved.

Without further information and consultation with the various professions and interested parties who participated in the consultation process, the Council does not wish to make a recommendation about this reserved act at the present time. However, the opportunity for comment regarding this reserved act and any other aspects of the scope review will be afforded to all interested parties at the public hearings. These hearings are the next step in the scope review process and will be scheduled after all preliminary reports are issued. Any comments regarding the appropriateness of this reserved act for physical therapists, the risk of harm involved, or any other issues raised by this preliminary report should be addressed to the Council in writing prior to the date of the public hearing.

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c) Movement of the Joints of the Spine

Joint mobilization and high velocity manipulation: In its 1995 brief, the College requested a reserved act referred to as "*joint mobilization and high velocity manipulation*". Comments concerning this proposed reserved act ranged from a question by RNABC whether "*joint mobilization*" included passive range of motion and a comment from the CMTBC that the definition of "*joint mobilization*" is vague. The CMTBC goes on to state that they assume the College is referring to "*joint play techniques*" which the CMTBC states have a risk of injuring joint structures. This technique should be designated a reserved act and shared by those with necessary training, according to the CMTBC submission. If passive joint movement techniques are part of this reserved act the CMTBC considers that a separate issue.

The Council's intention regarding this reserved act was not to reserve all manipulation but only that part of manipulative therapy which presents a significant risk of harm.

With regard to "*high velocity manipulation*" the CMTBC commented that the Council should consider the physical therapists' training program in this area to ensure it meets the concerns of other professions who employ high velocity manipulation. The British Columbia College of Chiropractors (BCCC) submitted extensive materials regarding the use of high velocity manipulation and asserted strongly that physical therapists are not adequately trained, indeed, no profession, other than chiropractors, was adequately trained in high velocity manipulation.

In their May 1998 letter to the Council, the College requests that the reserved act of "*moving the joints of the spine beyond the individuals usual physiological range of motion using a high velocity, low amplitude thrust*" be granted to members of the College. The College comments that "*Physical Therapists have been safely and effectively performing this technique since it was first identified as within our scope of practice in 1946.*"

The College submits at page 7 of its brief that:

development of advanced skills in this area is built on core physical therapy competencies. An approach, formally recognized by the College and Professional Association, is to participate in a rigorous post graduate education program followed by competency based examinations. This process is recognized nationally and internationally.

The Council has received the curriculum from the Orthopaedic Division of the Canadian Physiotherapy Association and information about the certification process by which physical therapists achieve advanced certification to perform this reserved act. The Council is satisfied that the certification process administered by the national Canadian Physiotherapy Association is appropriate to ensure competency and is accepted by the College.

Under section 19 [18] of the *HPA*> it is the duty of a health profession's regulatory body to ensure that its members practice within recognized standards and maintain competency. It is the Council's view that regulatory bodies have the duty to protect the public from untrained and incompetent practitioners, whether it be at an entrance to practice level, or at a level of advanced practice. In the Council's view, the College has demonstrated that physical therapists' core training gives the basis for postgraduate training in high velocity, low amplitude thrust and there is a competency program in place.

The Council notes that in Ontario members of the College of Physical Therapists of Ontario have been granted

the Controlled Act "*moving the joints of the spine beyond a person's usual physiological range of motion using a fast, low amplitude thrust*".

The Council recommends that the reserved act 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 be granted to members of the College of Physical Therapists of B.C.

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d) Putting an Instrument, Hand or Finger(s) Beyond Various Parts of the Body

Putting a Finger(s) Beyond the Anal Verge: In its May 1998 letter to the Council, the College submitted the following with regard to the reserved act of putting an instrument, hand or finger(s) beyond the anal verge which the College requested in its January 1998 submission:

"the manipulation of the coccyx requires special training. This is available to physical therapists at a post graduate level . . . physical therapists perform this act for the purpose of . . . mobilization or manipulation of the coccyx".

With regard to the reserved act of moving the joints of the spine, the College has demonstrated that there is an advanced competency program which was discussed on page 24, in place for training in the performance of this reserved act.

The Council recommends that members of the College be granted the reserved act of putting a finger(s) beyond the anal verge for 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 be granted to members of the College of Physical Therapists of B.C.

Bronchotracheal suctioning: In its May 1998 letter, the College requested that the reserved acts of putting an instrument, hand or finger(s) beyond the point in the nasal passages, where they normally narrow, beyond the pharynx, and or into an artificial opening into the body be granted to members of the College, commenting that "[P]hysical Therapists perform these acts when suctioning lung secretions for a client who cannot effectively clear secretions."

The RNABC and B.C. Society of Occupational Therapists commented that this act overlaps with their practice, however none of the respondents questioned the risk of harm outlined by the College in its brief or the training and competence of physical therapists to perform this reserved act.

The Council is satisfied on the basis of all the information submitted that this act is within the scope of physical therapists' practice and that physical therapists have training and education in this area.

The Council recommends that the reserved act of putting an instrument beyond the point in the nasal passages where they normally narrow, beyond the pharynx, or into an artificial opening into the body for the purpose of bronchotracheal suctioning be granted to members of the CPTBC.

Putting a Finger(s) Beyond the Labia Majora: In its May 1998 letter to the Council, the College stated that physical therapists perform this act for the purpose of assessment and treatment of pelvic floor musculature.

The College did not submit documentation or information about core training or advanced certification of physical therapists with regard to this reserved act. Nothing was submitted to support granting this act to members of the College, other than the College's request that this act be reserved.

Without further information and consultation with the various professions and interested parties who participated in the consultation process, the Council does not wish to make a recommendation about this reserved act at the present time.

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e) Administering a Substance by Injection or Inhalation

Administration of physical therapy related medications through iontophoresis: None of the respondents commented on this proposed reserved act, and the 1995 brief submitted by the College does not address the risk of harm associated with it. The Council asked the College to provide information and rationale to establish the risk of harm involved in this process.

In its January 1997 letter to the Council, the College defined "*iontophoresis*" as:

. . . the movement of ions across biological membranes by means of an electrical current for therapeutic purposes. It is commonly used in the treatment of inflammation or hyperhidrosis (excessive sweating).

Taber's Cyclopedic Medical Dictionary defines "*iontophoresis*" as: "*Introduction of various ions into tissues through the skin by means of electricity.*"

In its May 1998 letter to the Council, the College categorizes administration of substances by inhalation or via iontophoresis or photophoresis as falling within the Council's reserved act of administering a substance by injection or inhalation and comments that "*physical therapists administer substances by inhalation or via iontophoresis or photophoresis*" without further elaboration. The College does not offer details of the treatment itself nor the risks inherent in iontophoresis or photophoresis. The Council requested more specific information from the College. The College responded on July 30, 1998 but have not demonstrated any risks inherent in the procedures itself iontophoresis and photophoresis.

The College submits in its July 30th, 1998 response:

The types of medications administered via iontophoresis or photophoresis fall into three main categories: anti-inflammatories, analgesics, anti-hyperhidrodises. Where prescription medication is utilized, a physician would prescribe the medication (may be done on recommendation of physical therapists). Non

prescription medications are used at the discretion of the physical therapist (for example aspirin based creams).

As discussed in the [Working Paper](#), the Council is dealing here with the **route** of administration of **substances which are not drugs**. The College has not documented any specific risk associated with administration routes which utilize iontophoresis or photophoresis or substances which are not drugs. The Council will deal later in this report with the risks associated with administration of specific medications by inhalation or by any other route.

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3. Applying or Ordering the Application of a Hazardous Form of Energy

In its May 1998 submission, the College requested that the reserved act of applying or ordering the application of a hazardous form of energy including diagnostic ultrasound, electricity, magnetic resonance imaging, lithotripsy, laser and X-ray be granted to members of the College. The College commented:

We believe that there is a significant risk of harm from the inappropriate or improper application of:

- *Ultrasound,*
- *Laser and Infra red,*
- *Short Wave Diathermy,*
- *Interferential and*
- *electrical stimulation of innervated and denervated muscle with low and medium frequency current.*

Therefore, it is our belief that the above modalities should be included in the definition of "hazardous forms of electricity" and "laser". The use of these modalities is included in the existing scope of physical therapy practice and should continue to be designated to physical therapists. Our research has not found support for a risk of harm in the use of microcurrent or biofeedback.

In an April 1998 submission to the Council, the College included extensive documentation of the risk of harm in various procedures including the use of electricity and ultrasound, among other forms of energy.

Electrotherapy: The only respondent commenting on this proposed reserved act was the CMTBC: "*In general, any professional using electrotherapy should be trained, and if reserved, each type of electrotherapy should be investigated separately for risk of harm.*"

On July 23, 1998 the Council requested that the College provide more documentation about the use of EMG and interferential current and the risks inherent in their application.

In its July 30, 1998 response, the College discussed the risks associated with interferential current and EMG:

Interferential current presents a risk of skin irritation and electrical burns. Its use on a client with a pacemaker or in an environment where a person with a pacemaker may come in contact with the machine is contraindicated, as it may interfere with the function of the pacemaker.

EMG using surface electrodes can result in skin irritation and burns (As the electrical signal from the muscle is not efficiently transmitted through the skin and subcutaneous tissues, some electrodes utilize a pre-amplification system . . .)

The Council, on June 17, 1998, made an [Interim Report](#) to the Minister of Health seeking information on the subject of hazardous energy when used during the provision of health care services. . The Council will defer consideration of this reserved act pending receipt of information from the Minister.

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4. Prescribing, Compounding, Dispensing or Administering a Drug Restricted under Provincial or Federal Legislation

Administration of physical therapy related medications: None of the respondents commented directly on this aspect of the College's proposed reserved acts. The College did not include any documentation regarding risk of harm associated with these acts in its 1995 brief. The College had submitted that:

the most commonly used medications currently are:

- *bronchodilators through nebulizers or inhalers*
- *application of local topical anesthetics*

The College of Physicians and Surgeons' (CPSBC) response to the College's brief indicates that the "proposed reserved acts performed jointly with other professions" is open to more than one interpretation. The CPSBC states:

We assume that it is meant to convey recognition that certain other professions will also possess the privilege of performing those acts. However, it could also be interpreted that the involvement of another profession may be required, e.g., for the prescription of bronchial dilators through nebulization or inhalers, which is one example of an act which we believe it would be in the best interests of the public to permit only with medical consultation and direction.

In its [Working Paper](#) the Council recommended that the administration of medications listed in Schedule I or II of the [Pharmacists, Pharmacy Operations and Drug Scheduling Act](#) be a reserved act. This reserved act deals with both medication and the route of administration of those medications. The application of local topical anaesthetics would probably not be included in the administration routes considered to carry a significant risk of harm except when administered by inhalation. Any substance which is subject to restriction by prescription must be prescribed by a health professional who is granted that reserved act within their scope of practice, such as a

physician.

In its January 1997 letter to the Council, the College discusses the risk of harm associated with administration of "*physiotherapy related medications*" as falling within the category of being "*highly serious (e.g., worsen patients condition by provision of inappropriate or contraindicated treatment, delaying appropriate treatment or cause injury)*". The College also comments that "*as with administration of any medication, there is a risk of harm if it is administered improperly.*"

In the May 1998 letter the College also requested that the reserved act of prescribing, compounding or administering by any means a drug listed in Schedule I or II of the [Pharmacists, Pharmacy Operations and Drug Scheduling Act](#) be granted to members of the College. Documentation for granting this act was that "[*P*]physical Therapists administer medications on these schedules as prescribed by a physician or dentist." The College did not, however, discuss any routes of administration or specific medications in its submissions prior to July 1998.

In its July 1998 letter responding to the Council's request for more information, the College responded specifically:

The types of medications physical therapists may administer by inhalation include bronchodilators and mucolytic agents. In addition, physical therapists may administer, by instillation (through an ET tube), an analgesic solution (for example lidocaine or xylocaine) to decrease acute airway hypersensitivity prior to mobilization of an intubated client. All of these medications would be prescribed by a physician.

The Council recommends that the reserved act of 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 be granted to members of the College of Physical Therapists of B.C.

Equipment prescription: The B.C. Society of Occupational Therapists (BCSOT) agreed that this should be a reserved act shared with occupational therapists. RNABC commented that this reserved act would overlap with nursing practice.

Equipment prescription was not recommended as a reserved act discussed in the Council's [Working Paper](#).

The Council considered the issue of equipment prescription in its [Report on the Designation of Occupational Therapy](#), June 1996. In that Report, the Council determined that while considerable professional expertise must be exercised in the area of equipment prescription to avoid further deterioration in persons whose health may be compromised, it does not warrant reservation as a reserved act. Members of the public will be adequately protected by ascertaining that the professional who prescribes special adaptive equipment is a member of a professional college and is subject to minimum standards of practice, competency and disciplinary processes if not meeting those standards.

The Council is satisfied that equipment prescription is part of the scope of practice of physical therapists but it is not a reserved act.

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C. SUPERVISED ACTS

The [*Criteria and Guidelines*](#) which are attached to the [*Terms of Reference*](#) state that although reserved acts may only be performed by certain professions, it may be appropriate for other persons to perform them, or aspects of them, under the supervision of members of those professions. The [*Criteria and Guidelines*](#) also indicate that where the Council is satisfied that a reserved act may be performed under supervision, it may recommend training and qualification requirements, limitations regarding where the act may be performed and the degree of supervision which should be exercised.

The Council believes that some clarification of terms would be useful as the [*Terms of Reference*](#) do not define "supervision". In reviewing the responses to the scope of practice submissions, most professions have used the terms delegation and supervision interchangeably. However, technically, there appears to be a distinction between the terms.

In his book "A Complete Guide to the Regulated *Health Professions Act*" (Canada Law Book, 1995), Richard Steinecke discusses the meaning of these terms. Delegation is where the delegating professional makes a determination that an individual is competent to perform a task and that individual then carries out the task without the delegating professional being present. Supervision, on the other hand, implies a more intense control over the act than does delegation and will usually require the supervisor's physical presence.

In the Council's view, although this term of reference refers to "supervised" acts, it is intended to encompass any situation where someone other than the person to whom the reserved act has been granted performs that act. In other words, this term of reference refers to both delegation and supervision.

The College made the following submission with regard to the issue of supervised acts:

1. Delegation of Physical Therapists' Tasks

Physical Therapists may delegate specific tasks to other health care providers providing a physical therapy assessment has been completed, the caregiver receives appropriate instruction and can demonstrate the task safely. The College of Physical Therapists in consultation with other physical therapy organizations, has developed the following standards for the physical therapist when delegating activities.

Safety and Scope

- *Client goals have been identified in consultation with the client.*
- *The treatment program is aimed at meeting the identified goals.*
- *Both client and the non-physiotherapist identify and agree that the delegated tasks identified by the physical therapist can be performed safely.*
- *The non-physiotherapist understands that the delegated task is client specific and is not*

transferable to another client.

Training

- *The non-physiotherapist receives training to ensure that they can safely perform the task.*

Supervision

- *The physical therapist determines and communicates to the non-physical therapist the frequency of monitoring or review by the physical therapist.*

Accountability and Communication

- *The non-physical therapist is informed of any changes to the care plan.*
- *The non-physical therapist knows how and when to document relevant information about the client.*
- *The non-physical therapist is given information about contacting the physical therapist and how to access back up support when necessary.*

The College of Physical Therapists is reviewing the issue of physical therapist/physiotherapist assistants regarding the appropriateness of certifying or registering this new designation of health care worker under the present legislation. This would ensure that basic educational qualifications and standards are established as programs to train and positions for these workers emerge. Physical Therapy organizations are working together on this issue.

Delegation of Reserved Acts

The determination of whether an act is appropriately delegated is regularly reviewed. To date they include:

- *Supervision of established exercise programs*
- *Application of certain electrotherapy modalities*
- *Bronchotracheal suction*

Reserved Acts Not Delegated

Those acts that are not appropriately delegated include:

- *Physical therapy assessment*
- *Prescription of exercise*

- *Discharge from physical therapy service*
- *Acupuncture*
- *Joint mobilization or high velocity manipulation*
- *Ergonomic assessment*
- *Administration of physical therapy medication*
- *Equipment prescription*

The Council realizes that the College's submission was made prior to the [Working Paper](#) which set out the Council's position on supervised acts. However, the proposal by the College embodies some of the same principles adopted by the Council. The College has not amended its submission with regard to supervised acts, nor is it required to do so in light of the [Working Paper](#), which the Council believes is broad enough in scope to cover the supervised or delegated acts of all health professions.

The [Terms of Reference](#) imply that the Council will, for each reserved act granted to each profession, determine the circumstances in which the act may be performed by someone other than a member of that profession. The Council considered this issue in its [Working Paper](#).

In the [Working Paper](#), the Council stated that supervised acts would not be dealt with individually for each profession. In the Council's view, this general position should be applied to all professions. It is largely a recognition that the regulatory body is in the best position to determine when reserved acts can be performed under supervision or delegation. The regulatory body should be charged with determining when delegation is appropriate in accordance with the principles set out below. The Council believes this general approach to supervised acts more accurately reflects the reality that procedures to be delegated vary from profession to profession and may include subsets and variations of reserved acts and further, may be performed under a myriad of circumstances and conditions.

The Council recommends that a provision be enacted which sets out the duties of a health professional and his or her regulatory college when delegating a reserved act. The provision should require the following:

- **The assigning health professional's governing body must provide assent to the proposed reserved act being performed by someone else;**
- **The reserved act to be assigned as well as the level of supervision must be clearly defined and circumscribed by the assigning health professional's governing body;**
- **Where the person to whom the act will be assigned is a member of a self-regulating health profession, his or her governing body must approve of the assigning of the reserved act;**
- **The instruction to perform the act must be made in writing either by way of a general written protocol or through a case-specific instruction;**

- Where the person to whom the act will be assigned is a member of a self-regulating health profession, his or her governing body must approve of the assigning of the reserved act;
- The instruction to perform the act must be made in writing either by way of a general written protocol or through a case-specific instruction;
- The assigning health professional must be satisfied that the individual who will be performing the act has the necessary skills and training to perform the act safely; and
- The assigning health professional must ensure that the person who will be performing the act accepts the assignment.

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D. RESERVED TITLES

Reserved titles are titles reserved exclusively to a health profession. Reserved titles afford consumers a means to identify the different types of health care providers, to distinguish the qualified from the unqualified, and to differentiate those practitioners who are regulated from those who are not. Titles must adequately serve the public in describing the practitioner and the services being provided and must distinguish the practitioner from others performing services outside the jurisdiction of the college.

The College submits that the titles currently reserved under the *HPA>* should continue to be reserved for members of the College. They are:

Registered Physiotherapist
Physiotherapist
Physical Therapist

The Council recommends that the titles: "*Physiotherapist*" and "*Physical Therapist*" be reserved for members of the College. The Council's practice has been to avoid use of the term "registered" for members of self-regulating colleges designated under the *HPA>* since the regulatory scheme embodied in the *HPA>* is not a "*registration*" system. It has been the Council's practice to reserve the descriptive term, such as "*physical therapist*", for exclusive use of members of the College, so that the use of the term "*registered*" is unnecessary.

The Council recommends the titles "physiotherapist" and "physical therapist" be reserved for members of the College of Physical Therapists of B.C.

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IV. RECOMMENDATIONS

1. The Council recommends the following scope of practice statement for members of the College of Physical

Therapists of B.C.:

The practice of physical therapy is the assessment and treatment of the neuromusculoskeletal 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.

2. The Council recommends the following reserved acts be granted to members of the College of Physical Therapists of B.C.:

- 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 neuromusculoskeletal systems 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 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 in the nasal passages where they normally narrow, beyond the pharynx, or into an artificial opening into the body for the purpose of bronchotracheal 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](#).

3. The Council recommends that a provision be enacted which sets out the duties of a health professional and his or her regulatory college when delegating a reserved act. The provision should require the following:

- The assigning health professional's governing body must provide assent to the proposed reserved act being performed by someone else;
- The reserved act to be assigned as well as the level of supervision must be clearly defined and circumscribed by the assigning health professional's governing body;
- Where the person to whom the act will be assigned is a member of a self-regulating health profession, his or her governing body must approve of the assigning of the reserved act;
- The instruction to perform the act must be made in writing either by way of a general written protocol or through a case-specific instruction;
- The assigning health professional must be satisfied that the individual who will be performing the act has the necessary skills and training to perform the act safely;
- The assigning health professional must ensure that the person who will be performing the act accepts the assignment.

4. The Council recommends that the titles "physiotherapist" and "physical therapist" be reserved for members of the College of Physical Therapists of B.C.

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APPENDIX A: The Terms of Reference

APPENDIX B: Reserved Acts List

APPENDIX C: Glossary of Terms

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APPENDIX C

GLOSSARY

Throughout this report, the Council makes reference to the College submission and to the responses received during the consultation process. The Council has abbreviated its references to many of the responses received and for ease of reference, the Council has included the following glossary of medical terms and abbreviations used:

British Columbia Association of Kinesiologists	BCAK
British Columbia Association of Podiatrists	BCAP
British Columbia College of Acupuncturists	BCCA
British Columbia College of Chiropractors	BCCC
British Columbia Medical Association	BCMA
British Columbia Naturopathic Association	BCNA
British Columbia Recreation and Parks Association	BCRPA
Canadian Athletic Therapists Association	CATA
College of Acupuncturists of British Columbia.	CABC
College of Massage Therapists of British Columbia	CMTBC
College of Physical Therapists of British Columbia.	College

College of Physicians and Surgeons of British Columbia	CPSBC
Human Factors Association	HFA
Registered Nurses Association of British Columbia	RNABC
electromyogram: a graphic record of the contraction of a muscle as a result of electrical stimulation	EMG
Iontophoresis : the movement of ions across biological membranes by means of an electrical current for therapeutic purposes. It is commonly used in the treatment of inflammation or hyperidrosis (excessive sweating); Process of electrical current travelling through salt solution causing migration of metal (positive) ion to negative pole and radical (negative) ion to positive pole; Introduction of various ions into tissues through the skin by means of electricity.	
endotracheal tube	ET Tube
Photophoresis: photochemotherapy; use of light and chemicals together to treat certain conditions.	

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Health Professions Council POST-HEARING UPDATE OF PRELIMINARY REPORT: PHYSICAL THERAPISTS

Irvine E. Epstein, Q.C., Chair
Arminée Kazanjian, Member
David MacAulay, Member

March 2001

This Post-Hearing Update should be read in conjunction with the [Preliminary Report](#) for the profession.

The Council issued its *Physical Therapists Scope of Practice (Preliminary Report)* in January 1999. The public hearing was held on 7 June 1999. The following are changes to the *Preliminary Report* which arose from the submissions made either at the public hearing or in subsequent written submissions.

I. SCOPE OF PRACTICE

The Council in its *Preliminary Report* recommended the following scope of practice for physical therapists:

The practice of physical therapy is the assessment and treatment of the neuromusculoskeletal 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.

The College of Physical Therapists of British Columbia (College) requests that the following scope of practice statement be recommended for physical therapists:

*The practice of physical therapy is the assessment, **diagnosis** and treatment of neuromusculoskeletal and cardiorespiratory systems of the body by physical or mechanical means for the purposes of maintenance or restoration of function that has been impaired by injury or disease, for pain management and for the promotion of mobility and health.*

This definition differs from the one recommended by the Council in two ways: inclusion of "diagnosis" and deletion of the term "human" for consistency with the definitions of other professions.

The Council agrees that the term "human" is unnecessary. Also, the Council has determined, as a general

matter, that scope of practice statements should not contain or attempt to list the reserved acts granted to a profession. Accordingly, the Council has removed the term "diagnosis" from the scope of practice statement.

There is no doubt, however, that physical therapists may perform diagnosis as that reserved act has been granted to them. This is discussed in the reserved acts section of this post-hearing update.

The Health Professions Council recommends the following scope of practice for physical therapists:

The practice of physical therapy is the assessment and treatment of neuromusculoskeletal and cardiorespiratory systems of the 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 the promotion of mobility and health.

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II. RESERVED ACTS

The Council in its *Preliminary Report* recommended the following reserved acts for physical therapists:

1. Performing the following physically invasive or physically manipulative acts:
 - a. Procedures below the dermis for purposes of acupuncture for the management of pain and/or normalization of physiological functioning of the cardiorespiratory and neuromusculoskeletal systems 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 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 in the nasal passages where they normally narrow, beyond the pharynx or into an artificial opening into the body for the purpose of bronchotracheal suctioning.
2. 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.

A. Physiotherapy Diagnosis

The College has submitted a detailed brief in response to the Council's *Preliminary Report* which states:

Physical therapists do not make a diagnosis identifying a disease but physical therapists do name and identify disorders or conditions of the cardiorespiratory and neuromusculoskeletal systems.

The College provided seven case histories and legal cases where physical therapists were relied upon for a physical therapy diagnosis. The Physical Therapist National Examination for entry to practice tests the ability of the student to make a physical therapy diagnosis.

The Council has carefully considered the College's written response to its preliminary report as well as the oral submissions made at the public hearing. The College has acknowledged that its members do not diagnose diseases. The College has described the term "diagnosis" when used by physical therapists to be:

the determination of the cause of a client's presenting subjective symptoms and objective signs relating to movement dysfunction and functional limitations.

The College also points out that "physical therapists are primary care practitioners and must make a physical therapy diagnosis in order to appropriately treat or refer a client."

The Council has considered the recommended scope of practice and reserved acts utilized by physical therapists in recommending that members of the College be granted the following reserved act:

The Health Professions Council recommends the following reserved act for physical therapists:

- 1. Making a physical therapy diagnosis by determining the cause of subjective symptoms and objective signs relating to movement dysfunction and functional limitations.**

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B. Acupuncture

In response to discussion at the public hearing, the Traditional Chinese Medicine Association of British Columbia submitted a letter on 12 July 1999 which stated in part:

The proposal to allow the use of acupuncture to affect physiological systems is much too broad and is a transparent attempt to practice the whole of acupuncture without full training....If limited training is allowed, there must be a strict, well-defined limitation on practice....The subtle anatomy of the meridian system is the basis of all acupuncture treatments. An understanding of this system is required to direct the intention of the treatment of the acupuncturist. This unique diagnostic understanding is the basis of the treatment strategy followed. As TCM diagnosis is reserved for TCM Practitioners, a Physical Therapist would be treating without proper assessment....

...Just as Physical Therapists can provide pain relief through other means, they can use acupuncture needles to accomplish this as well, but to go beyond that involves a risk to the

public of incompetent practice of acupuncture. The practice of acupuncture is used to effect physiological systems, but not as described by Western medicine. It can also have effect on emotional states. Without a thorough understanding of TCM theory, one can inadvertently cause unwanted physiological and emotional responses through incorrect manipulation of the meridian system.

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There are three issues raised in this submission.

1. Training

The first issue is adequacy of the training for this reserved act. The acupuncture training recognized by the College, the College of Dental Surgeons of British Columbia and the College of Physicians and Surgeons of British Columbia is provided by the Acupuncture Foundation of Canada Incorporated (AFCI). It involves approximately nine days of training in what some have referred to as "anatomical acupuncture," "dry needling" or "focus needling." While the level of training provided by this course has been criticized by the College of Acupuncturists of British Columbia, it does fit within the Council's criteria as it is a post-graduate program approved by the profession's regulatory body.

2. Limitations

The second issue is granting the reserved act to physical therapists, without some limitation. The College has requested the reserved act acupuncture for "pain control" and for "normalization of physiological functions." However, AFCI admits and the Council acknowledges, that the traditional Chinese medicine content of this course is virtually non-existent, nor are graduates of the course examined in traditional Chinese medicine before receiving certification. The Traditional Chinese Medicine Association of B.C. submits that the use of acupuncture for normalization of physiological functions cannot be based upon a Western (allopathic) medical diagnosis. Physical therapists are not granted the reserved act of traditional Chinese medicine diagnosis. It is acknowledged in the *Preliminary Report* that physical therapists have no training in traditional Chinese medicine. The Council has recognized that the practice of traditional Chinese medicine and traditional Chinese medicine diagnosis carries a risk of harm and requires education, skill and training.

The College of Physicians and Surgeons of B.C. has guidelines which allow its members who have taken this course to use acupuncture for "pain control" only. The College of Physicians and Surgeons of B.C. bases this on medical studies which have shown that acupuncture is effective for pain control. The Council received a letter from the B.C. Medical Association on 1 October 1999. The letter was in reference to the 21 June 1999 designation of the College of Traditional Chinese Medicine and Acupuncture Practitioners. However, some of the comments are applicable here:

There is some evidence supporting the efficacy of Acupuncture in limited settings; most notably in the management of pain, and nausea and vomiting. The concepts used in TCM to explain the effects of Acupuncture are not evidence-based, and indeed are inconsistent with mainstream scientific understanding of pain. However, mainstream scientific thinking does offer at least a partial explanation for observed efficacy. There are various documented risks associated with needling.

Physical therapists have not claimed that they utilize acupuncture based upon a traditional Chinese medicine

diagnosis. The use of needles for pain control is a different issue, as pain is a subjective symptom which does not necessarily require diagnosis. At the public hearing, a representative of the College of Acupuncturists of B.C., Sheila Stickney, acknowledged that needles can be used for pain control but that would not properly be called acupuncture. It would appear that use of needles for pain control can be easily monitored by the practitioner and the patient. Either the pain is relieved, or it is not. Additionally, this seems to be properly within the scope of physical therapy, since many patients come to them for therapy related to neuromusculoskeletal problems and pain control is part of this therapy.

The College has informed the Council that physical therapists utilize acupuncture primarily to relieve or decrease pain, but:

[acupuncture] may also be used as an adjunct in treating clients with musculoskeletal, cardiorespiratory and neurological conditions to obtain maximum functional performance (for example to reduce spasticity, or aid in the treatment of urinary incontinence). In Canada, physical therapists have been using acupuncture since the early 1980s.

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3. Use of the term "acupuncture"

The third issue is the use of the word "acupuncture" by practitioners who have not been trained in traditional Chinese medicine. An addendum to the July letter from the Traditional Chinese Medicine Association of B.C. was received on 28 September 1999:

We still believe that physiotherapists should not have "acupuncture" in their scope of practice without full training in that therapy.... We believe that the term "acupuncture" is generally perceived by the public to be a therapy of Chinese medicine. If used with an intention based on a Western assessment, it should be identified as such in the public interest.... As practitioners we have experienced the common inquiries by the public as to what level of training we have received in the therapies we employ. This is one of the first concerns of patients who come for treatment.

...If physiotherapists are to be allowed the use of the acupuncture needle, there must be some indication of the intention of this use in regard to the level of training specific to this therapy. Some terms that have been in use are "dry needling" or "focus needling". This usage reserves the term "acupuncture" for those who are fully trained, preserving the connection to the process of Diagnosis-Treatment Plan-Therapy, and reduces the chance of public confusion as to what kind of treatment they are receiving.

The Council has carefully considered the comments of the traditional Chinese medicine and acupuncture practitioners and associations as well as those of representatives of the College of Acupuncturists of B.C. The Council believes it is inappropriate to refer to the term "acupuncture" when used in a Western medical context by a practitioner who has not been fully trained in the use of acupuncture in a traditional Chinese medicine context. The College acknowledges that the use of needles for pain control is the primary purpose, but that physical therapists may also utilize needles for specific neuromusculoskeletal conditions. In order to avoid any confusion or public misconception about education and training for "acupuncture" as well as to better describe physiotherapy practice, the Council has recommended the following reserved act for members of the College:

The Health Professions Council recommends the following reserved act for physical therapists:

2(a) Performing the physically invasive or physically manipulative act of inserting needles below the dermis for the purpose of pain management and normalization of physiological functioning of the neuromusculoskeletal system.

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C. Reducing a Dislocation of a Joint

The College disagreed with the Council's decision not to recommend this act for physical therapists. It states that there is currently no restriction of this activity in the *Physical Therapists Regulation*. The College submitted a letter from Sport Physiotherapy Canada, a division of the Canadian Physiotherapy Association, which states that reduction of dislocations are within the scope of physical therapists, and specifically recommends the particular joints physical therapists are qualified to reduce.

In light of the information received from the Canadian Physiotherapy Association, the Council has verified that physical therapists are trained and educated in simple joint reduction.

The Health Professions Council recommends the following reserved act for physical therapists:

2(b) Performing the physically invasive or physically manipulative act of reducing a simple joint dislocation.

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D. High Velocity, Low Amplitude Thrust

The British Columbia College of Chiropractors has reiterated its opposition to granting this reserved act to members of the College. The Council has again reviewed the objections in light of the criteria the Council has identified and utilized in granting reserved acts to professions. The College has a certification process in place and there is an educational program approved by the Canadian Physiotherapy Association as well as the College. The College states that "physical therapists have been safely and effectively performing this technique since it was first identified as within our scope of practice in 1946."

The Council remains persuaded that physical therapists are qualified to perform this reserved act.

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E. Pelvic Floor Re-education

The College requested the following reserved acts as part of pelvic floor re-education therapy:

- *Putting an instrument or finger(s) beyond the anal verge for re-education of the pelvic floor musculature; and*
- *Putting an instrument or finger(s) beyond the labia majora for purposes of re-education of the pelvic floor musculature.*

The College provided speakers at the public hearing who gave numerous examples of current practice in pelvic floor re-education therapy. There are six clinics in the Lower Mainland with one or more physical therapists practising in this field. Two physicians who work with physical therapists who perform this treatment wrote in support of physical therapists continuing to provide this type of therapy. However, there is no formal recognition by the College of this advanced practice. Additionally, in its written response to the Council's Preliminary Report, the College commented that:

This education was provided in the undergraduate programs until the mid 1970s when, with the advent of bladder surgery, the non invasive techniques fell from grace. In the last five to eight years, the muscle re-education approach to incontinence management has regained popularity as an effective alternative to surgery. The anatomy and physiology of the pelvic floor are covered during the undergraduate education of physical therapists, as are the principles and practice of muscle re-education, electrical stimulation and biofeedback. Physical therapists may obtain additional formal education at a post-graduate level specific to urinary and fecal incontinence.

It appears that for pelvic floor re-education, which involves two reserved acts, there is currently no clinical undergraduate training. The post-graduate training programs have not been approved by the College.

The Council recognizes that pelvic floor re-education may be a valuable health service. However, without a College approved program for post-graduate training and in the absence of clinical undergraduate training, this service can continue to be provided only as a delegated reserved act following the Council's delegation protocols outlined in the Council's *Final Report on the Scope of Practice Review*. This would allow for the services to continue uninterrupted, but only when a physician refers the patient to a physical therapist who the physician is confident can provide this service in a safe manner.

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F. Applying or Ordering the Application of a Hazardous Form of Energy

The Council's Reserved Acts List refers to hazardous forms of energy and includes some of the specific forms of hazardous energy currently utilized by health professionals. The list is not complete and is not intended to be so because technology which involves hazardous forms of energy is constantly changing and evolving.

The College indicates that its members utilize the following forms of energy included in the Reserved Acts List:

- *Ultrasound,*
- *Laser and Infra red,*
- *Short Wave Diathermy,*
- *Interferential current, and*

- *electrical stimulation of innervated and denervated muscle with low and medium frequency current.*

The College has presented information indicating that the last three forms of energy can be included in the term "electricity." The Council's information indicated that physical therapists utilize therapeutic ultrasound, not diagnostic. The Council recommends granting the following reserved act:

The Health Professions Council recommends the following reserved act for physical therapists:

4. **Applying a hazardous form of energy: laser, electricity, therapeutic ultrasound, or as prescribed by regulation.**

P>The College has also requested the use of iontophoresis and phonophoresis by its members. Both these are means of administration of medications. They would be covered under reserved act 5(a): "Prescribing, compounding, dispensing or administering by any means a drug listed in Schedule I or II of the *Pharmacists, Pharmacy Operations and Drug Scheduling Act*." The Council was presented with sufficient information to determine that physical therapists are currently administering Schedule I and II medications. Therefore, the Council makes the following recommendation:

The Health Professions Council recommends the following reserved act for physical therapists:

- 5(a) **Administering on prescription, by iontophoresis or phonophoresis, a drug listed in Schedule I or II of the *Pharmacists, Pharmacy Operations and Drug Scheduling Act*.**

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Health Professions Council Physicians and Surgeons Scope of Practice Review (Preliminary Report)

Irvine E. Epstein, Q.C., Chair
Arminée Kazanjian, Member
David MacAulay, Member

January 16, 1998

This Preliminary Report should be read in conjunction with the [Post-Hearing Update](#) for the profession.

A. INTRODUCTION

This is the preliminary report of the review of the scope of practice of medicine by the Health Professions Council (the Council).

The review was conducted pursuant to [Terms of Reference](#) issued by the Minister of Health and Minister Responsible for Seniors in accordance with section 25 of the [Health Professions Act](#) (the HPA). The [Terms of Reference](#) directed the Council to review the scopes of practice of the recognized health professions, of which medicine is one.

The *Terms of Reference*, which are included as an [Appendix](#) to this report, indicate that there are four main elements to the scope of practice review:

- scope of practice statements which describe what the profession does, the methods it uses and the purpose for which it does it;
- reserved acts which are those acts that present such a significant risk of harm that they should be performed only by professionals who are qualified to perform them;
- supervised acts which are reserved acts, or aspects of reserved acts, which may be performed by persons supervised by health professionals; and
- reserved titles which are titles that describe a profession's services and which are reserved exclusively for the health profession.

The general process for the review provides for an initial meeting with the profession, submission of briefs by the regulatory body and professional association for each profession, a consultation process involving all health professions and interested parties regarding each professions' submission, drafting of a preliminary report, public hearings and a final report.

The College of Physicians and Surgeons (the College) made a submission and the B.C. Medical Association (the BCMA) indicated its agreement with the thrust of the submission. The submission was then summarized and distributed for review and comment to interested groups and individuals including other regulated and unregulated health professions, educational institutions and other provinces. Many responses were received, and the Council has carefully considered them in drafting this preliminary report.

The Council also met with representatives of the College and the BCMA on December 11, 1997 after which the College made a further written submission.

This report will be circulated to all health professions and other interested parties who participated in the Council's consultation process.

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B. THE POLICY BACKGROUND

The main impetus for a scope of practice review was the Report of the British Columbia Royal Commission on Health Care and Costs (the Seaton Commission). The Seaton Commission stated that the existing legislation governing the health professions creates persistent jurisdictional disputes and a distinct lack of cooperation among the health professions, despite the fact that all health professional colleges have the same mandate - to protect the public from preventable harm.

The Seaton Commission stated that the primary reason for the jurisdictional disputes was the present regulatory system's reliance on exclusive scopes of practice. Under the exclusive scope of practice model, the various health professions have been granted an exclusive right to practice within a legislatively defined scope of practice. No one, other than a member in good standing of that profession, can perform acts within the profession's scope of practice unless they are granted an exemption.

The Commission concluded:

...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.

(Closer to Home, The Report of the Royal Commission on Health Care and Costs in British Columbia, Volume 2, 1991, p. D-33)

This recommendation is also consistent with legislative initiatives underway in Alberta.

The Seaton Commission was not the first review body to suggest that the present legislative model of exclusive scopes of practice was inappropriate. Restricting professional monopolies (exclusive scopes of

practice) was also recommended in an earlier study commissioned by the British Columbia Minister of Health. In discussing the conflicts which may arise between the professional college and the public interest, the issue of exclusive scopes of practice was raised:

It must be emphasized that any professional legislation which unduly restricts the scope of practice of skilled personnel may be contrary to the public interest in greater supply and accessibility of service through the development of team practice. Therefore, it is urged that: Professional legislation should not contain narrow restrictions or rigid definitions of scope of practice which are excessively exclusive; that measures should be taken (as indicated below) to reduce the area of interprofessional strain and conflict; and that no prosecutions for violations of scope of practice legislation should be undertaken without the prior consent of the appropriate public authority.

Insofar as may be possible with due regard for public safety, professional law should not place rigid restrictions on the scope of practice of allied health personnel, and greater flexibility should be encouraged in the allocation of roles between the health disciplines.

(Professor J.T. McLeod, "Public Regulation of the Professions" in Health Security for British Columbians, Special Report: Consumer Participation, Regulation of the Professions, and Decentralization (1974), the report of Richard D. Foulkes, B.A., M.D., F.A.P.H.A. to the Minister of Health, Province of British Columbia, Tome Three, p. 145)

Thus the trend in regulatory policy for the health professions has been towards reducing exclusivity in order to enhance interdisciplinary practice, improve accessibility to health care services and increase consumer choice, while at the same time maintaining the fundamental objective of protecting the public.

These policy trends are clearly reflected in the [Terms of Reference](#) for the scope of practice review which provide the basis for a new regulatory framework for health professions in British Columbia. The core elements of the new framework are scope of practice statements and reserved acts.

Under the present system, scope of practice statements are exclusive. In the new system, scope statements will not be exclusive but professions may be granted reserved acts.

Reserved acts are those elements of a profession's scope of practice which present such a significant risk of harm that they should be reserved to a particular profession, or shared amongst particular professions. Thus, unlike the present system in which each profession is granted exclusivity within its entire defined scope of practice (subject to specified exceptions), only those acts which present a significant risk of harm will be reserved.

In short, the government has assigned the Council the task of creating a regulatory model based on broad, non-exclusive scope of practice statements and narrowly defined reserved acts.

The government has the responsibility to ensure that those services which are accessible are safe and that the regulatory framework for the practice of health professions protects the public from incompetent, impaired, or unethical practitioners. At the same time, the regulatory framework should not entrench a paternalistic function for professions or reserve exclusive areas of practice simply to enhance professional status and control.

The new system of overlapping scopes of practice and narrow reserved acts removes barriers to interdisciplinary practice and offers greater choice and accessibility to the public. In the Council's view, the public interest is served by professional legislation which promotes quality in the delivery of health care services within safe parameters. Indeed, the Council's primary policy objective in conducting its review is achieving the optimum balance between safe practice and consumer choice.

With this in mind, the Council proposes to consider the practice of medicine having regard to the four elements of the scope review.

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C. DISCUSSION OF ISSUES

The main issues raised by this review are the four elements listed above: scope of practice, reserved acts, supervised acts and reserved titles.

1. Scope of Practice

The scope statement describes what the profession does, the methods it uses, and the purpose for which it does it. Unlike the present legislative scheme, the statement itself does not grant an exclusive scope of practice. Nonetheless, the statement is important because: 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; and it informs the public about the services practitioners are qualified to perform. It is expected that the Council's recommendations will increase overlapping scopes of practice.

The Council believes that it is not necessary or useful to itemize every facet of a profession's scope of practice. Rather, a scope of practice definition should be sufficiently descriptive so that other health professions and members of the public alike can understand what the particular health professional does.

The College of Physicians and Surgeons takes the position that the current scope of practice of medicine is clearly defined in section 81 of the [Medical Practitioners Act](#) (the MPA) and should remain the same:

Practising by unregistered persons an offence

81. (1) A person who practises or offers to practise medicine while not registered or while suspended from practice under this Act commits an offence.

(2) For the purposes of and without restricting the generality of subsection (1), a person practises medicine who

(a) holds himself out as being, or by advertisement, sign or statement of any kind, written or oral, represents or implies that he is qualified, able or willing to diagnose, prescribe for, prevent or treat any human disease, ailment, deformity, defect or injury, or to perform an operation to remedy a human disease, ailment, deformity, defect or injury, or to examine or advise on the physical or mental

condition of a person;

- (b) diagnoses, or offers to diagnose, a human disease, ailment, deformity, defect or injury, or who examines or advises on, or offers to examine or advise on, the physical or mental condition of a person;
- (c) prescribes or administers a drug, serum, medicine or a substance or remedy for the cure, treatment or prevention of a human disease, ailment, deformity, defect or injury;
- (d) prescribes or administers a treatment or performs surgery, midwifery or an operation or manipulation, or supplies or applies an apparatus or appliance for the cure, treatment, or prevention of a human disease, ailment, deformity, defect or injury; or
- (e) acts as the agent, assistant or associate of a person in the practice of medicine as set out in paragraphs (a) to (d).

Section 82 of the MPA sets out specified exceptions to section 81, as follows:

Exceptions

82. For the purposes of section 81, a person does not practise or offer to practise medicine who

- (a) practises chiropractic while registered under the *Chiropractors Act*,
- (b) practises dentistry while registered under the *Dentists Act*,
- (c) practises naturopathy while registered under the *Naturopaths Act*,
- (d) practises optometry while registered under the *Optometrists Act*,
- (e) is an orthoptic technician acting as provided in section 40 of the *Optometrists Act*,
- (f) practises pharmacy while registered under the *Pharmacists, Pharmacy Operations and Drug Scheduling Act*,
- (g) practises, under the supervision of a person registered under this *Act*, as a physiotherapist or dietitian;

(h) practises podiatry while registered under the [Podiatrists Act](#),

(i) practises psychology while registered under the [Psychologists Act](#),

(j) performs emergency procedures as authorized by the [Health Emergency Act](#),

(k) engages in the usual business of opticians, vendors of dental or surgical instruments, apparatus or appliances, or bath attendants or proprietors;

(l) engages in the ordinary calling of nursing; or

(m) practises a designated health profession while registered as a member of its college under the [Health Professions Act](#).

In the alternative, the College has submitted an abbreviated and general definition of the scope of practice of medicine:

The practice of medicine is the assessment of the physical or mental condition of an individual from conception onwards and the research, investigation, diagnosis, treatment and prevention of physical and mental diseases, disorders, dysfunctions, ailments, deformities, defects, trauma and injury.

The Council also discussed the scope statement at its meeting with the College and the BCMA on December 11, 1997 as a result of which the College made some further suggestions regarding its scope of practice statement.

In its original submission, the College explained its rationale for the proposed definition as follows:

Given the breadth of the practice of medicine and the requirement of flexibility, it is impossible to be more specific with respect to the scope of practice or to itemize the many facets of that practice. The practice involves all aspects of human health and can extend from marriage counselling to heart transplantation. A review of the extensive history of the practice of medicine illustrates that physicians have offered care to patients regarding almost every dysfunction of the mind or body.

The College's proposed scope statement was sent out for consultation to all health professions and other interested parties. Several respondents to the consultation appeared to misunderstand the nature of scope of practice statements. Some respondents stated that the physician's scope statement was too broad and that they performed acts which fall within the definition proposed by the College. Some health professions felt that the services they performed would potentially "violate" the proposed definition. **The Council emphasizes that, in the new regulatory system, a scope statement is not exclusive, it is only descriptive. Further, it is expected that the scope of practice review process will result in more overlapping scopes of practice.** Thus, a profession will not be prevented from performing an act simply because it falls within another profession's scope of practice.

In reviewing the College's submission and the responses received, the Council believes that the current definition, which gives physicians and surgeons an exclusive scope of practice and then makes exceptions for various professions, is inconsistent with the policy of the review process which is to reduce exclusive scopes of practice.

The Council is of the view that, with minor modifications, the College's proposed abbreviated definition is more consistent with the policy behind the scope review. It represents a concise legislative definition which fairly and accurately reflects the current state of practice in medicine. Another advantage of the abbreviated definition is that, in contrast to the present complex definition, it is easy to read and understand.

The Council believes that an addition to the proposed scope statement set out above is necessary to reflect the growing emphasis in the health care sector on health promotion. A review of several recent studies and reports, including the Report of the Seaton Commission, reflect a growing consensus that the focus of the health care system must move from institutional care and treatment to community based alternatives, disease prevention and health promotion. In our view, physicians are an important part of this change in focus. While the College's proposed scope of practice statement refers to "prevention", we believe an additional reference to promoting good health practices would further underscore and more accurately reflect the role physicians play in the health care delivery system. **Therefore, the Council recommends the following scope of practice statement for the practice of medicine:**

The practice of medicine is the assessment of the physical or mental condition of an individual or group of individuals at any stage of the biological life cycle; the prevention, diagnosis and treatment of physical and mental diseases, disorders, and conditions; and the promotion of good health.

Speciality Certification

By its very nature, the practice of medicine is very broad and encompasses virtually all aspects of human health. At the same time, many aspects of the practice of medicine are highly specialized. The College of Psychologists submits that the general scope statement for medicine must reflect speciality areas, at least for mental diseases and disorders:

Physical medicine is the appropriate scope of practice for most medical practitioners. Assessment, diagnosis, treatment and prevention of **mental** diseases, disorders, dysfunctions, ailments, defects, trauma and injury are included in the scope of practice of all medical practitioners regardless of their level of training and competence in these areas. For the protection of the public, **only those medical practitioners who are trained and competent** in assessment, diagnosis, treatment and prevention of **mental** diseases, disorders, dysfunctions, ailments, defects, trauma and injury should have these acts as their scope of practice.

This sort of argument could also be applied to any number of speciality areas, in support of the notion that the scope of practice of medicine should, in effect, be separated into speciality areas.

The College acknowledges that all physicians do not necessarily practice all services which fall within the general scope of practice:

[T]his general definition does not suggest that all physicians can perform all practices. Only

physicians who have demonstrated competence in a particular area or speciality can practice in that speciality. In other words, while physicians are qualified and licensed generally as physicians and surgeons, the actual practice of medicine is limited by the practical and ethical restraints which require that the practice clearly be within the physician's competence.

The College submits that the practical and ethical constraints include the following:

- a well established speciality certification process, administered through the Royal College of Physicians and Surgeons of Canada, through which patients who require more sophisticated treatments are referred to certified specialists;
- the Canadian Medical Association Code of Ethics which provides that each practitioner must "Recognize your limitations and the special skills of others in the prevention and treatment of disease.;"
- the fact that part of the function of the College of Physicians and Surgeons is to ensure that physicians practice within their level of competency; and
- the extensive and stringent entrance requirements for registration with the College.

The College submits that these constraints justify the broad basic scope of practice of medicine.

After carefully considering this issue, the Council is satisfied that there is no need to separate the general scope of practice of medicine into speciality areas. In the Council's view, a broad basic scope of practice of medicine is appropriate, particularly in light of the high level of basic training received by physicians and surgeons and the regulatory structures and processes of the College. These provide an assurance that physicians practice within their level of competency. Thus, in the absence of clear evidence of problems with a general approach to the scope of practice of medicine, the Council believes that different classes of registration or multiple scope statements are unnecessary.

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2. Reserved Acts:

The rationale underlying the granting of reserved acts is to protect the public by limiting provision of those particularly dangerous acts to members of specific professions who are qualified to perform them. Only those acts which present a significant risk of harm will be reserved.

The Council wishes to emphasize that its recommendations will likely provide for the sharing of many of the reserved acts. Thus, in conducting its review of the scope of practice of medicine the Council is not necessarily deciding which acts should be reserved exclusively to physicians and surgeons. It is possible and indeed likely that several of the acts reserved to physicians will also be reserved to other professions. Each profession will be given the opportunity to describe which acts it is qualified to perform in the course of the Council's review of its scope of practice.

The College submits that it is not feasible to attempt to list all of the acts currently practised by physicians which, if practised by other persons not similarly qualified, would or could potentially present risk to the public. Instead, it has identified areas of practice in which the risk to the public is readily apparent. They are:

- a. All treatments or investigations of physical and mental disease including those involving any application or ordering the application of energy, or administering of substances by injection or inhalation.
- b. All surgical procedures.
- c. Examinations and communications with individuals which might result in (a) or (b) or which involve a diagnosis identifying a disease or disorder as the cause of symptoms including the testing for and identification of allergies or the communication of such a diagnosis.
- d. Administering, prescribing, dispensing, selling or compounding a drug.
- e. Managing labour or conducting the delivery of a baby.
- f. Prescribing or dispensing for vision, eye or hearing problems, subnormal vision devices, contact lenses, eye glasses or hearing aids.

The College proposes that acts within any of these areas be reserved to physicians, and to other qualified health professionals as authorized by statute.

Many of the respondents to the consultation felt that the College's proposed reserved acts were too broadly stated. Much of the discussion focussed on the first proposed reserved act, "all treatments or investigations of physical and mental disease ...". Several respondents felt that this reserved act included many acts which are not dangerous and which should not be reserved. Generally, the respondents stated that the physicians should be more specific about the acts which present such a significant risk of harm that they can only be performed competently by the medical profession, or in conjunction with other qualified health professionals.

Several other respondents noted that they perform acts which fall within the physicians' proposed reserved acts and that the Council must recognize shared scopes of practice. Again, the Council wishes to emphasize that each profession will be afforded the opportunity, in the course of the Council's review of each profession's scope of practice, to establish its competencies to perform the various acts. At this point, the Council is simply concerned with the physicians' scope of practice and which reserved acts will be included in their scope of practice. It is expected that several of the acts reserved to physicians will also be reserved to other professions.

Nonetheless, the Council agrees with some of the points made about the College's proposed reserved acts, particularly the College's first and third proposed reserved acts. In the Council's view, the first and third proposed reserved acts are far too broad and encompass many acts which do not present a risk of harm. A key element of a reserved act model is a general prohibition against performing a reserved act in the course of providing health care services unless one has been specifically granted the right to perform such an act through legislation. Such acts are thus essentially removed from the public domain and restricted to specific health professionals. That is why it is so important to narrowly define the reserved acts to focus on preventing harm.

The Council is concerned that reserving acts as broad as the College's first and third proposed reserved acts would affect many unregulated professionals, particularly alternative health care practitioners. The Council wishes to emphasize that the purpose of reserved acts is to protect the public, and only those acts which present a significant risk of harm should be reserved to a health professional(s). If the act is not dangerous it should remain in the public domain.

The Council appreciates the College's difficulty in preparing a list of reserved acts, particularly in a generalist profession such as medicine. Clearly, it is a daunting task to attempt to list all those services provided by physicians which present a risk of harm. The Council believes, however, that it is possible and indeed necessary to define the reserved acts which present a significant risk of harm. The Council notes that this is precisely what the Ontario Legislature has done in the recently enacted *Regulated Health Professions Act*. The province of Alberta has embarked on a similar task. In any event, the Council's [Terms of Reference](#) indicate that reserved acts are an essential element of the new model of professional regulation.

To this end, the Council conducted further research, and considered the Ontario and Alberta regulatory models in an attempt to develop a list of activities which it believes present such a significant risk of harm that they should be reserved to regulated health professionals. The Council found the Ontario model to be most appropriate, and adopted the Ontario list of controlled acts with modifications made as a result of further deliberations. The Council's list is as follows:

1. Making a diagnosis identifying a disease, disorder or condition as the cause of signs or symptoms of the individual.
2. Performing the following physically invasive or physically manipulative acts:
 - a. procedures on tissue below the dermis, below the surface of a mucous membrane, in or below the surface of the cornea, in or below the surfaces of the teeth, including the scaling of teeth;
 - b. setting or casting a fracture of a bone or reducing a dislocation of a joint;
 - c. moving joints of the spine beyond the individual's usual physiological range of motion using a high velocity, low amplitude thrust;
 - d. administering a substance by injection or inhalation;
 - e. putting an instrument, hand or finger(s),
 - i. beyond the external ear canal,
 - ii. beyond the point in the nasal passages, where they normally narrow,
 - iii. beyond the pharynx,
 - 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.

3. Managing labour or delivery of a baby,

4. Applying or ordering the application of a hazardous form of energy including diagnostic ultrasound, electricity, magnetic resonance imaging, lithotripsy, laser and X-ray.

5. Prescribing, compounding or dispensing a drug restricted under provincial or federal legislation.

For the purposes of this reserved act, the following definitions shall apply:

"prescribing": the ordering of a drug.

"compounding": mixing ingredients, at least one of which is a drug.

"dispensing": preparing or filling a prescription for drugs.

6. Prescribing appliances or devices for vision, hearing or dental problems; dispensing a prescribed appliance or device for dental problems; fitting contact lenses or dental appliances or devices.

7. Allergy challenge testing of a kind in which a positive result of the test is a significant allergic response or allergy desensitizing treatment in which there is a risk of significant allergic response.

The Council has also considered which of these acts should be reserved to physicians and surgeons. In the course of its review, the Council provided the College with its proposed list of reserved acts. The College provided detailed submissions regarding each of the acts, indicating that physicians perform all of the reserved acts in some form or another in some circumstances, and that, generally, physicians are trained and educated to perform the acts.

The Council was concerned, however, that not all physicians are qualified to perform all reserved acts. For example, it is unlikely that many physicians are involved in prescribing or dispensing appliances for dental problems. The College pointed out, however, that plastic surgeons and emergency surgeons in rural areas do indeed perform such acts, and are trained and educated to do so.

The Council is persuaded that physicians, generally, should be granted all of the reserved acts. The Council is satisfied that the College will ensure that their members practice within their level of competency.

With respect to the reserved acts granted to physicians and surgeons, the Council is not prepared, at this time, to state that any of them should be reserved exclusively to physicians and surgeons. Of course, it may be the case that once the Council has completed its review of the scope of practice of the other health professions some of the acts may have been reserved only to physicians and surgeons.

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3. Supervised Acts

The [Criteria and Guidelines](#) which are attached to the [Terms of Reference](#) state that although reserved acts may only be performed by certain professions, it may be appropriate for other persons to perform them, or aspects of them, under the supervision of members of those professions. The [Criteria and Guidelines](#) also indicate that where the Council is satisfied that a reserved act may be performed under supervision, it may recommend training and qualification requirements, limitations regarding where the act may be performed and the degree of supervision which should be exercised.

The Council believes that some clarification of terms would be useful as the [Terms of Reference](#) do not define "supervision". In reviewing the responses to the scope of practice submissions, most professions have used the terms delegation and supervision interchangeably. However, technically, there appears to be a distinction between the terms.

In his book "A Complete Guide to the Regulated *Health Professions Act*" (Canada Law Book, 1995), Richard Steinecke discusses the meaning of these terms. Delegation is where the delegating professional makes a determination that an individual is competent to perform a task and that individual then carries out the task without the delegating professional being present. Supervision, on the other hand, implies a more intense control over the act than does delegation and will usually require the supervisor's physical presence.

In the Council's view, although this term of reference refers to "supervised" acts, it is intended to encompass any situation where someone other than the person to whom the reserved act has been granted performs that act. In other words, this term of reference refers to both delegation and supervision.

This term of reference implies that the Council will, for each reserved act granted to each profession, determine the circumstances in which the act may be performed by someone other than a member of that profession. In its submission, the College makes a compelling argument that legislation is a blunt instrument to deal with this issue. The College states that the issue of delegation and supervision is a question of individual competence and the circumstances of each case, and that supervision of certain acts can be addressed only after a careful review of all the circumstances surrounding a particular act and by imposing, where necessary, clear guidelines, restrictions or conditions on such supervision.

The College further submits that compiling a list of acts which may be delegated or performed under supervision would not adequately address the complexities of medical situations which present to physicians nor would it protect the public. The College notes that there will be situations where, because of the individuals involved, the site or location, or the specific nature of the presenting problem, it may not be appropriate to delegate an act which might otherwise be capable of delegation.

The Council accepts much of this submission, and believes that it would be better to take a general approach to the issue of supervision. The general thrust of the approach is that the decision as to whether an act can be performed under supervision should be left up to the health professions, and that a set of principles embodying the duties of the delegating professional and his or her regulatory college be established and enacted into legislation when the shared scope of practice model takes effect. The principles are derived largely from the CMA's Guidelines for the Delegation of a Medical Act which the College enclosed with its submission.

Therefore instead of dealing with supervised acts individually for each profession, the Council makes the following general recommendation:

The Council recommends that a provision be enacted which sets out the duties of a health professional and his or her regulatory college when delegating a reserved act. The provision should require the following:

- The assigning health professional's governing body must provide assent to the proposed reserved act being performed by someone else;
- The reserved act to be assigned as well as the level of supervision must be clearly defined and circumscribed by the assigning health professional's governing body;
- Where the person to whom the act will be assigned is a regulated health professional, his or her governing body must approve of the assigning of the reserved act;
- The instruction to perform the act must be made in writing either by way of a general written protocol or through a case-specific instruction;
- The assigning health professional must be satisfied that the individual who will be performing the act has the necessary skills and training to perform the act safely;
- The assigning health professional must ensure that the person who will be performing the act accepts the assignment.

There are ethical and legal issues involved in assigning reserved acts which will have to be addressed by all parties.

The Council wishes to emphasize that its proposal is not intended to apply on a case-by-case basis. The requirement for approval of the governing body is meant to apply generally and not to individual cases, and would be satisfied by, for example, a general protocol in respect of delegation of reserved acts.

The Council believes this general approach to supervised acts more accurately reflects the reality that procedures to be delegated vary from profession to profession and may include subsets and variations of reserved acts and further, may be performed under a myriad of circumstances and conditions.

Finally, the Council emphasizes that the issue of supervised or delegated acts arises only with respect to reserved acts. Thus, the general provision regarding supervision will not apply in respect of acts which are not reserved.

4. Reserved Titles

Reserved titles are titles reserved exclusively to a health profession. Reserved titles afford consumers a means to identify the different types of health care providers, to distinguish the qualified from the unqualified, and to differentiate those practitioners who are regulated from those who are not. Titles must adequately serve the public in describing the practitioner and the services being provided and must distinguish the practitioner from others performing services outside the jurisdiction of the college.

Section 95 of the MPA provides for the use of titles:

95. (1) A person not registered under this *Act* shall not use, assume, employ, advertise or hold himself out under the title of "doctor", "surgeon", or "physician", or any affix or prefix or abbreviation of those titles as an occupational designation relating to the treatment of human ailments.

(2) Subsection (1) does not apply to a person registered under the *Dentists Act*, or to a person having a diploma in medicine or surgery from a college or school of medicine and surgery requiring at least 4 years' course of study, who is not treating or attempting to treat human ailments for gain in the Province.

(3) Subsection (1) does not prevent the use by a person of the title "doctor" or of the abbreviation "Dr." where the use is authorized by another *Act*.

The College proposes that the provisions of section 95 continue.

The College also proposes the following:

- that the titles, "physician and/or surgeon", "medical doctor" and "family physician" be reserved exclusively for members of the College of Physicians and Surgeons of British Columbia;
- that the title "doctor" be reserved jointly to registrants of the College and other health professionals who, on the basis of their qualifications, satisfy the Council that they also should be able to employ this title; and
- that the titles of all specialists delineated by the Royal College of Physicians and Surgeons of Canada and the College of Family Physicians of Canada be reserved exclusively.

The Council believes that the current titles "doctor", "surgeon", and "physician" adequately serve the public in describing medical practitioners and the services they provide. The Council does not believe there is a public interest in adding to the titles currently reserved to physicians and surgeons, nor does the Council believe there is any public interest in the reservation of speciality titles.

Therefore, the Council recommends the following:

- that the titles, "doctor", "surgeon", "physician", "osteopath" and "osteopathic physician" and any affix of those titles be reserved; and
- that registrants of the College be granted the use of those reserved titles.

The Council emphasizes that it is not prepared to state, at this time, that any of the titles "doctor", "physician" or "surgeon" will be reserved exclusively to members of the College. Of course, it may be the case that after the reviews of the other professions are completed certain of those titles may have been reserved only to members of the College.

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5. Other Issues

As a result of a column in the Victoria paper, the Council received many submissions regarding a recent amendment to the *Medical Practitioners Act* of Alberta which provides that no practitioner will be prosecuted solely for the reason that he or she is practising an alternative form of health care. The Council believes that this issue is better left to its legislative review process in which the issue of barriers to entry will be reviewed in more detail. That process is currently underway, and more information will be forthcoming in the near future.

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D. RECOMMENDATIONS

Recommendation 1: The Council recommends the following scope of practice statement for the practice of medicine:

The practice of medicine is the assessment of the physical or mental condition of an individual or group of individuals at any stage of the biological life cycle; the prevention, diagnosis and treatment of physical and mental diseases, disorders, and conditions; and the promotion of good health.

Recommendation 2: The Council proposes the following reserved acts for physicians and surgeons:

1. Making a diagnosis identifying a disease, disorder or condition as the cause of signs or symptoms of the individual.

2. Performing the following physically invasive or physically manipulative acts:

(a) procedures on tissue below the dermis, below the surface of a mucous membrane, in or below the surface of the cornea, in or below the surfaces of the teeth, including the scaling of teeth;

(b) setting or casting a fracture of a bone or reducing a dislocation of a joint;

(c) moving joints of the spine beyond the individual's usual physiological range of motion using a high velocity, low amplitude thrust;

(d) administering a substance by injection or inhalation;

(e) putting an instrument, hand or finger(s),

i. beyond the external ear canal,

- ii. beyond the point in the nasal passages, where they normally narrow,
- iii. beyond the pharynx,
- 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.

3. Managing labour or delivery of a baby,

4. Applying or ordering the application of a hazardous form of energy including diagnostic ultrasound, electricity, magnetic resonance imaging, lithotripsy, laser and X-ray.

5. Prescribing, compounding or dispensing a drug restricted under provincial or federal legislation.

For the purposes of this reserved act, the following definitions shall apply:

"prescribing": the ordering of a drug.

"compounding": mixing ingredients, at least one of which is a drug.

"dispensing": preparing or filling a prescription for drugs.

6. Prescribing appliances or devices for vision, hearing or dental problems; dispensing a prescribed appliance or device for dental problems; fitting contact lenses or dental appliances or devices.

7. Allergy challenge testing of a kind in which a positive result of the test is a significant allergic response or allergy desensitizing treatment in which there is a risk of significant allergic response.

Recommendation 3: The Council recommends that a provision be enacted which sets out the duties of a health professional and his or her regulatory college when delegating a reserved act. The provision should require the following:

- The assigning health professional's governing body must provide assent to the proposed reserved act being performed by someone else;
- The reserved act to be assigned as well as the level of supervision must be clearly defined and circumscribed by the assigning health professional's governing body;
- Where the person to whom the act will be assigned is a regulated health professional, his or her governing body must approve of the assigning of the reserved acts.

- The instruction to perform the act must be made in writing either by way of a general written protocol or through a case-specific instruction;
- The assigning health professional must be satisfied that the individual who will be performing the act has the necessary skills and training to perform the act safely;
- The assigning health professional must ensure that the person who will be performing the act accepts the assignment.

Recommendation 4: On reserved titles, the Council recommends the following:

- that the titles, "doctor", "surgeon", "physician", "osteopath" and "osteopathic physician" and any affix of those titles be reserved; and
- registrants of the College be granted the use of those reserved titles.

Last Revised: March 08, 2002

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Health Professions Council POST-HEARING UPDATE OF PRELIMINARY REPORT: PHYSICIANS AND SURGEONS

Irvine E. Epstein, Q.C., Chair
Arminée Kazanjian, Member
David MacAulay, Member

March 2001

This Post-Hearing Update should be read in conjunction with the [Preliminary Report](#) for the profession.

The Council issued its *Physicians and Surgeons Scope of Practice Review (Preliminary Report)* in January 1998. The public hearing was held on 1 June 1999. The following are changes to the *Preliminary Report* which arose from the submissions made either at the public hearing or in subsequent written submissions.

I. SCOPE OF PRACTICE

The Council's *Preliminary Report* recommended the following scope of practice for physicians and surgeons:

The practice of medicine is the assessment of the physical or mental condition of an individual or group of individuals at any stage of the biological life cycle; the prevention, diagnosis and treatment of physical and mental diseases, disorders, and conditions; and the promotion of good health.

The Council has determined that, as a general matter, scope of practice statements should not contain or attempt to list the reserved acts granted to a profession. Accordingly, the Council has removed the term "diagnosis" from the scope of practice statement for physicians and surgeons.

There is no doubt, however, that physicians and surgeons may perform diagnosis since that reserved act has been granted to them.

The Health Professions Council recommends the following scope of practice for physicians and surgeons:

The practice of medicine is the assessment of the physical or mental condition of an individual or group of individuals at any stage of the biological life cycle; the prevention and treatment of physical and mental disease, disorder and condition; and the promotion of good health.

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II. ALTERNATIVE OR COMPLEMENTARY MEDICINE

The practice of alternative or complementary medicine in B.C. was hotly debated at the public hearing. Several participants, including the Association of Naturopathic Physicians of British Columbia, the Association of Complementary Physicians of British Columbia (ACP-BC), the Canadian Complementary Medical Association and the Health Action Network Society submitted that the College of Physicians and Surgeons of British Columbia (College), has no expertise in regulating alternative or complementary medical practice and that it takes too restrictive an approach to the issue. Some of these participants suggested that the Council recommend the adoption of the "Alberta amendment."

In April 1996, Alberta's legislature passed Bill 209 which contained the following provision (Alberta Amendment):

A registered practitioner shall not be found guilty of unbecoming conduct or be found to be incapable or unfit to practise medicine or osteopathy solely on the basis that the registered practitioner employs a therapy that is non-traditional or departs from the prevailing medical practices, unless it can be demonstrated that the therapy has a safety risk for that patient unreasonably greater than the prevailing treatment.

The Alberta Amendment is now section 34(3) of the *Alberta Medical Profession Act*, c. M-12.

Much of the discussion focussed on the College guidelines for complementary and alternative therapies, approved in January 1999. The ACP-BC stated that the policy applies a higher approval standard for complementary and alternative therapies than for traditional therapies. It noted in particular the requirement that a physician "must not expose the patient to any degree of risk from a complementary or alternative therapy of no proven benefit" [emphasis added].

One of the fundamental principles of the scope of practice review is that the public interest favours increasing choice within safe parameters. With this in mind, the Council agrees that it is wrong to establish higher standards for some therapies and not others. A prohibition of complementary or alternative practice cannot be justified so long as the risk is no greater than the risk of prevailing treatments. The College's policy has the potential to create an unnecessary barrier to the practice of complementary or alternative therapies.

The Council also received many submissions from supporters of chelation therapy. They stated that the College is unduly restricting the use of chelation therapy and that it should be prevented from prohibiting practitioners from using chelation therapy. It is not within the Council's mandate to evaluate the efficacy of specific

procedures or therapies. While we do not support general prohibitions of therapies for the sole reason that they may be considered alternative or complementary, in the final analysis it is the role of the College to set the standards of practice for the profession. In accordance with its statutory function, the College must carry out that role in accordance with the public interest.

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III. MODIFICATIONS OF RESERVED ACTS

In its *Preliminary Report* the Council has recommended all of the reserved acts for physicians and surgeons. The Council's recommendation was based on the following:

After carefully considering this issue, the Council is satisfied that there is no need to separate the general scope of practice of medicine into speciality areas. In the Council's view, a broad basic scope of practice of medicine is appropriate, particularly in light of the high level of basic training received by physicians and surgeons and the regulatory structures and processes of the College. These provide an assurance that physicians practice within their level of competency. Thus, in the absence of clear evidence of problems with a general approach to the scope of practice of medicine, the Council believes that different classes of registration or multiple scope statements are unnecessary.

Medicine was one of the first professions considered by the Council. During the Council's scope of practice review, certain changes were made to the reserved acts list. To reflect these changes, the Council has updated the reserved acts initially granted to physicians and surgeons.

Last Revised: March 08, 2002

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Health Professions Council Podiatrists Scope of Practice Preliminary Report

Irvine E. Epstein, Q.C., Chair
Arminée Kazanjian, Member
David MacAulay, Member

September 1999

This Preliminary Report should be read in conjunction with the [Post-Hearing Update](#) for the profession.

FOREWORD

This report is the result of the Health Professions Council's review of the scope of practice of podiatry pursuant to the [Terms of Reference](#) from the Minister of Health and Minister Responsible for Seniors. Under the [Health Professions Act](#), the Health Professions Council is a six-person advisory body appointed by the Government of British Columbia to make recommendations to the Minister of Health and Minister Responsible for Seniors about the regulation of health professions.

In this report the Health Professions Council examines how the existing scope of practice of podiatry should be legislatively defined in order to reflect fairly and accurately the current state of practice and the public interest in the practice of podiatry.

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PODIATRISTS

Available by contacting the [HPC Office](#).

EXECUTIVE SUMMARY

The Health Professions Council has conducted a review of the scope of practice of podiatry.

The purpose of the review is to provide recommendations to the Minister of Health and Minister Responsible for Seniors regarding four matters: scope of practice statements, reserved acts, supervised acts, and reserved titles.

The Health Professions Council has conducted a detailed consultation process and its recommendations regarding the four elements of the scope review are as follows:

1. The Council recommends the following scope of practice statement for members of the BC Association of Podiatrists:

The practice of podiatry is the diagnosis, therapeutic, orthotic or palliative treatment and prevention of disease, disorders or dysfunctions of the foot, and includes the muscles, tendons, ligaments or other soft tissue structure directly attached to the anatomical foot and which impacts on or affects the foot or foot function and osseous structure up to and including the articulating surfaces of the ankle joint.

2. The Council recommends the following limitation to podiatry scope of practice:

The practice of podiatry does not include treatment of the foot that may affect the course or treatment of a systemic disease unless that treatment is carried out at the direction or under the supervision of a medical practitioner.

3. The Council recommends the following reserved acts for members of the BC Association of Podiatrists:

- a. making a diagnosis identifying a disease or disorder of the foot as the cause of signs or symptoms of the individual;
- b. performing the physically invasive or physically manipulative act of procedures on tissue below the dermis of the foot, including bony tissue and muscle, tendon, ligament or other soft tissue;
- c. applying or ordering the application of a hazardous form of energy: X-ray.

4. The Council recommends that the following reserved act be granted to members of the BC Association of Podiatrists:

Prescribing, compounding, dispensing or administering by any means a drug listed in Schedule I or II of the [Pharmacists, Pharmacy Operations and Drug Schedule Act](#).

For the purposes of this reserved act, the following definitions shall apply:

"prescribing": the ordering of a drug.

"compounding": mixing ingredients, at least one of which is a drug.

"dispensing": preparing or filling a prescription for drugs.

5. The Council recommends that a provision be enacted which deals with general principles regarding delegation of reserved acts. The provision would apply generally, not to individual cases. It should require the following:

- The assigning health professional's governing body must provide assent to the proposed reserved act being performed by someone else;
- The reserved act to be assigned as well as the level of supervision must be clearly defined and circumscribed by the assigning health professional's governing body;
- Where the person to whom the act will be assigned is a member of a self-regulating health profession, his or her governing body must approve of the assigning of the reserved act;
- The instruction to perform the act must be made in writing either by way of a general written protocol or through a case-specific instruction;
- The assigning health professional must be satisfied that the individual who will be performing the act has the necessary skills and training to perform the act safely; and
- The assigning health professional must ensure that the person who will be performing the act accepts the assignment.

6. The Council recommends the titles "Podiatrist" and "Doctor (Dr.)" when used with the affix "Podiatric" or "Podiatry" be reserved for members of the BC Association of Podiatrists.

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I. INTRODUCTION

A. THE NATURE OF THE REVIEW

This is the preliminary report of the review of the scope of practice of podiatry by the Health Professions Council (Council).

The review was conducted pursuant to [Terms of Reference](#) issued by the Minister of Health and Minister Responsible for Seniors in accordance with section 25 of the [Health Professions Act \(HPA\)](#). The [Terms of Reference](#) direct the Council to review the scopes of practice of the recognized health professions, of which podiatry is one.

The [Terms of Reference](#), which are included as [Appendix A](#) to this report, indicate that there are four main elements to the scope of practice review:

- i. scope of practice statements which describe what the profession does, the methods it uses and the purpose for which it does it;
- ii. reserved acts which are those acts that present such a significant risk of harm that they should be performed only by professionals who are qualified to perform them;

- iii. supervised acts which are reserved acts, or aspects of reserved acts, which may be performed by persons supervised by health professionals; and
- iv. reserved titles which are titles that describe a profession's services and which are reserved exclusively for the health profession.

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B. THE PROCESS FOR THE REVIEW

The general process for the review provides for an initial meeting with the profession(s), submission of briefs by the regulatory body and professional association for each profession, a consultation process involving all health professions and interested parties regarding each professions' submission, drafting of a preliminary report, public hearings and a final report.

The Council met with various health professions, including podiatry, in a general meeting convened on October 11, 1994. The BC Association of Podiatrists (Association) submitted a brief concerning the scope of podiatric practice. In April 1996, the Council conducted a consultation process which was completed in July 1996. In October 1997 the Association and the BC Board of Examiners in Podiatry (Board) commented jointly on the responses to the consultation process. In November 1998, the Association and the Board submitted a further document, *Legislative and Policy Impediments to the Practice of Podiatry*.

This preliminary report will be circulated to all health professions and other interested parties who participated in the Council's consultation process. A public hearing is scheduled on January 13, 2000, after which a final report will be issued. Persons or organizations who have made written responses to either the original consultation letter or to this preliminary report will be invited to speak at the hearing.

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C. THE REGULATION OF PODIATRY

The first provincial enactment was the *Chiropody Act*, RSBC 1960, c. 53. This first act, among others, restricted the use of title "chiropodist" to registered persons and prohibited unregistered persons from practising the profession. It was later renamed the *Podiatry Act* in 1963. The *Podiatry Act* retained the elements of the *Chiropody Act* but merely changed the name from "chiropody/ist" to "podiatry/ist" throughout the Act. The *Podiatry Act*, SBC 1963, c. 8, constituted the Board of Examiners in Podiatry as the regulatory body, and the British Columbia Association of Podiatrists as the membership association. It restricted use of the titles "chiropodist" and "podiatrist" to registered persons and continued the prohibition against unregistered persons practising the profession.

The *Podiatry Amendment Act*, SBC 1965, c. 36, enabled the Board to issue interim certificates to any persons who held a doctorate degree whether or not it is called "Doctor of Surgical Podiatry." An *Act to Amend the Podiatry Act*, SBC 1972, c. 44, defined "Association", "Board" and "hospital", and redefined "surgical treatment" and "practice of podiatry". It also provided for interim certificates for the practice of podiatry and the criteria for

issuance and revocation of such certificates.

A number of amendments took place in the next years, among others, the regulation of the use of the title "doctor" by podiatrists in the *Health Statutes Amendment Act*, SBC 1984, c. 19. Subsequently, the *Health Professions Statutes Amendment Act*, SBC 1993, c. 50, set out the duties and objects for the Board. It mandated public representation in the Association while enhancing the Association's investigatory and suspension powers.

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II. THE POLICY BACKGROUND

The main impetus for a scope of practice review was the Report of the British Columbia Royal Commission on Health Care and Costs (Seaton Commission). The Seaton Commission stated that the existing legislation governing the health professions creates persistent jurisdictional disputes and a distinct lack of cooperation among the health professions, despite the fact that all health professional colleges have the same mandate - to protect the public from preventable harm.

The Seaton Commission stated that the primary reason for the jurisdictional disputes was the present regulatory system's reliance on exclusive scopes of practice. Under the exclusive scope of practice model, the various health professions have been granted an exclusive right to practice within a legislatively defined scope of practice. No one, other than a member in good standing of that profession, can perform acts within the profession's scope of practice unless they are granted an exemption.

The Commission concluded:

...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 BC were to follow the Ontario initiative.

(Closer to Home, The Report of the Royal Commission on Health Care and Costs in British Columbia, Volume 2, 1991, p. D-33)

This recommendation is also consistent with legislative initiatives underway in Alberta. The Seaton Commission was not the first review body to suggest that the present legislative model of exclusive scopes of practice was inappropriate. Restricting professional monopolies (exclusive scopes of practice) was also recommended in an earlier study commissioned by the British Columbia Minister of Health. In discussing the conflicts which may arise between the professional college and the public interest, the issue of exclusive scopes of practice was raised:

It must be emphasized that any professional legislation which unduly restricts the scope of practice of skilled personnel may be contrary to the public interest in greater supply and accessibility of service through the development of team practice. Therefore, it is urged that: Professional legislation should not contain narrow restrictions or rigid definitions of scope of practice which are excessively exclusive; that measures should be taken (as indicated below) to reduce the area of interprofessional strain and conflict; and that no prosecutions for violations of

scope of practice legislation should be undertaken without the prior consent of the appropriate public authority.

Insofar as may be possible with due regard for public safety, professional law should not place rigid restrictions on the scope of practice of allied health personnel, and greater flexibility should be encouraged in the allocation of roles between the health disciplines.

(Professor J.T. McLeod, *Public Regulation of the Professions in Health Security for British Columbians*, Special Report: *Consumer Participation, Regulation of the Professions, and Decentralization* (1974), the report of Richard D. Foulkes, B.A., M.D., F.A.P.H.A. to the Minister of Health, Province of British Columbia, Tome Three, p.145)

Thus, the trend in regulatory policy for the health professions has been towards reducing exclusivity in order to enhance interdisciplinary practice, improve accessibility to health care services and increase consumer choice, while at the same time maintaining the fundamental objective of protecting the public.

These policy trends are clearly reflected in the [Terms of Reference](#) for the scope of practice review which provide the basis for a new regulatory framework for health professions in British Columbia. The core elements of the new framework are scope of practice statements and reserved acts.

Under the present system, scope of practice statements are exclusive. In the new system, scope statements will not be exclusive but professions may be granted reserved acts.

Reserved acts are those elements of a profession's scope of practice which present such a significant risk of harm that they should be reserved to a particular profession, or shared amongst particular professions. Thus, unlike the present system in which each profession is granted exclusivity within its entire defined scope of practice (subject to specified exceptions), only those acts which present a significant risk of harm will be reserved.

In short, the government has assigned the Council the task of creating a regulatory model based on broad, non-exclusive scope of practice statements and narrowly defined reserved acts.

The government has the responsibility to ensure that those services which are accessible are safe and that the regulatory framework for the practice of health professions protects the public from incompetent, impaired, or unethical practitioners. At the same time, the regulatory framework should not entrench a paternalistic function for professions or reserve exclusive areas of practice simply to enhance professional status and control.

The new system of overlapping scopes of practice and narrow reserved acts removes barriers to interdisciplinary practice and offers greater choice and accessibility to the public. In the Council's view, the public interest is served by professional legislation which promotes quality in the delivery of health care services within safe parameters. Indeed, the Council's primary policy objective in conducting its review is achieving the optimum balance between safe practice and consumer choice.

With this in mind, the Council proposes to consider the practice of podiatry having regard to the four elements of the scope review.

III. DISCUSSION OF ISSUES

The main issues raised by this review are the four elements listed above: scope of practice, reserved acts, supervised acts and reserved titles.

The Council's [Terms of Reference](#) direct it to review these four elements with regard to podiatry.

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A. SCOPE OF PRACTICE

1. Scope Statement

The scope statement **describes** what the profession does, the methods it uses, and the purpose for which it does it. Unlike the present legislative scheme, the statement itself does not grant an exclusive scope of practice. Nonetheless, the statement is important because: 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; and it informs the public about the services practitioners are qualified to perform. It is expected that the Council's recommendations will increase overlapping scopes of practice.

The current scope of practice of Podiatry is defined by the [Podiatrists Act](#), RSBC 1996 c. 366 (PA). Subsection 1(2) defines the practice of podiatry as:

...the diagnosis and medical, surgical, mechanical, manipulative and electrical treatment of the human foot, including the nonsurgical treatment of the muscles and tendons of the leg governing the functions of the foot, or any combination of those practices or treatments...

Subsection 1(1) further defines "diagnosis" and "medical", "surgical", "mechanical", "manipulative" and "electrical" "treatment" for purposes of the PA:

"diagnosis" means the process of ascertaining a disease or ailment by its general symptoms;

"electrical treatment" means the administration of electricity to the foot or leg by means of electrodes, rays and the like, other than Xray unless used for diagnostic purposes;

"manipulative treatment" means the use of the hand or machinery in the operation or working on the foot or its articulations;

"mechanical treatment" means the application of a mechanical appliance to the foot or in the shoe to treat a disease, deformity or ailment;

"medical treatment" means the application to, or prescription for, the foot of medicines, pads,

adhesives, felt, plasters or a medicinal agency;

"surgical treatment" means

- a. *minor surgery on the foot by the use of cutting instruments for treatment of a disease, ailment or condition such as corns, callouses, warts, cysts, hammer toes, ingrown, infected or deformed toe nails or infected or ulcerative lesions and other minor surgery on the foot the board may by unanimous resolution approve, and*
- b. *other surgery on the foot when performed in a hospital as the medical staff of that hospital permits.*

The proposed scope of practice as suggested by the Association in its brief to the Council encompasses several changes. They are as follows:

- *"Regarding the definition of "podiatric medicine", subsection 1(2) should be repealed and in its place the following should be added to subsection 1(1):*

'podiatry' is synonymous with 'podiatric medicine' and the 'practice of podiatry' means the diagnosis and treatment of the foot and includes electrical, manipulative, mechanical, medical, pharmacological, radiological and surgical means or any combination of those means.'

- *In addition two new subsections should be added:*

(2) the practice of podiatry includes the diagnosis and treatment necessary for the ailing foot as well as that necessary for the preventative care of the well foot.

(3) the foot means the human foot and includes the anatomical foot and any muscle, tendon, ligament, or other soft tissue structure directly attached to the anatomical foot and which impacts upon or affects the foot or foot function and osseous structure up to and including the articulating surfaces of the ankle joint.

- *The definition of diagnosis should read:*

'diagnosis' means the process of ascertaining a disease or other ailment by its symptoms'.

- *The definitions of the various means of diagnosis and treatment should read:*

'electrical' means the administration of electricity to the foot or lower leg and includes but is not limited to the use of electrodes, electrocautery and laser;

'manipulative' means the use of the hand or machinery in the operation or working on the foot or its articulations;

'mechanical' means the application of a mechanical appliance to the foot or in the shoe

to treat a disease, deformity or ailment;

'medical' means the application to, or prescription for, the foot of medicines, pads, adhesives, felt, plasters and the like;

'radiation' means...and includes but is not limited to Xrays...; and

'surgical' means surgery on the foot.

- Finally, there should be added a new subsection 1(2) as follows:

For purposes of this Act, the definition of:

'electrical' does not include cosmetic activities such as electrolysis;

'manipulative' does not include the legitimate activities of physiotherapists, occupational therapists and massage therapists;

'mechanical' does not include the legitimate activities of occupational therapists and orthotists, and;

'medical' does not include legitimate nursing care activity.

The Council looked to other jurisdictions' definitions of the practice of podiatry. It found the Washington state description of podiatry which was submitted with the Association's materials to be helpful. While this description does not fit the [Terms of Reference](#) precisely, it is useful in that it sets out the limits and parameters for the practice of podiatry:

**Chapter 18.22 RCW
Podiatric Medicine and Surgery
(Formerly: Podiatry)**

RCW 18.22.035 Practice of podiatric medicine and surgery -- Quality -- Prescriptions -- Limitations. (1) A podiatric physician and surgeon is responsible for the quality of podiatric care

(2) The practice of podiatric medicine and surgery is the diagnosis and the medical, surgical, mechanical, manipulative, and electrical treatments of ailments of the human foot.

(3) Podiatric physicians and surgeons may issue prescriptions valid at any pharmacy for any drug, including narcotics, necessary in the practice of podiatry.

(4) Podiatrists shall not:

(a) Amputate the foot;

(b) Administer spinal anesthetic or any anesthetic that renders the patient unconscious; or

(c) Treat systemic conditions.

The Council also considered the Ontario description of chiropody and podiatry contained in the Ontario *Chiropody Act*, SO 1991, c. 20, which covers both professions:

3. (1) *There shall be a class of members called podiatrists.*

3. (2) *No person shall be added to the class of members called podiatrists after the 31st day of July, 1993.*

4. *The practice of chiropody is the assessment of the foot and the treatment and prevention of disease, disorders or dysfunctions of the foot by therapeutic, orthotic or palliative means.*

5. (2) *In the course of engaging in the practice of chiropody, a member who is a podiatrist is authorized, subject to the terms, conditions and limitations imposed on his or her certificate of registration, to perform the following:*

1. *Communicating a diagnosis identifying a disease or disorder of the foot as the cause of a person's symptoms.*

2. *Cutting into subcutaneous tissues of the foot and bony tissues of the forefoot.*

3. *Administering, by injection into feet, a substance designated in the regulations.*

4. *Prescribing drugs designated in the regulations.*

The Council believes that it is not necessary or useful to itemize every facet of a profession's scope of practice. Rather, a scope of practice definition should be sufficiently descriptive so that other health professions and members of the public alike can understand what the particular health professional does.

The results of the consultation process reveal few objections to the scope of practice statements proposed by the Association. Most comments were concerned with overlapping scope of practice (Registered Nurses Association of BC [RNABC], West Coast Association of Chiropodists [WCAC], BC Society of Occupational Therapists [BCSOT] and Victorian Order of Nurses [VON]). However, the New Brunswick Health and Community Services (NBHCS) pointed out that the statement proposed does not reflect the Council's aim of fairly and accurately describing the current state of practice of the profession. In addition, a certified orthotist, Patricia Flanigan, was concerned that podiatrists' services should not extend beyond the ankle joint. The Association included this restriction in its proposed restriction "*up to and including the articulating surface of the ankle joint.*"

While the terms chiropody and podiatry appear often to have been used interchangeably they are not synonymous. It is important in the Council's deliberations to distinguish between them. Chiropodists receive a diploma after three years of training with some exposure to minor surgical procedures. A school of Chiropody is located in Ontario. In contrast, podiatry education is a four-year program with one additional year for surgical residency, which includes more major surgical procedures. Most podiatry schools are located in the United

States.

The Council found that the Ontario *Chiropody Act* scope of practice statement describes the scope of podiatry that most closely meets the Council's *Terms of Reference*.

Therefore, the Council recommends the following scope of practice statement for members of the BC Association of Podiatrists:

The practice of podiatry is the diagnosis, therapeutic, orthotic or palliative treatment and prevention of disease, disorders or dysfunctions of the foot, and includes the muscles, tendons, ligaments or other soft tissue structure directly attached to the anatomical foot and which impacts on or affects the foot or foot function and osseous structure up to and including the articulating surfaces of the ankle joint.

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2. Practice Limitations

The Association suggests retaining current limitations on practice which are expressed as follows in subsection 1(2) of the *PA*:

the practice of podiatry ... does not include treatment of the foot that may affect the course or treatment of a systemic disease unless that treatment is carried out at the direction or under the supervision of a medical practitioner.

Therefore, the Council recommends the following limitation to podiatry scope of practice:

The practice of podiatry does not include treatment of the foot that may affect the course or treatment of a systemic disease unless that treatment is carried out at the direction or under the supervision of a medical practitioner.

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B. RESERVED ACTS

The rationale underlying the granting of reserved acts is to protect the public by limiting provision of those particularly dangerous acts to members of specific professions who are qualified to perform them. Only those acts which present a significant risk of harm will be reserved. The Council developed a list of reserved acts, and

included it in a report it recently issued, the [Shared Scope of Practice Model Working Paper](#) (*Working Paper*).

In its original 1996 brief presented to the Council, made without benefit of the [Working Paper](#) issued in 1998, the Association takes the position that the current exclusive scope of practice as expressed in sections 1(2) and 10(1) of the *PA* is appropriate and should be reserved:

1.(2) For the purposes of this Act, the practice of podiatry is the diagnosis and medical, surgical, mechanical, manipulative and electrical treatment of the human foot, including the nonsurgical treatment of the muscles and tendons of the leg governing the functions of the foot, or any combination of those practices or treatments, does not include treatment of the foot that may affect the course or treatment of a systemic disease unless that treatment is carried out at the direction or under the supervision of a medical practitioner.

10.(1) A person, unless he is a holder of a certificate of registration issued and recorded under this Act shall not practise podiatry in the Province.

Under section 11 of the *PA*, physicians and surgeons authorized to practice under BC law are exempt from the above scope statement.

The brief submitted by the Association states that although the reservation of the current exclusive scope of practice is appropriate, it should be expressed in a manner which would clarify the provision of other types and levels of foot care by specifying "joint" reserved acts, shared with the following:

- nurses: the provision of basic non-surgical nursing foot care;
- occupational therapists: the provision of ankle-foot orthotics (AFO's);
- certified orthotists: the provision of non-podiatric shoe modifications, various modifications and AFO's.

The Council is not dealing in this report with the reserved acts granted to nurses, occupational therapists and orthotists. These will be dealt in those professions' preliminary reports.

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1. Diagnosis, Procedures Below the Dermis, Hazardous Forms of Energy

In February 1999 the Association and the Board responded to the Council's reserved acts list contained in the [Working Paper](#) and submitted a revised list of those acts which they consider appropriate for podiatry:

- *Making a diagnosis*

They feel this is an appropriate reserved act for podiatry and state that "[podiatrists] are trained (in the same way as M.D.s and dentists) to evaluate and diagnose diseases of the lower extremity."

- *Performance of physically invasive or physically manipulative acts*

They state that this is within podiatrists' scope as podiatrists provide surgery and manipulation of the foot. This reserved act includes the following procedures within podiatrists' scope of practice:

- *procedures below the dermis*

They state that this act is appropriate given the surgical scope of podiatry.

- *setting or casting fractures*

They state that this act is within the normal purview of podiatrists' scope of practice. However, they did not elaborate.

- *administration of substance by injection or inhalation*

Again, they state that this act is within podiatrists' scope of practice.

- *putting an instrument, hand or finger(s) into an artificial opening into the body*

They state that this act is appropriate for normal podiatric scope of practice. However, they did not elaborate.

- *Applying or ordering the application of hazardous forms of energy*

The Association and the Board state that this act is within podiatrists' scope in the form of ultrasound, x-ray, C.A.T. scans, magnetic resonance imaging, laser and T.E.N.S. (transcutaneous electrical nerve stimulator).

- *Prescribing, compounding, dispensing or administering by any means a drug listed in Schedule I or II of the [Pharmacists, Pharmacy Operations and Drug Schedule Act](#)*

Both groups state that podiatrists prescribe and dispense medications, and occasionally compound them as necessary. They state that the Association is currently restricted from prescribing or dispensing narcotics which is often necessary in the course of treatment of the pathology of the foot. Both groups ask that they be allowed to prescribe narcotics as podiatrists are able to in the United States.

- *Prescribing of appliances and devices*

The Association and the Board suggest that this reserved act be expanded to include custom foot orthotics and/or accommodative foot devices to the list of devices.

- *Allergy testing*

Both groups state that podiatrists occasionally challenge a patient with local anesthetics to determine any allergic reaction. They argue that this is another activity within their scope of practice.

The results of the consultation process did not reveal any significant objection to the reserved acts originally proposed which were diagnosis, electrical and pharmacological treatment, x-ray and surgery.

The Association's revised request for reserved acts corresponds to its original request, with several notable exceptions. They are:

- *administering a substance by injection or inhalation*
- *allergy challenge testing;*
- *setting or casting a fracture;*
- *applying or ordering a hazardous form of energy (ultrasound, CAT scanning, MRI, laser)*
- *prescription of orthotics*
- *putting an instrument, hand or finger(s) into an artificial opening into the body.*

These have not been subject to the consultation process until this report and the Council has some concerns with the lack of documentation of podiatrists' education and training in some of these procedures.

The Council would need more information about the bones to be involved before granting setting or casting a fracture to podiatrists.

Allergy challenge testing should not be undertaken by any health professional without evidence of education and training to deal with a systemic allergic (anaphylactic) reaction.

Podiatrists' education and training to use forms of imaging, other than x-ray, has not been documented nor has it been determined that this is part of their current practice.

Administration of a substance by injection or inhalation is not intended to address administration of pharmacological agents. The [Working Paper](#) indicates this reserved act is intended to cover intravenous fluids and gases, not pharmacological agents.

The use of pharmacological agents by podiatrists will be reviewed later in this report.

Prescription of orthotics has been reviewed previously by the Council in its reports on Recommendations on the Designation of Occupational Therapy and on Recommendations on the Designation of Prosthetics and Orthotics, and has not been found to constitute a reserved act. The use of electricity is currently under review to determine which forms of electricity should be included in hazardous substances.

It is unclear whether the Association was referring to surgical instruments such as scalpels when it referred to "putting an instrument, hand or finger(s) into an artificial opening into the body" or were referring to use of scopes. If the former, it would be covered by the reserved act, "performing the physically invasive or physically manipulative act of procedures on tissue below the dermis".

The Council notes the controlled acts granted to podiatrists in Ontario are:

1. *Communicating a diagnosis identifying a disease or disorder of the foot as the cause of a person's symptoms.*
2. *Cutting into subcutaneous tissues of the foot and bony tissues of the forefoot.*

3. Administering, by injection into feet, a substance designated in the regulations.
4. Prescribing drugs designated in the regulations.

Therefore, the Council recommends the following reserved acts for members of the BC Association of Podiatrists:

- a. making a diagnosis identifying a disease or disorder of the foot as the cause of signs or symptoms of the individual;
- b. performing the physically invasive or physically manipulative act of procedures on tissue below the dermis of the foot, including bony tissue and muscle, tendon, ligament or other soft tissue;
- c. applying or ordering the application of a hazardous form of energy: X-ray.

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2. Prescription of Narcotics under the Controlled Drugs and Substances Act

The Association submitted the following with respect to prescription of narcotics:

The inability of podiatrists to prescribe narcotic drugs is an important and unwarranted restriction on podiatrists. Proper management of patients' pain requires the ability to prescribe narcotic drugs. This is a federal legislative and policy matter at present but will also be a provincial matter when the pending Bill C-7, the Controlled Drug and Substances Act is enacted.

The limitation exists because federal drug control legislation now in force, namely the Narcotic Control Act and Food and Drug Act make an important omission. They do not list Podiatrists as "practitioners" for the purpose of narcotic drug prescription. They do however, require that a "practitioner" be one of a physician, dentist or veterinarian. The province takes a more appropriate approach to the prescription of provincially controlled medication and includes podiatrists on the list of those who can prescribe.

...

The limitation seriously affects the scope of practice of podiatric medicine, in a manner which is detrimental to the public interest. In order to practice in a manner which best serves the welfare and comfort of their patients and efficient use of the health care system, Podiatrists should have the right to prescribe narcotic medication. This is because Podiatrists perform surgical and other procedures on the foot. In particular they manage pain associated with these procedures as well as arthritis, bone fractures, infections, neuralgia and nerve impingement. This aspect of the practice requires the ability to prescribe appropriate analgesic medications in order to relieve patient discomfort. The alternative, current situation is costly to the patient and the health care

system; Podiatrists must refer patients back to their G.P.'s for the appropriate prescription.

There is no medical basis for this situation; rather it is a legislative oversight. Podiatrists are at least as well trained in anaesthesiology and pharmacology as the traditional federal "practitioner" disciplines ... They administer drugs employed in pre-anaesthetic sedation and understand their pharmacology, administer local anaesthesia, and know the signs and stages of general anaesthesia ad post-anaesthesia medications.

Podiatry is a medical profession; thus in pharmacology as well as other areas it involves training and practice at a level comparable to physicians, dentists and veterinarians. Because of this and for the patients' welfare, Podiatrists should be accorded comparable legislative treatment in matters relating to the prescription of narcotic medications. The public has an interest in safe minimum standard of foot health care which should encompass appropriate pharmacological treatment, delivered in a manner which is cost-effective to the patient and the health care system.

...

In summary, although Doctors of Podiatric Medicine in the United States are licensed to prescribe narcotic medications, the Canadian government has overlooked this important practice necessity. This omission is significant from the public interest standpoint. Podiatrists meet all necessary requirements for the prescribing of narcotic drugs to patients and should be included in the definition of "practitioner". The BCAP urges the provincial government to take steps to amend this situation. [Footnotes omitted.]

The Pharmacists, Pharmacy Operations and Drug Schedule Act, RSBC 1996, c. 363, provides in s. 1 that "practitioner" means:

a person authorized to practice medicine, dentistry, podiatry, veterinary medicine ...

The Controlled Drug and Substances Act, SC 1996, c.19, while omitting specific reference to podiatry, defines practitioners as:

...a person who is registered and entitled under the laws of a province to practise in that province the profession of medicine, dentistry or veterinary medicine, and includes any other person or class of persons prescribed as a practitioner.

Currently, the regulations to the Controlled Drug and Substances Act do not provide for any other person or class of persons prescribed as a practitioner.

In the Council's view the practice of podiatry, which includes surgery, clearly requires the use of narcotics in certain instances. However, even though the provincial statute lists narcotics under Schedule I and II and defines podiatrists as practitioners, narcotics and the prescription thereof are under federal jurisdiction through the federal Controlled Drugs and Substances Act. Matters under federal jurisdiction are outside the mandate or purview of the Council.

Therefore, the Council recommends that the following reserved act be granted to members of the BC Association of Podiatrists:

Prescribing, compounding, dispensing or administering by any means a drug listed in Schedule I or II of the *Pharmacists, Pharmacy Operations and Drug Schedule Act*.

For the purposes of this reserved act, the following definitions shall apply:

"prescribing": the ordering of a drug.

"compounding": mixing ingredients, at least one of which is a drug.

"dispensing": preparing or filling a prescription for drugs.

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C. SUPERVISED ACTS

The [Criteria and Guidelines](#) attached to the [Terms of Reference](#) state that although reserved acts may only be performed by professions to whom they have been specifically granted, it may be appropriate for other persons to perform them or aspects of them, under the supervision of members of those professions. The [Criteria and Guidelines](#) also indicate that where Council is satisfied that a reserved act may be performed under supervision it may recommend training and qualification requirements, limitations regarding where the act may be performed and the degree of supervision required.

The Association's brief includes, as Appendix H, the Delegation to Unlicensed Persons Rule, which has been adopted by the Association. This Rule contains an extensive list of tasks which a podiatrist may delegate to persons who are not licensed to practice podiatry. The following definition of "supervision" is included in the Rule:

For purposes of this rule, a person is "supervised" when the podiatrist who delegated the task to that person or another podiatrist who is responsible for that person's performance of the task is present at all times during the person's performance of the task within the same practice premises as the person who performs the task and inspects the performance of the task sufficiently to satisfy himself or herself that the task is being and has been performed in a satisfactory manner.

In the [Working Paper](#), the Council stated that supervised acts would not be dealt with individually for each profession. In the Council's view, this general position should be applied to all professions. It is largely a recognition that the regulatory body is in the best position to determine when reserved acts can be performed under supervision or delegation. The regulatory body should be charged with determining when delegation is appropriate in accordance with the principles set out below. The Council believes this general approach to supervised acts more accurately reflects the reality that procedures to be delegated vary from profession to

profession and may include subsets and variations of reserved acts and further, may be performed under a myriad of circumstances and conditions.

Therefore, the Council recommends that a provision be enacted which deals with general principles regarding delegation of reserved acts. The provision would apply generally, not to individual cases. It should require the following:

- The assigning health professional's governing body must provide assent to the proposed reserved act being performed by someone else;
- The reserved act to be assigned as well as the level of supervision must be clearly defined and circumscribed by the assigning health professional's governing body;
- Where the person to whom the act will be assigned is a member of a self-regulating health profession, his or her governing body must approve of the assigning of the reserved act;
- The instruction to perform the act must be made in writing either by way of a general written protocol or through a case-specific instruction;
- The assigning health professional must be satisfied that the individual who will be performing the act has the necessary skills and training to perform the act safely; and
- The assigning health professional must ensure that the person who will be performing the act accepts the assignment.

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D. RESERVED TITLES

Reserved titles are titles reserved exclusively to a health profession. Reserved titles afford a means for consumers to identify the different types of health care providers, to distinguish the qualified from the unqualified, and to differentiate those practitioners who are regulated from those who are not. Titles must adequately serve the public in describing the practitioner and the services being provided and must distinguish the practitioner from others performing services outside the jurisdiction of the college.

Two titles are currently reserved under section 8 of the PA to persons entitled to practice podiatry. They are:

- *chiropodist*
- *podiatrist*

Section 9 of the PA states:

9 (1) A podiatrist registered under this Act who holds the academic qualification of Doctor of

Podiatric Medicine, granted by a school or college of podiatric medicine for a course of studies accepted by the board as qualification for registration under this Act, may display or make use of the title "doctor" or the abbreviation "Dr.", but only as "Doctor of Podiatric Medicine", "Dr. of Podiatric Medicine", "Podiatric Doctor" or "Podiatric Dr."

The Association brief submitted in February 1996, proposes to amend the PA to omit the term "chiropodist" from titles reserved for its members.

The Association requested in October 1996 to amend its scope of practice submission with respect to reserved titles. It proposes that:

"the use of the terms 'podiatrist' and 'chiropodist' shall be restricted to persons authorized to practice podiatry under this Act."

It appears that the Association has returned to its original position to retain "chiropodist" as a reserved title.

In a December 31, 1998 amendment to this section of the scope submission, the Association asks for the following titles:

- *Doctor of Podiatric Medicine;*
- *Physician and Surgeon of the Foot;*
- *Foot Physician and Surgeon;*
- *Foot Doctor;*
- *Podiatric Physician;*
- *Podiatric Surgeon;*
- *Podiatric Practitioner;*
- *Foot Specialist; and*
- *Foot and Ankle Specialist.*

"Doctor of Podiatric Medicine" is an academic degree which podiatrists are free to use whether it is reserved or not. The Council's Physicians Scope of Practice (Preliminary Report) indicated that reserving many different titles to describe the same practitioner may be confusing to the public. The Council believes that the title "podiatrist" serves the public in identifying podiatric practitioners and the services they provide. The Council also believes that members of the Association should continue to be entitled to use the title "Doctor" or "Dr." when used in conjunction with "Podiatric" or "Podiatry".

Because "chiropodist" refers to practitioners whose credentials are not the same as those of a "podiatrist" and who are not currently licensed to practise in BC, this title should not be reserved. However, if chiropodists are in the future considered for membership in the podiatrists' regulatory body, the title "chiropodist" could be reserved at that time.

Therefore, the Council recommends the titles "Podiatrist" and "Doctor (Dr.)" when used with the affix "Podiatric" or "Podiatry" be reserved for members of the BC Association of Podiatrists.

E. OTHER ISSUES

1. Hospital Privileges

The Board has made numerous submissions to the Council and Ministry of Health with regard to the issue of admitting privileges to hospitals and to out patient surgical facilities. A joint submission of the Association and the Board: *Legislative and Policy Impediments to the Practice of Podiatry*, November 1998, addresses these concerns about hospital and non-hospital surgical facilities.

The Association and the Board request that podiatrists to be on hospital medical staff. They contend that the Hospital Act, which regulates hospital access, fails to treat podiatrists in the same way as medical practitioners and dentists, and fails to grant podiatrists hospital surgical and treatment privileges. Both groups argue that other legislation, such as the Medicare Protection Act, the [Pharmacists, Pharmacy Operations and Drug Schedule Act](#) treats podiatrists in the same way as medical practitioners and dentists. Both groups propose that the Hospital Act and the Medical Practitioners Act be amended to grant podiatrists hospital access and to define podiatrists as "practitioners" and as part of medical staff.

The Council commented generally on this issue in its July 1998 Dentists Scope of Practice (Preliminary Report) at page 11:

An issue related to the performance of procedures on the orofacial complex is hospital admitting privileges. Representatives of the College and the Federation have indicated that, at present, dentists do not have admitting privileges and must arrange admissions through the patient's medical practitioner. This practice is problematic because it causes duplication of service, greater bureaucracy and the potential for communication difficulties. In the Council's view, to the extent that access to hospitals is necessary in order to carry out the scope of practice of oral and maxillofacial surgery, dentists should be granted hospital admitting privileges.

The Council also addressed this issue in its December 1998 Naturopathic Physicians Scope of Practice (Preliminary Report) at page 48:

In its submission the BCNA requests that naturopathic physicians be granted hospital privileges:

In relation to having access to specialists, naturopathic physicians also require hospital privileges. Although they currently act as primary care physicians, they are limited to offering ambulatory care. Limiting hospital care to medical doctors is also a conflict of interest. Patients are denied choice, and the publicly-funded hospitals are monopolized by a single health profession. In addition to choice, the health care system would benefit, cost-wise, from the preventative medicine by naturopathic physicians.

A regulation under the Hospital Act, BC Reg. 121/97, deals with the issue of hospital privileges. It distinguishes between "attending or treating patients in a hospital" and "patient admitting and discharging privileges". The former are restricted to physicians and surgeons, dentists, and midwives, while the latter are restricted to physicians and surgeons and midwives.

The Council's investigation indicated no need for granting naturopathic physicians hospital admitting privileges to carry out their scope of practice. But that is not to say that, from a scope of

practice perspective, there is no place for naturopathic treatment for patients admitted to hospitals under the care of other health care providers. The [Terms of Reference](#) indicate that any barriers to such treatment that exist, such as for example the provisions of the Hospital Act Regulation, ought to be reviewed with a view to removal of such barriers. In fashioning this recommendation the Council has not considered other factors such as insurance, internal hospital protocols regarding hospital patients and costs, all of which are beyond its mandate.

The Council recommends that any barriers to members of the ANPBC providing treatment services within a hospital be reviewed with a view to removal of such barriers.

The Council has carefully considered this issue. To the extent that access to hospitals is necessary in order to carry out the scope of practice of podiatric surgery, podiatrists should be granted hospital privileges, as necessary.

The Association and the Board also recommend that the governance of non-hospital surgical facilities should be removed from the College of Physicians and Surgeons of BC because, in their opinion, it constitutes a conflict of interest. Access to non-hospital surgical facilities is a matter for the Council's legislative review when considering barriers to interdisciplinary practice.

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2. The Practice of Chiropody in British Columbia

The Council was instructed by the Ministry of Health to consider the practice of chiropody in its review of the podiatry scope of practice.

In 1960, the practice of chiropody was considered synonymous with the practice of podiatry. According to submissions by the Association, in 1963, with the establishment of the Board of Examiners in Podiatry, the practice of chiropody was essentially phased out of existence in BC, since the new Board required a doctorate degree to be registered. Chiropodists receive a diploma. The Podiatry Amendment Act, SBC 1965, c. 36, enables the Board to issue interim certificates to any persons who held a doctorate degree whether or not it is called "Doctor of Surgical Podiatry."

Currently, there are only a few chiropodists in BC, who are non-practising, because they are not granted licensure in BC by the Board.

The Council reviewed the practice of chiropody in other provinces. In Ontario chiropodists have the same scope of practice as podiatrists, however, their reserved acts are the following:

5.--(1) In the course of engaging in the practice of chiropody, a member is authorized, subject to the terms, conditions and limitations imposed on him or her certificate of registration, to perform the following:

- 1. Cutting into subcutaneous tissues of the foot.*
- 2. Administering, by injection into feet, a substance designated in the regulations.*

3. Prescribing drugs designated in the regulations.

Chiropodists are not granted the controlled act of "cutting into the ... bony tissues of the forefoot", which is granted to podiatrists. The College of Chiropodists of Ontario (CCO) is the regulatory body governing podiatrists and chiropodists in Ontario.

The CCO notes the following comparisons between BC and Ontario:

- *It states that "diagnosis", though not granted to chiropodists in the Ontario Chiropody Act, is considered a necessary element of the scope of practice.*

Diagnosis is granted to podiatrists who are registered under the Chiropody Act. However, no podiatrists are to be registered under the act after 1993. The CCO notes the following additional comparisons between BC and Ontario:

- *It states that "electrical" means is dealt with in the Forms of Energy regulation under the Regulated Health Professions Act (RHPA), and permits podiatrists and chiropodists to apply electrocoagulation and fulguration to the foot.*
- *The CCO states that "manipulative" as pertaining to the foot is not a controlled (i.e., reserved) act.*
- *The CCO also states that "mechanical" as regards the treatment of foot diseases, disorders or dysfunctions by orthotic devices (appliances) is part of the scope of practice statement. Further, "medical" means is also considered part of the scope of practice.*
- *The CCO states that under "radiation" means, podiatrists and chiropodists are authorized to take and order x-rays under the Healing Arts Radiation Protection Act.*
- *Finally, the CCO states that "surgical" means as it pertains to cutting into the subcutaneous tissues of the foot is a controlled act for both podiatrists and chiropodists, and cutting into the bony tissues of the forefoot is a controlled act authorized to podiatrists.*

In sum, the CCO states that the scope of practice proposed for BC podiatrists is within the scope of practice of Ontario podiatrists.

An August 1996 submission by Steve Hardy, a chiropodist, states that if foot care by chiropodists is governed by the PA, then chiropody should share the scope of practice that the PA defines. He states that removing the exclusive scope of practice for podiatrists will benefit the public by an improved access to foot care.

Hardy states that chiropodists and podiatrists should be granted three controlled (i.e., reserved) acts:

- *cutting into subcutaneous tissues of the foot;*
- *administering, by injection into the feet, a substance designated in the regulations; and*
- *prescribing drugs designated in the regulations.*

Hardy refers to the Ontario model as appropriate, where the scope of practice of individual podiatrists is

modified by the imposition of terms, conditions and limitations on certificates of registration. In Ontario both podiatrists and chiropodists are regulated under the Chiropody Act.

The West Coast Association of Chiropodists (WCAC) has made submissions to the Council. Its main concern is that chiropodists are prevented from practising their profession because of the current requirements of the PA which requires the doctorate level for practice in podiatry. There is no avenue for registration of a person with a diploma in chiropody. The leadership of the WCAC has been encouraged to submit an application for designation as a health profession under the HPA. It asserts that many chiropodists have left BC because they are unable to practise and that currently, there are only five to six trained chiropodists in BC. Because of their numbers they have not felt that a separate college of chiropody would be viable and therefore have not submitted an application for designation.

The Ministry of Labour writes in response to a letter from the WCAC. The WCAC presented the barrier to employment Canadian-trained chiropodists encounter in BC. In response, the Ministry of Labour states it will assess the situation as a labour mobility issue.

While the WCAC has not submitted sufficient materials on curriculum and training requirements, it is clear that chiropody is a "health profession" as that term is defined in the HPA.

Having reviewed the materials submitted by the WCAC and Mr. Hardy as well as the regulation of chiropody in other provinces, the Council concludes that the practice of chiropody is clearly not equivalent to the practice of podiatry. While the scopes of practice are overlapping and both are foot care providers, there is a different level of knowledge, skill and ability, and each would provide a different level of care. However, their practices would be complementary and in the public interest.

The Council, in principle, sees no reason why chiropody should not be practised in BC. Given the aging population, it is likely that there will be an increased need for qualified foot care professionals. The Seaton Report discussed the issue of chiropody and podiatry, at D-32 to D-33:

To become a podiatrist, the Board of Examiners in Podiatry has determined that one must complete a four year course of study, which includes courses in minor foot surgery ...

Chiropodists, on the other hand, take a three-year college program that does not include courses in surgery. Upon graduation, they can provide basic but important and useful foot care which does not involve surgery.

...

There is a great need for a wide range of foot care services, in particular for elderly residents in the rural areas. And chiropodists appear just as capable of providing this care as podiatrists without compromising patient safety. If the scope of practice for podiatrists were narrowed to focus on those acts which chiropodists are not trained to do and which have a significant potential to cause real harm, many other foot care services could be safely provided by chiropodists.

Should chiropody become a regulated health profession, the Council sees no need to "narrow" the scope of practice of podiatry. The [Terms of Reference](#) clearly contemplate overlapping scopes with narrowly defined reserved acts. A clear distinction between reserved acts granted to podiatrists and those granted to chiropodists would be sufficient to protect the public.

The issue of how chiropody should best be regulated is a perplexing one. A separate College of Chiropodists would not be viable given current numbers of chiropody practitioners in BC. One practical solution appears to be the establishment of a separate class of registrants under the current regulatory body of podiatrists. A revised administrative structure should provide representation, appropriate regulations which recognize differences in education, training and scope and be designed to minimize friction and impediments to chiropodists' practice. Should this occur, consideration should be given to defining the scope of chiropodists, reserved titles, the name of the regulatory body and any reserved acts to be granted to chiropodists. The Council does not have sufficient information at present to make recommendations on these issues.

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3. Pharmacare Decision-Making

The Association raised the issue of Pharmacare reimbursement:

Lamisil, or terbinafine hydrochloride, is a provincially controlled medication. It is used in the treatment of tinia fungus infections and exists in topical and oral forms.

The oral form of Lamisil is crucial to the proper treatment of patients who have onychomycosis, which is a tinial infection under the toenail. ...

The oral medication is costly. A patient must take a twelve week course at a cost of approximately \$400.00.

A significant practice impediment which results in unnecessary expense to the patient and the health care system exists with respect to the prescription of oral Lamisil. At present Pharmacare will reimburse patients for the medication only if it is prescribed by dermatologists. Therefore patients who attend a podiatrist's office must be referred back to the patient's G.P. and thence to a dermatologist before Pharmacare will approve the reimbursement. This is a costly and needless procedure. ... For the patients and in interests of cost effectiveness [podiatrists] should be able to provide appropriate medication to their patients. [Footnotes omitted.]

Concerns raised regarding reimbursement paid by Pharmacare are not within the mandate of the Council, but will be passed on to the Ministry of Health department which has authority to deal with this issue.

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IV. RECOMMENDATIONS

1. *The Council recommends the following scope of practice statement for members of the BC Association of Podiatrists:*

The practice of podiatry is the diagnosis, therapeutic, orthotic or palliative treatment and prevention of disease, disorders or dysfunctions of the foot, and includes the muscles, tendons, ligaments or other soft tissue structure directly attached to the anatomical foot and which impacts on or affects the foot or foot function and osseous structure up to and including the articulating surfaces of the ankle joint.

2. *The Council recommends the following limitation to podiatry scope of practice:*

THE PRACTICE OF PODIATRY DOES NOT INCLUDE TREATMENT OF THE FOOT THAT MAY AFFECT THE COURSE OR TREATMENT OF A SYSTEMIC DISEASE UNLESS THAT TREATMENT IS CARRIED OUT AT THE DIRECTION OR UNDER THE SUPERVISION OF A MEDICAL PRACTITIONER.

3. *The Council recommends the following reserved acts for members of the BC Association of Podiatrists:*

- (a) *making a diagnosis identifying a disease or disorder of the foot as the cause of signs or symptoms of the individual;*
- (b) *performing the physically invasive or physically manipulative act of procedures on tissue below the dermis of the foot, including bony tissue and muscle, tendon, ligament or other soft tissue;*
- (c) *applying or ordering the application of a hazardous form of energy: X-ray.*

4. *The Council recommends that the following reserved act be granted to members of the BC Association of Podiatrists:*

Prescribing, compounding, dispensing or administering by any means a drug listed in Schedule I or II of the [Pharmacists, Pharmacy Operations and Drug Schedule Act](#).

For the purposes of this reserved act, the following definitions shall apply:

"prescribing": the ordering of a drug.

"compounding": mixing ingredients, at least one of which is a drug.

"dispensing": preparing or filling a prescription for drugs.

5. *The Council recommends that a provision be enacted which deals with general principles regarding delegation of reserved acts. The provision would apply generally, not to individual cases. It should require the following:*

- *The assigning health professional's governing body must provide assent to the proposed reserved act being performed by someone else;*
- *The reserved act to be assigned as well as the level of supervision must be clearly defined and circumscribed by the assigning health professional's governing body;*

- *Where the person to whom the act will be assigned is a member of a self-regulating health profession, his or her governing body must approve of the assigning of the reserved act;*
- *The instruction to perform the act must be made in writing either by way of a general written protocol or through a case-specific instruction;*
- *The assigning health professional must be satisfied that the individual who will be performing the act has the necessary skills and training to perform the act safely; and*
- *The assigning health professional must ensure that the person who will be performing the act accepts the assignment.*

6. *The Council recommends the titles "Podiatrist" and "Doctor (Dr.)" when used with the affix "Podiatric" or "Podiatry" be reserved for members of the BC Association of Podiatrists.*

Last Revised: March 08, 2002

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Health Professions Council POST-HEARING UPDATE OF PRELIMINARY REPORT: PODIATRISTS

Irvine E. Epstein, Q.C., Chair
Arminée Kazanjian, Member
David MacAulay, Member

March 2001

This Post-Hearing Update should be read in conjunction with the [Preliminary Report](#) for the profession.

The Council issued its *Podiatrists Scope of Practice (Preliminary Report)* in September 1999. The Council met with representatives of the profession in lieu of a public hearing on 7 February 2000. The following are changes to the *Preliminary Report* which arose from the submissions made either at the public hearing or in subsequent written submissions.

I. SCOPE OF PRACTICE

The Council's *Preliminary Report* recommended the following scope of practice for podiatrists:

The practice of podiatry is the diagnosis, therapeutic, orthotic or palliative treatment and prevention of disease, disorders or dysfunctions of the foot, and includes the muscles, tendons, ligaments or other soft tissue structure directly attached to the anatomical foot and which impacts on or affects the foot or foot function and osseous structure up to and including the articulating surfaces of the ankle joint.

At the February 2000 meeting, representatives of the Board of Examiners in Podiatry (Board) and of the B.C. Association of Podiatrists (Association) continued to request that the word "surgery" appear in their scope of practice. Their concern was that they have been denied surgical privileges in hospitals and that the use of the word "surgery" would clearly establish that they are able to perform this service. They also asked that the Council go farther in its final recommendation to allow podiatrists the same hospital privileges as those recommended for oral surgeons. Their concern is that without hospital privileges, podiatrists would not be able to have access to anesthesiologists for major surgery and would therefore be limited in the kind of surgery they could perform safely outside the hospital setting. They commented that this affects patient choice because patients must then be referred to an orthopedic surgeon for major surgical procedures which can only be safely performed under general anesthesia.

Both the Board and the Association discussed the importance of allowing podiatrists to practice at the level for which they are trained. They submitted additional information about training and the Board discussed its surgical committee which examines the level of training for each registrant. The committee then establishes which procedures can be utilized by an individual podiatrist. They also discussed the podiatry residency at Vancouver General Hospital and reiterated that this is not advanced or expanded practice but rather a matter of curriculum at the various training institutions. Some of the major procedures which were discussed were: calcaneal osteotomy of the heel, fusion of the subtalar joint, mid-foot fusion and open reduction with internal fixation of ankle fractures. Many podiatrists learn how to perform these procedures during a residency program which, although not mandatory, is commonly undertaken. The Board and Association pointed out that the scope of practice of podiatry should include the foot and lower leg since podiatrists are trained to treat disorders of the lower leg such as high fibular fractures. The Board also discussed the training podiatrists receive in the administration of intravenous sedation. Podiatrists, although trained in this area, would prefer not to utilize it but rather retain the services of an anesthesiologist.

The Council has given careful consideration to the submissions made by the College and Association. It appears that the procedures requested are currently within the podiatry scope of practice, but that podiatrists are not allowed to access hospital surgical facilities, except in rare cases, and thus are limited in their practice, not by their education and training, but rather by resistance from hospital boards. This was pointed out in the preliminary report and was not challenged. In addition, podiatrists are not defined as a "practitioner" in the *Hospital Act*, which the Board and the Association state is a problem for gaining access to hospital surgical facilities. They pointed out that midwives have been added to the *Hospital Act* as "practitioners," but that podiatrists have not. The Council has recommended in its *Preliminary Report* that these barriers to full podiatric practice be removed.

The Council has concluded that the scope of practice statement for podiatrists should be modified as follows:

The Health Professions Council recommends the following scope of practice for podiatrists:

The practice of podiatry is the prevention, treatment and palliation of disease, disorder or dysfunction of the foot, and includes the bones, muscles, tendons, ligaments or other soft tissue of the foot and lower leg which impact on or affect the foot or foot function.

The Council has determined, as a general matter, that scope of practice statements should not contain or attempt to list the reserved acts granted to a profession. Accordingly, the Council has removed the term "diagnosis" from the scope of practice statement.

There is no doubt, however, that podiatrists may perform diagnosis as that reserved act has been granted to them.

The Council believes that the reserved acts and reserved titles, discussed below, will reflect the fact that podiatrists are qualified to perform surgery.

II. RESERVED ACTS

The Council's *Preliminary Report* recommended the following reserved acts for podiatrists:

1. *Making a diagnosis identifying a disease or disorder of the foot as the cause of signs or symptoms of the individual;*
2. *Performing the physically invasive or physically manipulative act of procedures on tissue below the dermis of the foot, including bony tissue and muscle, tendon, ligament or other soft tissue;*
3. *Applying or ordering the application of a hazardous form of energy: X-ray.*
4. *Prescribing, compounding, dispensing or administering by any means a drug listed in Schedule I or II of the Pharmacists, Pharmacy Operations and Drug Scheduling Act.*

For the purposes of this reserved act, the following definitions shall apply:

"prescribing": the ordering of a drug.

"compounding": mixing ingredients, at least one of which is a drug.

"dispensing": preparing or filling a prescription for drugs.

The Council received evidence of education and training from the Board and the Association in its December 1999 response to the Council's preliminary report on the podiatry scope of practice. The Board and the Association submitted the curriculum from the California College of Podiatric Medicine in San Francisco. With regard to reserved act 7, in its December 1999 response to the Council's preliminary report, the Association and the Board submitted evidence that podiatrists are:

extensively trained in the area of emergency medicine and specifically in the area of anaphylactic shock. Our didactic instruction includes training in the areas of immune response, physiology, pharmacology, general medicine, emergency medicine, and anesthesiology... It is crucial that Podiatrists be allowed to challenge a patient, for an immune response, with medications (topical or injected) that may be necessary for treatment or anesthesia of the foot... We are not suggesting that we would be testing a patient for systemic allergies in the way that an Internist or Naturopath would. However, given the outline that was provided by the Shared Scope of Practice paper, we must request the right to test a patient for allergies.

With regard to use of hazardous energy, the Board and Association submitted curricula which demonstrated podiatrists' training in ordering the application of diagnostic ultrasound, MRI and CT scanning, and in the use of laser and surgery.

In response to information provided to the Council at its meeting with the Board and Association and in the December 1999 response to its preliminary report, the Council made the following changes to the reserved acts recommended in the preliminary report:

The Health Professions Council recommends the following reserved acts for podiatrists:

2. Performing the following physically invasive or physically manipulative acts:

(b) setting or casting a fracture of a bone or reducing a dislocation of a joint of the foot or lower leg;

(d) administering intravenous fluids by injection and anaesthetics by inhalation;

(e)(vii) for the purpose of arthroscopic surgery of the ankle putting an instrument, hand or finger(s) into an artificial opening of the body.

4. Ordering the application of a hazardous form of energy: X-ray, diagnostic ultrasound, MRI, CT scanning; applying a hazardous form of energy: laser;

7. Allergy challenge testing involving injection, scratch tests or inhalation, and allergy challenge testing by any means with respect to a patient who has had a previous anaphylactic reaction.

III. RESERVED TITLES

The Council's *Preliminary Report* recommended the following reserved titles for podiatrists:

- "Podiatrist" and
- "Doctor (Dr.)" when used with the affix "Podiatric" or "Podiatry."

The use of the title "surgeon" was again discussed at the February 2000 meeting. The Council has determined that it is appropriate that the title "surgeon" be reserved for podiatrists.

The Health Professions Council recommends the following reserved titles for podiatrists:

- "Podiatrist";
- "Doctor," "Surgeon," but only when used in conjunction with "Podiatric" or "Podiatry"; and
- any abbreviation of those titles.

Last Revised: March 08, 2002

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Health Professions Council Psychologists Scope of Practice Preliminary Report

Irvine E. Epstein, Q.C., Chair
Arminée Kazanjian, Member
David MacAulay, Member

August 1999

This Preliminary Report should be read in conjunction with the [Post-Hearing Update](#) for the profession.

FOREWORD

This report is the result of the Health Professions Council's review of the scope of practice of psychology pursuant to the [Terms of Reference](#) from the Minister of Health and Minister Responsible for Seniors. Under the [Health Professions Act](#), the Health Professions Council is a six-person advisory body appointed by the Government of British Columbia to make recommendations to the Minister of Health and Minister Responsible for Seniors about the regulation of health professions.

In this report the Health Professions Council examines how the existing scope of practice of psychology should be legislatively defined in order to reflect fairly and accurately the current state of practice and the public interest in the practice of psychology.

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EXECUTIVE SUMMARY

The Health Professions Council has conducted a review of the scope of practice of psychology.

The purpose of the review is to provide recommendations to the Minister of Health and Minister Responsible for Seniors regarding four matters: scope of practice statements, reserved acts, supervised acts, and reserved titles.

The Health Professions Council has conducted a detailed consultation process and its recommendations regarding the four elements of the scope review are as follows:

1. The Health Professions Council recommends the following scope of practice be granted to members of the College of Psychologists:

The practice of psychology is the diagnosis, treatment and prevention of mental and psychological disorders, dysfunctions and conditions, and the assessment, treatment and enhancement of behavioural, emotional and interpersonal functioning by the application and use of psychometric testing, psychological assessment, and the treatment and management of clinical and non-clinical conditions.

2. The Health Professions Council recommends the following reserved act be granted to members of the College of Psychologists:

Making a diagnosis, identifying a mental or psychological disorder, dysfunction or condition as the cause of signs or symptoms of the individual.

3. The Health Professions Council recommends that a provision be enacted which deals with general principles regarding delegation of reserved acts. The provision would apply generally, not to individual cases. It should require the following:

- The assigning health professional's governing body must provide assent to the proposed reserved act being performed by someone else;
- The reserved act to be assigned as well as the level of supervision must be clearly defined and circumscribed by the assigning health professional's governing body;
- Where the person to whom the act will be assigned is a member of a self-regulated health profession, his or her governing body must approve of the assignment;
- The instruction to perform the act must be made in writing either by way of a general written protocol or through a case-specific instruction;
- The assigning health professional must be satisfied that the individual who will be performing the act has the necessary skills and training to perform the act safely;
- The assigning health professional must ensure that the person who will be performing the act accepts the assignment.

4. The Health Professions Council recommends that the title "psychologist" be reserved for members of the College of Psychologists.

5. The Health Professions Council recommends that there be no exemptions from the title protection provisions of Recommendation 4.

I. INTRODUCTION

A. THE NATURE OF THE REVIEW

This is the preliminary report of the review of the scope of practice of psychology by the Health Professions Council (Council).

The review was conducted pursuant to [Terms of Reference](#) issued by the Minister of Health and Minister Responsible for Seniors in accordance with section 25 of the [Health Professions Act \(HPA\)](#). The [Terms of Reference](#) direct the Council to review the scopes of practice of the recognized health professions, of which psychology is one.

The [Terms of Reference](#), which are included as Appendix A to this report, indicate that there are four main elements to the scope of practice review:

1. scope of practice statements which describe what the profession does, the methods it uses and the purpose for which it does it;
2. reserved acts which are those acts that present such a significant risk of harm that they should be performed only by professionals who are qualified to perform them;
3. supervised acts which are reserved acts, or aspects of reserved acts, which may be performed by persons supervised by health professionals; and
4. reserved titles which are titles that describe a profession's services and which are reserved exclusively for the health profession.

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B. THE PROCESS FOR THE REVIEW

The general process for the review provides for an initial meeting with the profession(s), submission of briefs by the regulatory body and professional association for each profession, a consultation process involving all health professions and interested parties regarding each professions' submission, drafting of a preliminary report, public hearings and a final report.

The Council initially met with the College of Psychologists of BC (College) on April 3, 1995, and again on July 28, 1995, to discuss the scope review process. The College made a submission to the Council in July 1995. The Council also met with the BC Psychological Association (Association) on June 26, 1995. The Association handed its submission to the Council at that meeting. A public consultation process was conducted in 1996 based upon the submissions of the College and the Association. In February, 1998, the College and the Association made a joint submission responding to the submissions to the Council's consultation letter.

This report will be circulated to all health professions and other interested parties who participated in the Council's consultation process. A public hearing is scheduled on December 2, 1999, after which a final report

will be issued. Persons or organizations who have made written responses to either the original consultation letter or to this preliminary report will be invited to speak at the hearing.

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C. THE REGULATION OF PSYCHOLOGY

The first provincial enactment was the [*Psychologists Act*](#), SBC 1977, c.19. It defined the practice of psychology and the term "registered psychologist", and restricted the use of the titles "psychologist" and "registered psychologist" to registered persons. It prohibited an unregistered person from practising psychology and representing him/herself as a psychologist, unless he/she fell within a class of exemptions. The exemptions included persons authorized to practise their profession under another Act; a person teaching, lecturing or engaging in research as a psychologist in a university setting; and a person acting in the course of employment by government or government agency or by a board of school trustees, where qualifications in psychology are a condition of such employment.

Various amendments were enacted from time to time which extended exemption from the Act, permitted the use of the restricted title "psychologist", expanded the disciplinary powers, set out the duties of the College and provided for public membership on the board.

Finally, at the end of 1998, the College of Psychologists of BC requested designation under the *HPA* and the repeal of the [*Psychologists Act*](#).

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II. THE POLICY BACKGROUND

The main impetus for a scope of practice review was the Report of the British Columbia Royal Commission on Health Care and Costs (Seaton Commission). The Seaton Commission stated that the existing legislation governing the health professions creates persistent jurisdictional disputes and a distinct lack of cooperation among the health professions, despite the fact that all health professional colleges have the same mandate - to protect the public from preventable harm.

The Seaton Commission stated that the primary reason for the jurisdictional disputes was the present regulatory system's reliance on exclusive scopes of practice. Under the exclusive scope of practice model, the various health professions have been granted an exclusive right to practice within a legislatively defined scope of practice. No one, other than a member in good standing of that profession, can perform acts within the profession's scope of practice unless they are granted an exemption.

The Commission concluded:

...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.

(*Closer to Home, The Report of the Royal Commission on Health Care and Costs in British Columbia*, Volume 2, 1991, p. D-33)

This recommendation is also consistent with legislative initiatives underway in Alberta. The Seaton Commission was not the first review body to suggest that the present legislative model of exclusive scopes of practice was inappropriate. Restricting professional monopolies (exclusive scopes of practice) was also recommended in an earlier study commissioned by the British Columbia Minister of Health. In discussing the conflicts which may arise between the professional college and the public interest, the issue of exclusive scopes of practice was raised:

It must be emphasized that any professional legislation which unduly restricts the scope of practice of skilled personnel may be contrary to the public interest in greater supply and accessibility of service through the development of team practice. Therefore, it is urged that: Professional legislation should not contain narrow restrictions or rigid definitions of scope of practice which are excessively exclusive; that measures should be taken (as indicated below) to reduce the area of interprofessional strain and conflict; and that no prosecutions for violations of scope of practice legislation should be undertaken without the prior consent of the appropriate public authority.

Insofar as may be possible with due regard for public safety, professional law should not place rigid restrictions on the scope of practice of allied health personnel, and greater flexibility should be encouraged in the allocation of roles between the health disciplines.

(Professor J.T. McLeod, *Public Regulation of the Professions in Health Security for British Columbians, Special Report: Consumer Participation, Regulation of the Professions, and Decentralization* (1974), the report of Richard D. Foulkes, B.A., M.D., F.A.P.H.A. to the Minister of Health, Province of British Columbia, Tome Three, p. 145)

Thus, the trend in regulatory policy for the health professions has been towards reducing exclusivity in order to enhance interdisciplinary practice, improve accessibility to health care services and increase consumer choice, while at the same time maintaining the fundamental objective of protecting the public.

These policy trends are clearly reflected in the [Terms of Reference](#) for the scope of practice review which provide the basis for a new regulatory framework for health professions in British Columbia. The core elements of the new framework are scope of practice statements and reserved acts.

Under the present system, scope of practice statements are exclusive. In the new system, scope statements will not be exclusive but professions may be granted reserved acts.

Reserved acts are those elements of a profession's scope of practice which present such a significant risk of harm that they should be reserved to a particular profession, or shared amongst particular professions. Thus, unlike the present system in which each profession is granted exclusivity within its entire defined scope of practice (subject to specified exceptions), only those acts which present a significant risk of harm will be reserved.

In short, the government has assigned the Council the task of creating a regulatory model based on broad, non-exclusive scope of practice statements and narrowly defined reserved acts.

The government has the responsibility to ensure that those services which are accessible are safe and that the regulatory framework for the practice of health professions protects the public from incompetent, impaired, or unethical practitioners. At the same time, the regulatory framework should not entrench a paternalistic function for professions or reserve exclusive areas of practice simply to enhance professional status and control.

The new system of overlapping scopes of practice and narrow reserved acts removes barriers to interdisciplinary practice and offers greater choice and accessibility to the public. In the Council's view, the public interest is served by professional legislation which promotes quality in the delivery of health care services within safe parameters. Indeed, the Council's primary policy objective in conducting its review is achieving the optimum balance between safe practice and consumer choice.

With this in mind, the Council proposes to consider the practice of psychology having regard to the four elements of the scope review.

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III. DISCUSSION OF ISSUES

The issues raised by this review are the four elements listed above: scope of practice, reserved acts, supervised acts and reserved titles.

The Council's [Terms of Reference](#) direct it to review these four elements with regard to psychology.

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A. SCOPE OF PRACTICE

The scope statement **describes** what the profession does, the methods it uses, and the purpose for which it does it. Unlike the present legislative scheme, the statement itself does not grant an exclusive scope of practice. Nonetheless, the statement is important because-- 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; and it informs the public about the services practitioners are qualified to perform. It is expected that the Council's recommendations will increase overlapping scopes of practice.

The Council believes that it is not necessary or useful to itemize every facet of a profession's scope of practice. Rather, a scope of practice definition should be sufficiently descriptive so that other health professions and members of the public alike can understand what the particular health professional does.

Currently the [Psychologists Act](#) (PA) describes "the practice of psychology." However, it does not confer an exclusive scope of practice on members of the College.

1 In this Act:

the practice of psychology includes

- (a) the provision to individuals, groups, organizations or the public of any service involving the application of principles, methods and procedures of understanding, predicting and influencing behaviour, including the principles of learning, perception, motivation, thinking, emotion and interpersonal relationships,*
- (b) the application of methods and procedures of interviewing, counselling, psychotherapy, behaviour therapy, behaviour modification, hypnosis, research, or*
- (c) the construction, administration and interpretation of tests of mental abilities, aptitudes, interests, opinions, attitudes, emotions, personality characteristics, motivations of psychophysiological characteristics and the assessment or diagnosis of behavioural, emotional and mental disorder*

for a fee or reward, or otherwise.

Both the College and the Association agree that section 1 of the PA does not define a scope of practice and in their individual submissions , each proposes a new scope of practice.

The College proposed the following scope statement in its 1995 brief to the Council:

Registered Psychologists

- (a) diagnose, treat, and prevent any mental disease or disorder, or emotional or family disturbance, from infancy through the entire life span. These activities are accomplished by providing psychological assessment, psychometric testing, treatment and management of clinical and non-clinical conditions with the goal of furthering both emotional and physical health.*
- (b) provide consultative advice to other health providers, to legal counsel, to courts, to government agencies, to corporations, and to other community agencies.*
- (c) develop and evaluate assessment and intervention methods for use with normal and clinically-dysfunctional persons and groups.*

The Association, proposed a similar scope but expanded it to include lengthy descriptions of what registered psychologists, school psychologists, industrial/organizational psychologists, and counselling psychologists do. The descriptions, while informative, go far beyond the prescribed purpose of a scope of practice statement as previously set out in this report (the full description as submitted by the Association is set out in Appendix C).

Respondents to the consultation process generally supported the scope of practice statements proposed by the College and the Association, as long as the scope statement is not exclusive, recognizing many other professionals provide services which fall within the proposed scope statements. Scope of practice statements, under the *Shared Scope of Practice Model Working Paper (Working Paper)* which the Council has been directed to review, are not exclusive, but descriptive, and aspects may be shared with others, including both regulated and unregulated practitioners. Reserved acts represent the only portion of a scope of practice which is restricted, but reserved acts may also be shared by more than one profession.

Many respondents recommended limitations to the scope so that psychologists practice only within their specialty areas of expertise. The College is currently utilizing a competency model for describing the areas in which a registered psychologist is competent to practice . As was stated in the College's August 11, 1998 letter to the Council:

Whether or not an individual has a Masters or Doctorate, it does not automatically qualify them for all possible tasks a psychologist can perform. Rather like most professions there are a number of different general areas of practice and specialties. Thus the College is pursuing a competency model for describing what areas a psychologist is competent to practice in. . . Please note that there are a wide range of areas of competency, many of which do not overlap and require specific training in order to develop specific expertise.

The College's position is consistent with the mandate of all regulated health professional bodies which must protect the public by determining that all registrants are practicing within their particular professional competency. However, specialty certification is not an issue to be addressed in a scope of practice statement.

There were specific concerns by some respondents about both the College and the Association scope statements. In particular, the BC Medical Association (BCMA), the College of Physicians and Surgeons of BC (CPSBC), the UBC Department of Psychiatry and the Registered Psychiatric Nurses Association of BC (RPNABC) object to the use of the term "any mental disease or disorder" to describe the range of conditions which psychologists are qualified to diagnose, treat and prevent. The BCMA believes that this proposed change to the scope of practice is unacceptable and would imply to the public that purely psychological treatment of an illness with mental or emotional manifestations would be adequate treatment. The RPNABC states that mental illnesses often involve a complex interplay of physical and mental causes, and psychologists are usually not trained to detect underlying physical causes. In short, the RPNABC believes that psychologists at best are able to diagnose the "psychological aspects" of a mental disorder or disease. The MOH (Adult Clinical Service Branch) is concerned about the use of the term "mental disease" as it would include psychiatric conditions which a psychologist may not be able to treat.

The College of Massage Therapists of BC (CMTBC) states that the Association's proposal is too long and procedure-specific to become a meaningful definition. It further states that like all professions, the psychology scope of practice definition should be sufficiently descriptive and complete so that an average person can understand what someone practising that profession does. The CMTBC submits that the definition used in Ontario's legislation is the most focused and best articulated of the alternatives and suggests that it be adopted.

The Council agrees that the Association's proposed scope of practice statement, while it usefully lucidates the specialty areas of psychology, is too detailed to meet the Council's [Terms of Reference](#). However, certain aspects of it and of the College's proposed scope are appropriate to include in a scope statement.

The Council considered the scope of practice descriptions for psychology which have been adopted in other jurisdictions across Canada and the United States. Several were submitted by the College and Association.

Ontario: The practice of psychology is the assessment of behavioural and mental conditions, the diagnosis of neuropsychological disorders and dysfunctions and psychotic, neurotic and personality disorders and dysfunctions and the prevention and treatment of behavioural and mental disorders and dysfunctions and the maintenance and enhancement of physical, intellectual, emotional, social and interpersonal functioning.

Alberta: "practice of psychology" means the application of professional psychological knowledge for compensation for the purpose of the diagnosing, preventing, remedying or ameliorating human mental, emotional, behavioural or relationship difficulties, in order to evaluate or enhance human performance and to enhance mental or physical health;

Ohio: "The practice of psychology" means rendering or offering to render to individuals, groups, organisations, or the public any service involving the application of psychological procedures to assessment, diagnosis, prevention, treatment, or amelioration of psychological problems or emotional or mental disorders of individuals or groups; or to the assessment or improvement of psychological adjustment or functioning of individuals or groups; whether or not there is a diagnosable pre-existing psychological problem. Practice of psychology includes the practice of school psychology. For purposes of this chapter, teaching or research shall not be regarded as the practice of psychology, even when dealing with psychological subject matter, provided it does not otherwise involve the professional practice of psychology in which patient or client welfare is directly affected.

California: The practice of psychology is defined as rendering or offering to render for a fee to individuals, groups, organisations or the public any psychological service involving the application of psychological principles, methods and procedures of understanding, predicting, and influencing behaviour, such as the principles pertaining to learning, perception, motivation, emotions, and interpersonal relationships; and the methods and procedures of interviewing, counselling, psychotherapy, behaviour modification, and hypnosis; and of constructing, administering, and interpreting tests of mental abilities, aptitudes, interests, attitudes, personality characteristics, emotions, and motivations.

The application of such principles includes, but is not restricted to: diagnosis, prevention, treatment, and amelioration of psychological problems and emotional and mental disorders of individuals and groups.

Psychotherapy within the meaning of this chapter means the use of psychological methods in a professional relationship to assist a person or persons to acquire greater human effectiveness or to modify feelings, emotions, conditions, attitudes, and behaviour which are emotionally, intellectually, or socially ineffective or maladaptive.

After consideration of the respondents' comments and the College's and Association's proposed scope statements, the Council concludes that the following scope of practice definition most closely meets the requirements of the [Terms of Reference](#).

Recommendation 1:

The Council recommends the following scope of practice be granted to members of the College of Psychologists:

The practice of psychology is the diagnosis, treatment and prevention of mental and psychological disorders, dysfunctions and conditions, and the assessment, treatment and enhancement of behavioural, emotional and interpersonal functioning by the application and use of psychometric testing, psychological assessment, and the treatment and management of clinical and non-clinical conditions.

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B. RESERVED ACTS

The rationale underlying the granting of reserved acts is to protect the public by limiting provision of those particularly dangerous acts to members of specific professions who are qualified to perform them. Only those acts which present a significant risk of harm will be reserved. The Council developed a list of reserved acts, and included it in a report it recently issued, the *Working Paper*.

The College and the Association have proposed reserved acts which differ slightly but overlap significantly. For ease of reference to respondents' positions with regard to those acts, these will be set out separately, first dealing with the College's proposed reserved acts. The Association's proposed reserved acts will be highlighted should they differ in a manner which would significantly affect the recommendation.

The College has proposed that the following act be reserved exclusively to psychologists:

- Interpretation of Psychometric Tests designed and intended for the exclusive use of psychologists.

The description of psychometric tests which was contained in the 1996 consultation letter is included as [Appendix D](#).

The College has proposed the following act be reserved and shared by psychologists and physicians:

- Diagnosis of mental and emotional conditions as defined by the *Diagnosis and Statistical Manual: Fourth Edition* (A.P.A., 1994), and the *International Classification of Diseases and Related Health Problems: Tenth Edition*, or their future editions.

In support of its request for reserved acts the College provides the following rationale and documentation of risk of harm at pages 2 to 8 of its July 1995 submission. The 1995 submission states:

Psychologists offer services to normal individuals, individuals with mental disorders, with stress-related and chronic physical disorders (e.g., chronic headache, benign back pain, irritable bowel

syndrome), and those requiring educational or vocational assessment and advice. These services involve assessment, diagnosis, counselling, and more technically complicated treatments including different psychotherapies.

...

Psychological assessments ... involve ... interviews concerning (a) current mental status, (b) social, medical, educational, vocational, and psychological histories, and (c) referral-question relevant issues. Psychologists administer and interpret standardised psychometric instruments (e.g., measures of personality, psychopathology, intelligence, academic aptitude or achievement, neuropsychological functioning) as part of their assessments. Psychologists review other records (e.g., health, school, criminal records etc.) and gather collateral information from family members and acquaintances to aid in their assessment. Psychologists also use published epidemiological and local base rate data for making diagnoses or other decisions.

...

The proposed scope will restrict the interpretation of those psychometric instruments designed and intended for the exclusive use of trained psychologists (i.e., level B & C tests).

In Louisiana, ... a specific judgment has been made in regards to who may administer and interpret tests ... [which] restricts them from administering or interpreting other tests considered to be "within the exclusive domain of psychologists and physicians."

...

The law further provides that a test must be considered "psychological" if it is used "for the purpose of treatment planning and diagnosis, classification or description of mental and emotional disorders and disabilities, disorders of personality, psychological aspects of physical illness, accident, injury or disability, and neuropsychological impairment. ..."

Restricting psychological testing will serve the public interest by best ensuring that consumers will receive safe services. Thus, it will be less likely for example, that individuals would be misdiagnosed as Mentally Retarded or Schizophrenic and suffer the stigma and restrictions that accompany those labels. Similarly, such restrictions will improve the reliability of psychological assessments. This is especially important given the remarkable growth in the use of psychological tests and psychological expertise in family, civil, and criminal litigation, and the serious consequences of assessments in these venues.

The proposed reserved act of diagnosis within the scope of practice of psychology will have beneficial consequences for the general public. This will reduce the likelihood of misdiagnosis by untrained professionals and reduce the likelihood of misguided therapy.

...

The current act does not protect the public from the mis-use of psychometric instruments (e.g., psychometric measures of psychopathology, personality, neuropsychological functioning, or intelligence), mis-diagnosis of mental health conditions, and incompetent counselling or therapy

by untrained individuals. This results in harm to a large number of individual residents of British Columbia.

The Council has previously recognized the significant risk of harm inherent in the diagnostic process in its *Working Paper*. Diagnosis is a reserved act.

The College and the Association provided a number of cases where misdiagnosis resulted in harm to individuals. The examples involved persons who were exempted from regulation under the *PA*, however, they made diagnoses which were used to support treatment plans, court decisions regarding custody or institutionalization or long-term educational planning:

Case 1: ... [A] government employee (not a registered psychologist) diagnosing an individual as Mentally Retarded solely on the basis of a test score obtained in non-standardised conditions, and without reference to other data in conflict with that test score...

Case 2: A counsellor, trained in neither applied human processes nor sychopathology diagnoses her patient's panic attacks as a consequence of repressed memories of childhood sexual abuse.

Case 3: A physician, untrained in the interpretation of psychological tests ... routinely uses the M.M.P.I. for his assessments of motor vehicle accident litigants. He routinely mis-scores the test ... in a manner inconsistent with instructions in the manual ... the Court receives erroneous data for making its decision.

Case 4: A child was evaluated using questionable testing practices by a non-psychologist during a custody assessment. The report was instrumental in the decision to remove the child from the mother's custody. When challenged, the non-psychologist revised his report, stating that he had made numerous unsubstantiated conclusions.

Case 5: A girl was tested by a school psychologist who was not competent to evaluate her overall neuropsychological, cognitive, personality and behavioral development. The diagnosis was congruent with the test scores, but too few and the wrong tests were used. The girl was placed in a special class for mentally handicapped students and deprived of an appropriate education.

The Association originally proposed in 1995 that all psychometric testing should be either reserved to psychologists (Levels B and C) or supervised by psychologists (Level A). Within the context of a reserved acts system, only those acts or activities which carry a significant risk of harm and thus designated as reserved acts would qualify to be "supervised acts." Therefore, the Association's original submission was actually requesting that all three levels of testing should be reserved to Psychologists. This position appears to have been substantially altered by a joint submission of the College and the Association made on February 18, 1998 . This submission was made after both had reviewed the consultation process responses. The 1998 joint submission provides clarification and uniformity to the College and Association's request for reserved acts:

Determining the cause and naming a disease, disorder or condition is the feature which sets the act of diagnosis apart from testing or assessment. Only psychologists are qualified to accurately diagnose psychological conditions which are present, and characteristics or conditions which might also be present. ... The identification of a disease, disorder or condition as the cause of signs or symptoms of the individual, which may be termed diagnosis, is recommended by the BC Psychological Association to be a reserved act. The province of Ontario has reserved the act of

diagnosis to Psychology. " In the course of engaging in the practice of psychology, a member is authorized to communicate a diagnosis identifying, as the cause of a person's symptoms, a neuropsychological disorder or a psychologically based psychotic, neurotic or personality disorder."

In diagnosis, tests are used to assist in naming a disease, condition or disorder, as part of decision-making regarding individuals' ability and education (intelligence testing), or treatment (personality testing) or punishment (forensic personality testing). Tests listed as Level C test and some Level B tests must be administered and interpreted in the correct context. In contrast, Level A and many Level B tests are used to evaluate preferences, vocational interests, reading ability, and other non-life threatening domains of behaviour. Their administration and interpretation requires a limited amount of training. Possible abuse of Level A and B tests is limited by the weight which others give to the test results when they make decisions regarding the patient, student or worker.

The February 18, 1998 joint submission appears to narrow the College's and the Association's request for reserved acts to diagnosis and to Level B and C testing.

Respondents to the consultation appeared to generally support the request for the reserved act of diagnosis, so long as it is worded to encompass the concerns already mentioned with regard to the scope of practice statement, i.e., to avoid the use of the term "any mental disease." Another concern of a number of respondents was that other professionals who are trained and competent to perform diagnosis not be prohibited from performing any type of diagnosis that may be granted to psychologists.

Reserved acts may be shared among regulated health professionals who are granted those acts. The reserved act of diagnosis, when occurring in a mental health or psychological context, can be shared among regulated health professionals, including medical practitioners, psychologists and others, if any, who demonstrate training and competency to perform this type of diagnosis.

The Ministry of Education, Skills and Training (MOEST) recommends that members of the College of Teachers be included in the following reserved acts proposed by the MOEST: diagnosis of mental and emotional disorders; mental retardation, learning disorders, motor skill disorder; developmental disorders and communication disorders. The MOEST further states that restricting diagnosis and treatment of conditions to registered psychologists would significantly infringe upon good educational practice, and would severely restrict the ability of educational professionals to perform the services for which they are trained. This submission fails to take into account that granting the reserved act to psychologists who are members of the College does not mean it is exclusive to them.

The issue of reserved acts for Level B and C testing caused a range of comments. The most controversy appears to surround level B testing, since many of these tests are used by counsellors, teachers, therapists of all kinds and others. In addition, it is not clear which level B tests carry sufficient risk of harm to require reservation. The College has acknowledged in its February 18, 1998 submission that:

Tests listed as Level C tests and some Level B tests must be administered and interpreted in the correct context. In contrast, Level A and many Level B tests are used to evaluate preferences, vocational interests, reading ability and other non-life threatening domains of behaviour.

In general, respondents who commented about Level C testing support reservation of Level C tests to those who have the requisite training and qualifications. The MOEST commented that Level C tests are commonly

used by teachers. The BCMA finds the reservation of levels B and C testing to the exclusion of general medical practitioners and psychiatrists to be unacceptable. The BC Association of School Psychologists (BCASP) states that individuals certified by BCASP are as competent as registered psychologists to administer and interpret "psychological" and educational tests used in the school setting. The BC Society of Occupational Therapists indicates that there are a number of Level B and C tests which occupational therapists competently use at the present time. The Adlerian Psychology Association of BC objects to the exclusive reservation of levels A, B and C testing, to psychologists, noting that many educators, counsellors and other trained professionals have training and expertise in using these tests. The BC Teachers' Federation (BCTF) says there is no potential for harm in administration of Level A and B tests because of the "safeguards in the system." The BCASP states that supervision by its members or registered psychologists is desirable as incompetent administration of these tests can result in harm to individuals. The Canadian Association of Rehabilitation Professionals objects to the exclusive reservation of Level B and C testing and comments, as do many others, that these tests were not designed exclusively for psychologists but rather for specific uses. The American Association of Pastoral Counsellors objects because many of the tests are within the training of other counselling professionals. The BC Association of Clinical Counsellors notes that reservation of psychometrics is contrary to the position of the American Psychological Association which states that access to such tests should be based on knowledge and behaviours of test users rather than job titles or credentials.

The above comments are not an exhaustive list of responses to the issue of reservation of levels B and C testing. They however represent the range of concerns expressed. Although it appears that the majority of respondents see some degree of risk associated with Level C and some Level B tests, the principal objections seem to be based upon the exclusive nature of the reserved act requested. Respondents' comments were for the most part concerned that members of their particular profession or others might be prohibited from use of these tests. There appears to be general consensus that some degree of training and education must be possessed by persons who utilize some Level B and all Level C testing. There were concerns about both the administration and evaluation of these tests and in the interpretation of results by unqualified persons.

Most respondents did not directly address the risk of harm associated with the use of Level B and C testing. The College and the Association have provided examples of harm arising from misuse or misinterpretation of Level C and some Level B tests which can result in harm to individuals, even when utilized by a qualified individual. The most significant risk of harm, in the Council's view, is in the misapplication, scoring, administration, or interpretation of test results which can lead to a mis-diagnosis or erroneous treatment plan. This is particularly important where, as is submitted by the Association:

in diagnosis, tests are used to assist in naming a disease, condition or disorder, as part of decision-making regarding individuals' ability and education (intelligence testing), or treatment (personality testing) or punishment (forensic personality testing). Tests listed as Level C tests and some Level B tests must be administered and interpreted in the correct context.

It is clear that only qualified individuals should administer and interpret Level C tests. Level C testing is one aspect of diagnosis. It is a critical component but the results and interpretation of Level C testing are not viewed in isolation when a health professional is arriving at a diagnosis or planning treatment interventions. For this reason, the Council's conclusion with regard to reserved acts is that members of the College be granted the reserved act of diagnosis as defined below. The use of the full range of psychological testing, including level B and C tests, may contribute to that diagnosis. However, it is the identification and naming of a psychological disorder, dysfunction or condition as the cause of signs and symptoms of the individual which carries a significant risk of harm and should be reserved to members of the College and others who are trained and qualified to perform it.

The College has expressed concern with physicians whose scope includes the diagnosis of mental disease,

who use psychological testing in making their diagnosis even though unqualified to do so. The use of psychometric testing is no different than any other diagnostic tool and no one should use any diagnostic tool unless they have the requisite knowledge, skill and ability to use it competently.

Recommendation 2:

The Council recommends the following reserved act be granted to members of the College of Psychologists:

Making a diagnosis, identifying a mental or psychological disorder, dysfunction or condition as the cause of signs or symptoms of the individual.

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C. SUPERVISED ACTS

The [Criteria and Guidelines](#) attached to the [Terms of Reference](#) state that although reserved acts may only be performed by professions to whom they have been specifically granted, it may be appropriate for other persons to perform them or aspects of them, under the supervision of members of those professions. The [Criteria and Guidelines](#) also indicate that where Council is satisfied that a reserved act may be performed under supervision it may recommend training and qualification requirements, limitations regarding where the act may be performed and the degree of supervision required.

The College has proposed that its members supervise psychological diagnosis and testing, should the current exemptions from registration and title protection, be continued as they exist under section 28 of the *PA*.

The Association has proposed that persons in government and school settings performing psychological services but currently exempted from the *PA* should be supervised by a Registered Psychologist. This would apply to the reserved act, diagnosis.

Recommendation 3:

The Council recommends that a provision be enacted which deals with general principles regarding delegation of reserved acts. The provision would apply generally, not to individual cases. It should require the following:

- The assigning health professional's governing body must provide assent to the proposed reserved act being performed by someone else;**
- The reserved act to be assigned as well as the level of supervision must be clearly defined and circumscribed by the assigning health professional's governing body;**

- Where the person to whom the act will be assigned is a member of a self-regulated health profession, his or her governing body must approve of the assignment;
- The instruction to perform the act must be made in writing either by way of a general written protocol or through a case-specific instruction;
- The assigning health professional must be satisfied that the individual who will be performing the act has the necessary skills and training to perform the act safely;
- The assigning health professional must ensure that the person who will be performing the act accepts the assignment.

The reserved act of diagnosis as defined in Recommendation 2 has been recommended for members of the College. Therefore, the above recommendation regarding delegation of this reserved act would apply in all settings where diagnosis occurs, whether or not the exemption to title protection and College membership continue to exist.

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D. RESERVED TITLES

Reserved titles are titles reserved exclusively to a health profession. Reserved titles afford a means for consumers to identify the different types of health care providers, to distinguish the qualified from the unqualified, and to differentiate those practitioners who are regulated from those who are not. Titles must adequately serve the public in describing the practitioner and the services being provided and must distinguish the practitioner from others performing services outside the jurisdiction of the college.

The current title protection is contained in section 26 of the *PA*:

Prohibition

26 (1) A person must not engage in or carry on the practice of psychology and represent himself or herself as a psychologist, unless the person is registered under this Act.

(2) A person must not use, assume, or employ, or advertise or hold himself or herself out under the title of a "registered psychologist" or "psychologist" or any affix, prefix or abbreviation of the title as an occupational designation relating to the practice of psychology, unless the person is registered under this Act.

(3) A person must not obtain or attempt to obtain registration under this Act by fraud or misrepresentation.

(4) A person who contravenes subsection (1), (2) or (3) commits an offence.

(5) A person represents himself or herself as a psychologist if the person, for a fee or reward,

monetary or otherwise, acts, represents, holds himself or herself out or advertises as a psychologist, and uses a title or description or words incorporating the word "psychology", "psychological" or "psychologist", or other terms implying training, experience or expertise as a psychologist.

The title protection is subject to the following exemptions:

Exemptions

28 (1) Nothing in this Act prevents a person

(a) who is authorized to practise a profession under an Act from practising that profession,

(a.1) from practising a profession in the course of the person's employment with a board or council under the Health Authorities Act or with a community health services society, designated by the minister for the purposes of this paragraph, incorporated under the Society Act,

(b) from teaching, lecturing or engaging in research as a psychologist, if those activities are carried out by reason of, and in the course of, duties under an academic appointment or program in a university as defined by the University Act, or

(c) from acting in the course of employment by a Provincial, federal or municipal government or government agency, by a francophone education authority as defined in the School Act or by a board of school trustees constituted under the School Act, if qualifications in psychology are a condition of such employment.

(2) Nothing in this Act prevents

(a) a person to whom subsection (1) (b) or (c) applies from using the title "psychologist" or an affix, prefix or abbreviation of the title, or

(b) a society whose members are persons to whom subsection (1) (b) or (c) applies from using a title or designation incorporating the word "psychology", "psychological" or "psychologist".

The College has requested the following reserved titles for its members:

- psychologist
- psychology
- psychological, and its derivatives

The College's rationale for reserving these terms and title is that:

Currently, most members of the public do not understand the difference between a Psychologist and a Psychiatrist, a Psychologist and a Counsellor, a Psychologist and a Therapist, etc.

The Association has requested the titles:

- psychologist
- psychological associate
- psychotherapist, to be used only by a psychologist or psychological associate

The Association's rationale is as follows:

"Psychologist" should be reserved for those who are Registered Psychologists. A second title "Psychological Associate" should be reserved for...persons acting in the course of employment by government or school boards...Currently, practitioners exempted from registration are not required to be trained to the standards required for registration, and they are not governed by the ethical guidelines of the profession of psychology. This has created a two-tiered system of service delivery, where Registered Psychologists in private practice often provide higher quality psychological services than do practitioners who are exempted.

The Association has also proposed that psychological associates be subject to general supervision by a psychologist.

Most respondents to the consultation process support the title "psychologist"; however, they do not see the usefulness of the term "psychological associate" when applied to persons trained at a masters degree level. The term "psychotherapist" was controversial as many respondents considered that it did not distinguish members of the College from those performing services outside the jurisdiction of the College.

Recommendation 4:

The Council recommends that the title "psychologist" be reserved for members of the College of Psychologists.

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E. OTHER ISSUES

1. Current Exemptions from Title Protection and Registration under the *Psychologists Act*

The first provincial enactment to regulate the practice of psychology was the *Psychologists Act*, SBC 1977, c.19. It defined the practice of psychology and the term "registered psychologist" and restricted the use of the titles "psychologist" and "registered psychologist" to registered persons. It prohibited an unregistered person from practising psychology and representing him/herself as a psychologist, unless he/she fell within a class of exemptions.

The *Health Statutes Amendment Act*, SBC 1987, c.55, expanded persons exempt from the *Psychologists Act* to include employees of a board of school trustees constituted under the *School Act*. It also provided that university psychology teachers and lecturers, and government employees in positions where psychology was a

condition of employment may use the title psychologist.

In 1997, RSBC 1996, c. 381 was amended to include section 28(1)(a.1) and to add the phrase "by a francophone education authority as defined in the School Act" in section 28(1)(c).

a) The College of Psychologists of BC's Position on the Exemption Issue

The College, in its scope of practice submission in July 1995, states that the exemptions in the *PA* render it without jurisdiction over the exempted persons. It feels that the exemptions place the public at greater risk as there is no professional regulatory body to which these exempted professionals currently report and no one ascertains their competence or adjudicates complaints about either their competence or ethical conduct. The majority of individuals providing psychological services in the public school system are currently not regulated.

The College also states that there are multiple risks to the public through incompetent practice in school psychology. These include the misuse of specific psychological tests and miscommunication of psychological tests results, thereby resulting in erroneous conclusions and misdirection of the education and rehabilitation of students.

Further, the College states that there is a large number of psychologists employed by the Ministry of Health (MOH) and the College receives frequent complaints against these psychologists. To date, all psychologists found guilty of serious sexual impropriety in BC have been MOH employees and committed the sexual improprieties with MOH patients. Because there is no oversight by a professional body in place, the College believes that those who can afford private sector psychologists receive care from a generally more qualified psychologist than a person who can only afford government subsidized health care. Finally, the College states that non-psychologist supervisors often subscribe to a different set of ethical values.

The College suggests introducing categories of psychologists depending on qualifications. School psychologists in BC could create their own regulatory body or be regulated under a sub-section of another college. The College states that other jurisdictions have gradually withdrawn the exemption clause, by "grandparenting" currently exempted psychologists.

In 1998, the College wrote a number of letters to the Minister of Health regarding the recent amendments to the *PA*. The most significant factor for the Council's review of the scope of practice of psychology is the College's concern that public protection is compromised by the exemptions and that the College is unable to discipline exempted psychologists.

The College states that it receives complaints from the public regarding government-exempted psychologists. The College asks whether government's intention is to have two standards of practice; one for the government and one for the private sector.

The College further states that the amendments leave only private practitioners within the jurisdiction of the *PA*. It asks how it can protect the public from incompetence and harm when it will have no jurisdiction to discipline a large number in its profession.

Because there are three distinct categories of persons exempted from the *PA* under section 28, the Council will deal with each in turn.

Section 28(1)(a.1):

Persons authorized to practise a profession in the course of employment with a board or council under the Health Authorities Act or with a community health services society, designated by the minister for the purposes of this paragraph, incorporated under the Society Act

The Council has received submissions on the exemption issue as it applies to persons employed in government service under the *Health Authorities Act*, with community health services societies, or with various levels of government specifically mentioned in section 28(1)(c). In the Council's view, the issues of exempted persons employed by any of the above are similar.

The College and the Association have made their position clear on these issues and their reasons have been quoted earlier in this report.

In its response to the consultation, the MOH (Mental Health Division) commented with regard to risk of harm inherent in psychological services:

Important decisions are made on the basis of test results for a school-aged child that will affect his/her entire school program; test findings are used for court decisions; treatment activities are so personal that there is a greater risk of abuse by individuals who are not regulated by a profession.

With regard to the exemption, the MOH (Mental Health Division) further stated:

This exemption should be eliminated...Maintaining this exemption puts the public at a significant risk of harm. There are a number of cases in point, such as a former government employee who was convicted for fraudulently holding himself out as a registered psychologist. The importance of controlling the title and function of psychologists lies basically in the maintenance of standards and ethics in practice. If government employees are not subject to the same standards as the private sector, the result will be a two-tiered system with lower standards for those who avail themselves of government services.

MOH, Adult Clinical Services Branch, supports elimination of the exemption if the person currently in such positions in government are given the opportunity to be evaluated for "grandparenting" for registration as a psychologist.

Section 28(1)(b):

Persons teaching, lecturing or engaging in research as a psychologist, if those activities are carried out by reason of, and in the course of, duties under an academic appointment or program in a university as defined by the University Act.

The College and Association have not provided specific examples of harm that has been documented as a result of the exemption for university teaching, lecturing or engaging in research under section 28(1)(b), however the Council is not aware of any other regulated health professionals who are exempt from membership in their regulatory body by virtue of university employment. The College has indicated that persons exempted from registration under s.28(1)(b) are frequently involved in unregulated private practice or consultation, outside the course of employment.

[+ Top]**Section 28(1)(c):**

Persons acting in the course of employment by a Provincial, federal or municipal government or government agency, by a francophone education authority as defined in the School Act or by a board of school trustees constituted under the School Act, if qualifications in psychology are a condition of such employment.

The College's position on the issue of persons employed by government agencies, other than in the school system, has been canvassed under section 28(1)(a.1).

The MOEST has made a lengthy submission to the Council. The MOEST acknowledges the need to protect the public by regulating all professionals practicing psychology. The education system employs professionals to provide services which may be regarded as having a psychology component using either a narrow or a broader definition of the scope of psychology. These include school psychologists, counsellors, specialist teachers and other professional support personnel, faculty in colleges, universities and institutes and researchers. The Council intends to review the practice of psychology in the context of the school system as it applies to those practising school psychology, not counselling, thereby taking the narrow approach to the definition of the scope of psychology.

There is no formal regulatory body for school psychologists, although the BC Association of School Psychologists (BCASP) is their voluntary professional association. Entry to practice as a school psychologist is determined by the local school Board or Authority.

MOEST Guidelines recommend that school psychologists be teachers with a masters degree in one of three areas: special education, school psychology or educational psychology. UBC offers masters degrees in all of these areas, however, the three programs vary in their content of psychometric testing. Masters level programs in school psychology throughout North America have training in levels A, B and C tests. Only those with an MA in School Psychology are guaranteed to have received formal training in psychometric testing.

Information provided during the consultation process indicates that there have been difficulties attracting qualified persons for positions as school psychologists in some areas of BC including major metropolitan areas. Some persons employed and utilizing this exemption may have no formal training at all. The MOEST Guidelines for credentials of school psychologists are not mandatory, therefore persons who are not otherwise qualified may fill a position when there are no qualified persons. By virtue of some local union agreements, after filling a position for a number of months, that person is deemed "qualified".

While membership is not required, a number of school boards expect that persons hired for the position of school psychologist be eligible for membership in the BCASP. BCASP submitted that most of its approximately 200 members are certified teachers, however 15 are not. It has also come to the attention of the Council that approximately 50 per cent of psychometrists who perform diagnostic psychological testing and are employed at one of the larger Vancouver area school boards are not certified teachers. Non-teaching psychometrists are reportedly employed by a Victoria-area school board.

The BC College of Teachers (BCCT) and the MOEST have submitted that school psychologists, as qualified teachers, are currently regulated by "safeguards in the system." The MOEST makes reference to the *School Act* (SA), RSBC 1996, c.412, and the [*Teaching Profession Act*](#) (TPA), RSBC 1996, c.449, among others, in its

submission with regard to the authority vested in the education system and to establish accountability mechanisms and states that the *TPA* and the *SA* address issues of accountability and professional standards. The MOEST further states:

There are no recorded cases in this province where the provision of psychological services by professionals in the education system in BC has resulted in harm to a member of the public.

The MOEST indicates it would support the removal of exemptions provided the *PA* included appropriately qualified employees of school boards, universities and accredited colleges and universities in reserved acts and did not limit the ability of professionals working in the education system from continuing to carry out their work based on standards accepted in the education system.

The Council examined the accountability mechanisms referred to in the MOEST submission. The MOEST states all professionals certified to teach in the school system are subject to the authority of the BCCT and are accountable to locally elected boards. The legal authority referred to by the MOEST and the BCCT is set out in Appendix E and includes section 28 of the *TPA* and section 16 of the *SA*.

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The combined operation of section 28 of the *TPA* and section 16 of the *SA* provide that the only means by which a complaint can reach the BCCT discipline committee is via the local school board or authority, from 5 BCCT members, or from the Registrar of the BCCT. The *TPA* does not appear to provide any mechanism for receipt or adjudication by the registrar or the discipline committee of complaints from a member of the public (a student or parent) about a member of the BCCT. The *SA* does not provide for receipt or adjudication of complaints from a member of the public (a student or parent) about the conduct of an employee of a school Board. Section 11 of the *SA* provides for an appeal to the Board of a "decision" made by an employee of the Board. Other conduct or unethical practices do not appear to be covered in the *SA*.

The BCASP has submitted and the Council accepts that because there is no mandatory minimum education and training required of persons employed by a board of school trustees where qualifications in psychology are a condition of employment, there is the possibility that the public will be at risk from unqualified persons making diagnoses of educational and learning disabilities within the school system. Additionally, there are persons providing psychological services within the schools who are not certified teachers, therefore are not subject to any regulatory body. These persons may be supervised by non-psychologists. Even persons who possess qualifications in school psychology may be supervised by non-psychologists.

The risk of harm inherent in the practice of psychology has not been disputed by any of the respondents. The MOEST acknowledges the need to protect the public by regulating all professionals practicing psychology. The Ministry of Health (MOH), Mental Health Division comments as follows:

Important decisions are made on the basis of test results for a school-aged child that will affect his/her entire school program; test findings are used for court decisions; treatment activities are so personal that there is a greater risk of abuse by individuals who are not regulated by a profession.

The MOH, Mental Health Division, notes that the issue of school psychologists requires special attention and suggests that they may need to be regulated separately.

Others who commented on the exemption issue and are in support of eliminating the exemption are: the BCASP; the B.C. Medical Association; the BC Association of Clinical Counsellors; the Canadian Psychiatric Association; BC Psychiatric Association; the BC Colleges and Institutes Counsellors' Association; Riverview Hospital (with qualification that elimination of the exemption be prospective only); P. Anne Carney, Vocational Evaluator with WCB; and UBC Department of Counselling Psychology, Faculty of Education, UBC Department of Psychiatry and Faculty of Medicine.

Those who oppose elimination of the exemption are: BC Teachers' Federation; the BCCT; UBC Faculty of Education; the Canadian Association for Vocational Evaluation and Work Adjustment; Michael and Associates Vocational Testing and Evaluation; the BC Art Therapy Association; Janice A. Booth, MA., Ed.D. Educational Consultant; North Shore Counselling Centre; SRS Vocational Services; and Youngs Ferris International Vocational Testing Service; LTD.

Others gave qualified support to the exemption. The University of Victoria, Department of Psychological Foundations, recommends retaining the exemption and comments that as long as individuals providing services "are qualified in their sub-specialization as defined in the exemption provision of the PA, the exemption presents no risk of harm to the public." The Council points out that, outside the jurisdiction of the College, there is no effective minimum qualification for exempted persons. Although the various professions may have voluntary membership in a professional association and while membership, or eligibility for membership may be recommended, the Council has received information that such membership is not mandatory or uniformly recommended by all employers who hire exempted persons.

UBC Department of Counselling Psychology, Faculty of Education, recommends that masters trained personnel should be included within the College and comments that the exemptions (contingent upon the inclusion of masters prepared personnel in the College) likely increase the risk of harm to the public as the competence of psychological practitioners in government ministries may not be at the accepted level.

The BCASP believes that while the exemption encourages the possibility of inadequate service, it also feels that the provision of psychological services should be undertaken within a "*pluralistic model*" which recognizes the variety of expertise that are often essential to the diagnosis and treatment of individual difficulties.

The submissions indicate that the practice of psychology is clearly a health care service. There is a risk of harm in the practice of psychology, whether in the school setting, in the health care system, or in private practice. The Council has recommended that the title "psychologist" be reserved to members of the College. The Council has recommended that psychologists be granted a reserved act, diagnosis. That reserved act can only be performed by a qualified member of the College; however it may be shared with other qualified professions, including psychologists currently exempted from registration under the *PA*, should they become regulated by this or some other means. Under the *HPA*, delegation of the reserved act diagnosis may only occur, if at all, in accordance with the principles outlined in Recommendation 3, whether or not the current exemptions are retained in some form.

In the Council's view, those who submit that the public interest is protected by the safeguards within the system must show how that system effectively protects the public interest. That burden has not been met by the submissions of the MOEST or the BCCT which the Council has received to date.

The employment relationship which exists for employees of school boards, regional health boards and other government or private agencies, who are functioning as school psychologists where qualifications in psychology are a condition of employment, has not been shown to provide any mandatory minimum educational requirements, nor has it demonstrated that in all cases, such persons are supervised by persons who are qualified psychologists. There is no clear mechanism for a member of the public to make an effective complaint

about the conduct, practice or ethics of a person providing psychological services in the schools or in government or private agency employment.

There are no guarantees that such a person who resigns from one school board or government or private agency could not be rehired by another, as there is no mandatory reporting of such action to a regulatory body.

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Further, the College and the Association have submitted the following with regard to the operation of the exemption at all levels:

many government, school, and university practitioners also provide private services to the public without regulation. Although they are not members of the College of Psychologists and may not use the title Psychologist, they provide psychological services in their private practices on a fee for service basis. They are currently exempt from regulation, and thus an increased risk of harm to the public.

Here the College and the Association are addressing their concern that although these exempt government, school and university employees are currently able to use the title "psychologist" by virtue of their exempt employment, such employees are frequently asked to provide private consultation and psychological services, such as testing or psychotherapy outside of their employment. Because they are able to use the title "psychologist" in the employment context, a member of the public would not be able to ascertain that the person was not subject to any professional regulation. Although the private provision of psychological services, outside of the exemption, would be considered practice in violation of the PA, even as it is currently worded, the public has no way of knowing that a person able to use the title "psychologist" in his or her employment situation may not meet the standards of education or ethics that a member of the College must adhere to. Nor would such a person be subject to the disciplinary processes provided by the regulatory body. Whether in private practice, or in the school setting or government employee setting, use of the title "psychologist" by persons who are not members of the College and subject to its regulation is misleading to the public and may place it at risk.

Recommendation 5:

The Council recommends that there be no exemptions from the title protection provisions of Recommendation 4.

The Council has received various suggestions with regard to the issue of exemptions from membership in the College for persons mentioned in section 28(1)(a), (b) and (c) of the PA. The Council has recently received information which indicates that the College is considering a variety of mechanisms which would open its membership to exempted persons, including those with masters level preparation.

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The Council currently has insufficient information about the details of such proposals. There has been no formal presentation to the Council on this option, nor was it subject to the consultation process. Because there are a variety of routes open to exempted persons, including forming a separate college, the Council believes it is premature to make a recommendation directly on this issue. However, the Council has concerns that all persons practising psychology and using the title "psychologist" should be subject to effective regulation or supervised

by a member of the College if performing the reserved act of diagnosis.

Clearly there is a public interest in preserving the uninterrupted provision of psychological services within schools, government or private agencies. However, there must be effective regulation of those professionals who call themselves "psychologists" when delivering psychological services especially when performing a reserved act. For the most part, it is only within the school system that children receive psycho-educational support services, since most children are identified as having needs for these services by the schools. For children whose parents cannot afford private psychological services, the school system is the only place where these services can be delivered. Persons receiving psychological services through governmental or private agencies, likewise deserve services and assurances of competency on a par with those of private psychologists' patients.

The College has indicated a willingness to include school psychologists within its membership. The College has suggested regulation of school psychologists either as associate members of the College of Psychologists or through supervision of school psychologists should the exemption be continued. The BCASP has indicated that it is considering applying for designation under the *HPA* as a self-regulating profession, but is awaiting the outcome of the review of the psychologists scope of practice.

The BCCT and the MOEST submit that school psychologists should be regulated by the BCCT, not the College. They argue that regulation of school psychologists by a regulatory body other than the BCCT would cause fragmentation of the education system. They assert that there would be different ethical constraints and standards of practice among the various professions who provide services through the education system. The Council does not see how the regulation of professions by different regulatory bodies would be detrimental to the education system. The MOH has authority to administer the health care system through a number of statutes including the *HPA*. Other professionals who practise in both the health care and the education systems are regulated or have applied to be regulated under the *HPA*, i.e., speech/language pathologists and audiologists. Numerous professions are currently regulated in the public interest by separate regulatory bodies under the *HPA* or separate statutes. They function in a multidisciplinary team approach within the health care system. The regulation of professional standards of ethics, competency and practice should only enhance the performance of individual members of that profession in an interdisciplinary team approach, whether in the health care or the education system.

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F. IMPLICATIONS OF THE COUNCIL'S RECOMMENDATIONS

Many regulated professionals and unregulated persons provide services which fall within the scope of practice of psychology as defined by the scope of practice statement. A scope of practice statement is descriptive, not exclusive. Persons who provide such services, except for reserved acts, within the school system, governmental and private agencies, or in a university or college setting, would be able to continue to do so without registering with the College. However, they would not be able to use the title "psychologist".

Reserved acts are restricted to members of the College or other regulated health professionals who have been granted those acts or activities. In this case diagnosis, as described in Recommendation 2, has been granted to members of the College. The Council recognizes that many qualified professionals who may currently be exempt from the registration provisions of the *PA* are performing diagnosis in the schools and in governmental or private agencies. Clearly, there is a public interest in the uninterrupted provision of these services.

A number of comments and suggestions were made during the consultation process to address this issue. Membership in the College was suggested by some and could be achieved by either "grandparenting" or by the College establishing masters level entrance requirements. An alternative to College membership is establishment of a separate college(s) to regulate those professionals who perform diagnostic services outside the jurisdiction of either the College of Psychologists or the College of Physicians and Surgeons. Another alternative, although not supported by many respondents, is supervision of diagnosis by a member of the College who is qualified to practise in that particular area.

The Council encourages submissions in response to this preliminary report that would address this issue as it is in the public interest to continue the provision of psychological services within the province without interruption.

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IV. RECOMMENDATIONS

1. The Health Professions Council recommends the following scope of practice be granted to members of the College of Psychologists:

The practice of psychology is the diagnosis, treatment and prevention of mental and psychological disorders, dysfunctions and conditions, and the assessment, treatment and enhancement of behavioural, emotional and interpersonal functioning by the application and use of psychometric testing, psychological assessment, and the treatment and management of clinical and non-clinical conditions.

2. The Health Professions Council recommends the following reserved act be granted to members of the College of Psychologists:

Making a diagnosis, identifying a mental or psychological disorder, dysfunction or condition as the cause of signs or symptoms of the individual.

- 3 The Health Professions Council recommends that a provision be enacted which deals with general principles regarding delegation of reserved acts. The provision would apply generally, not to individual cases. It should require the following:

- The assigning health professional's governing body must provide assent to the proposed reserved act being performed by someone else;
- The reserved act to be assigned as well as the level of supervision must be clearly defined and circumscribed by the assigning health professional's governing body;
- Where the person to whom the act will be assigned is a member of a self-regulated health profession, his or her governing body must approve of the assignment;
- The instruction to perform the act must be made in writing either by way of a general

written protocol or through a case-specific instruction;

- The assigning health professional must be satisfied that the individual who will be performing the act has the necessary skills and training to perform the act safely;
- The assigning health professional must ensure that the person who will be performing the act accepts the assignment.

4. The Health Professions Council recommends that the title "psychologist" be reserved for members of the College of Psychologists.

5. The Health Professions Council recommends that there be no exemptions from the title protection provisions of Recommendation 4.

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APPENDIX C

THE BC PSYCHOLOGICAL ASSOCIATION PROPOSED SCOPE OF PRACTICE

The Association suggests the following scope of practice:

Registered psychologists are qualified to:

- (a) *diagnose, prevent or treat any mental disease or disorder, or emotional or family disturbance, from infancy through the entire life span, and to examine or advise on the behavioral, mental, neuropsychological, or emotional conditional of a person;*
- (b) *consult with other professionals to assist in the diagnosis of a behavioral, mental, neuropsychological, or emotional condition;*
- (c) *provide or advise on a course of treatment for a person, a family or a group or organization to improve their behavioral, mental, neuropsychological or emotional condition;*
- (d) *provide clinical, counselling, organizational/industrial or school psychological services as described below.*

School Psychology

In schools, psychologists provide:

- A. *Psychological and psycho-educational evaluations and assessments of the functioning of children. Procedures include screening, the use of psychological educational tests (particularly individual psychological tests of intellectual functioning, cognitive development, affective tests of*

intellectual functioning, cognitive development, affective behaviour, and neuropsychological status), interviews, observations, and behavioral evaluations.

B. Interventions to facilitate the functioning of individuals or groups. Such interventions may include, but are not limited to, counselling, affective education programs and training programs to improve coping skills; recommending, planning and evaluating special education services, and carrying out psycho-educational therapy.

C. Interventions to facilitate the educational services and child care functions of school personnel, parents and community agencies. Such interventions may include, but are not limited to, in-service school-personnel education programs, parent education programs, and parent counselling.

D. Consultation and collaboration with school personnel and/or parents concerning school-related problems of students and the professional problems of staff. Such services may include planning educational programs from a psychological perspective, consultation with teachers and other school personnel to enhance their understanding of the needs of particular pupils; modification of the classroom instructional programs to facilitate children's learning; promotion of a positive climate for learning and teaching; assistance to parents to enable them to contribute to their children's development and school adjustment, and other staff development activities.

E. Program development services to schools, school systems, and community agencies in such areas as needs assessment and evaluation of programs, liaison with community, provincial and national agencies concerning the mental health and educational needs of children, coordination, administration and planning of specialized educational programs; generating, collecting, organizing and disseminating information from psychological research and theory to educate staff and parents.

F. Supervision of school psychological services.

Industrial/Organizational Psychology

Industrial/organizational psychological services involve the development and application of psychological theory and methodology to problems of organizations and problems of individuals and groups in organizational settings. The purpose of such applications to the assessment, development, or evaluation of individuals, groups, or organizations is to enhance their effectiveness. Examples are:

A. Selection and placement of employees. Services include development of selection programs, optimal placement of key personnel, and early identification of management potential.

B. Organizational development. Services include analysing organizational structure, formulating corporate personnel strategies, maximising the effectiveness and satisfaction of individuals and work groups, effecting organizational change, and counselling employees to improve employee relations, personal and career development, and superior-subordinate relations.

C. Training and development of employees. Services include identifying training and development needs; formulating and implementing programs for technical training, management training, and organizational development; and evaluating the effectiveness of training and development programs.

D. Personnel research. Services include continuing development of assessment tools for selection, placement, classification, and promotion of employees, validating test instruments, and measuring the effect of cultural factors on test performance.

E. Improving employee motivation. Services include enhancing the productive output of employees, identifying and improving factors associated with job satisfaction, and redesigning jobs to make them more meaningful.

F. Design and optimization of work environments. Services include designing work environments and optimizing person-machine effectiveness.

(American Psychological Association Committee on Standards for Providers of Psychological Services & the American Psychological Association Professional Affairs Committee of the Division of School Psychology, 1981).

Counselling Psychology

Counselling psychology services refers to services that apply principles, methods and procedures for facilitating effective functioning during the life-span developmental process. Counselling psychologists place significant emphasis on positive aspects of growth and adjustment, with a developmental orientation. Their services help persons acquire or alter personal-social skills, improve adaptability to changing life demands, enhance environmental coping skills, and develop a variety of problem-solving and decision-making capabilities. Counselling psychology services are used by individuals, couples, and families to cope with problems connected with education, career choice, work, sex, marriage, family, other social relations, health, aging, and handicaps or a social or physical nature. Counselling psychological services include the following:

A. Assessment, evaluation and diagnosis. Procedures may include, but are not limited to, behavioral observation, interviewing, and administering and interpreting instruments for the assessment of educational achievement, academic skills aptitudes, interests, cognitive abilities, attitudes, emotions, motivations, status, personality characteristics, or any other aspect of human experience and behaviour that may contribute to understanding and helping the user.

B. Interventions with individuals and groups. Procedures include individual and group psychological counselling (e.g. education, career, couples, and family counselling) and may use a therapeutic, group process, or social-learning approach. Interventions are used for purposes of prevention, remediation, and rehabilitation; they may incorporate a variety of psychological modalities, such as psychotherapy, behaviour therapy, marital and family therapy, biofeedback techniques, and environmental design.

C. Professional consultations relating to A and B above. For examples, in connection with developing in-service training for staff or assisting an educational institution or organization to design a plan to cope with persistent problems of students.

D. Program development services in the areas of A, B, and C above, such as assisting in a rehabilitation centre to design a career-counselling program.

E. Supervision of all counselling psychological services, such as the review of assessment and

intervention activities of the staff.

F. Evaluation of all services noted in A to E above and research for the purpose to their improvement.

(American Psychological Association Committee on Standards for Providers of Psychological Services & the American Psychological Association Professional Affairs Committee of the Division of School Psychology, 1981).

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APPENDIX D

PSYCHOMETRIC TESTS (LEVELS A, B AND C)

Level A tests are tests which can be adequately administered, scored, interpreted, and reported with the aid of a manual, a familiarity with the client population, an orientation to the kind of setting within which the testing is done, and a general knowledge of measurement principles and of the limitations of test interpretation. Their misuse results in bad advice and, in the case of employment proficiency tests, lost job opportunity or inappropriate job placement. These tests are generally 'transparent' in that it is easy for the client to ascertain how his or her responses to individual items will affect the overall results.

Level B tests are complex tests and require graduate level training for selection, administration, scoring, and interpretation. The outcome from these tests can also have influence on the course of one's life. Level B tests are generally 'opaque', that is they are designed so that clients are unable to determine how their responses affect the outcome. Because the results cannot be distorted, the interpretation to the client can be very confrontative. It must be done by a Psychologist trained in test interpretation to avoid any harm that may come from information the client was psychologically unprepared to receive.

Level C tests are more complex than Level A and B tests. They are developed using the most sophisticated test construction methods because the outcome from these tests often has a significant impact on the course of a person's life. Level C tests are tests which require graduate level training in such areas as abnormal psychology, personality, psychometrics, statistics, and psychometrics in order to be able to appropriately select, administer and provide interpretation in the specific professional field to which the tests apply. Level C tests include an aptitude or language or personality or clinical diagnostic test, group or individual.

(For actual listing of tests in each category, if necessary, please contact the Council's office.)

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APPENDIX E

TEACHING PROFESSION ACT AND SCHOOL ACT

Section 28 of the *Teaching Profession Act*, RSBC 1996, c. 449, provides:

Discipline committee and inquiry

28 (1) The council must appoint 2 council members to act as the chair and vice chair of a discipline committee.

(2) All members of the council are entitled to sit on the discipline committee.

(3) The quorum of the discipline committee is 3 members.

(4) If the college receives

(a) in respect of a member, a report from the board under section 16 or 166.28 of the School Act,

(b) in respect of a member or other person, a report from an authority under section 7 of the Independent School Act,

(c) a complaint in writing signed by 5 members about the conduct of a member, or

(d) a report from the registrar relating to the conduct of a member,

the council or discipline committee may, after considering the report or complaint, make or cause to be made a preliminary investigation into the conduct or competence of the member in respect of whom the report or complaint is made.

(4.1) If a grievance has been taken under the terms of a collective agreement respecting a dismissal, suspension or other disciplinary action reported under section 16 of the School Act, the council or disciplinary committee must not proceed under subsection (4) in response to the report until the grievance procedure has been concluded.

(4.1) If a grievance has been taken under the terms of a collective agreement respecting a dismissal, suspension or other disciplinary action reported under section 166.28 of the School Act, the council or discipline committee must not proceed under subsection (4) in response to the report until the grievance procedure has been concluded.

(5) The council or discipline committee may, whether or not it has conducted a preliminary investigation under subsection (4), inquire into the conduct or competence, or both, of any member in respect of whom a report or complaint referred to in subsection (4) is made.

(6) If a member of the discipline committee ceases to be a council member, he or she may, with the consent of the committee chair, continue to be a member of the discipline committee for the purpose of completing any hearings in which he or she has been involved.

(7) For the purposes of subsection (4), the registrar may make reports in accordance with the directions of the council.

Section 16 of the *School Act*, RSBC 1996, c. 412, provides:

Report of dismissal, suspension and discipline

16 (1) If a board dismisses, suspends or otherwise disciplines a member of the college or a person holding a letter of permission to teach issued under section 25(2) of the Teaching Profession Act, it must

- (a) without delay, report the dismissal, suspension or other disciplinary action to the council of the college, giving reasons, and*
- (b) send a copy of the report to the member or the person, as the case may be.*

(2) If a member of the college or a person holding a letter of permission to teach issued under section 25(2) of the Teaching Profession Act resigns, the board must

- (a) without delay, report the circumstances of the resignation to the council of the college if the board considers that it is in the public interest to do so, and*
- (b) send a copy of the report to the member or the person, as the case may be.*

(3) A board that has made a report to the college under this section in respect of a member of the college or a person holding a letter of permission to teach issued under section 25(2) of the [Teaching Profession Act](#) must, without delay after being requested to do so by the college,

- (a) provide the college with all of the records available to the board that touch on the matter in respect of which the report was made, and*
- (b) send a copy of the records referred to in paragraph (a) to the member or the person.*

Last Revised: March 08, 2002

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Health Professions Council POST-HEARING UPDATE OF PRELIMINARY REPORT: PSYCHOLOGISTS

Irvine E. Epstein, Q.C., Chair
Arminée Kazanjian, Member
David MacAulay, Member

March 2001

This Post-Hearing Update should be read in conjunction with the [Preliminary Report](#) for the profession.

The Council issued its *Psychologists Scope of Practice (Preliminary Report)* in August 1999. The public hearing was held on 2 December 1999. The following are changes to the *Preliminary Report* which arose from the submissions made either at the public hearing or in subsequent written submissions.

I. SCOPE OF PRACTICE

The Council's *Preliminary Report* recommended the following scope of practice for psychologists:

The practice of psychology is the diagnosis, treatment and prevention of mental and psychological disorders, dysfunctions and conditions; and the assessment, treatment and enhancement of behavioural, emotional and interpersonal functioning by the application and use of psychometric testing, psychological assessment and the treatment and management of clinical and non-clinical conditions.

The Council has determined, as a general matter, that scope of practice statements should not contain or attempt to list the reserved acts granted to a profession. Accordingly, the Council has removed the term "diagnosis" from the scope of practice statement. There is no doubt, however, that psychologists may perform diagnosis as that reserved act has been granted to them.

The Council has also added the word "psychotherapy" to the scope of practice statement as discussed below.

The Health Professions Council recommends the following scope of practice for psychologists:

The practice of psychology is the treatment and prevention of mental and psychological disorders, dysfunctions and conditions; and the assessment, treatment and enhancement of behavioural, emotional and interpersonal functioning by the application and use of psychometric testing, psychological assessment, psychotherapy and the treatment and management of clinical and non-clinical conditions.

II. RESERVED ACTS

The Council's *Preliminary Report* recommended the following reserved act for psychologists:

Making a diagnosis, identifying a mental or psychological disorder, dysfunction or condition as the cause of signs or symptoms of the individual.

A. Psychotherapy: Proposed Reserved Act

The B.C. Psychological Association (Association) and others have submitted a number of post-hearing articles and letters which discuss the restrictions on psychotherapy which exist in Quebec and Alberta and forty-three states. The Association continues to assert that psychotherapy presents a significant risk of harm when used with patients who have a documented psychological diagnosis. This is the position being advocated in Ontario by the College of Psychologists of Ontario in response to the *Regulated Health Professions Act Five-Year Review*. For persons without a documented psychological diagnosis, the Association asserts that psychotherapy can be performed without significant risk. This would allow counselors and social workers to perform psychotherapy for clients who have not been diagnosed with a substantial disorder of thought, mood, perception, orientation or memory that grossly impairs judgment, behaviour, capacity to recognize reality or ability to meet the ordinary demands of life. This rationale is based upon the vulnerability of such patients and the belief that a substantial risk of harm can involve both physical and psychological, emotional or mental harm.

The Association cites the Montreux Clinic situation in Victoria as an example of psychotherapy which proved harmful when used with patients who had been diagnosed with such a disorder. Hypnotherapy was also cited as potentially harmful when used with a patient having a diagnosed psychological disorder.

The Association's argument is that psychotherapy requires the ability to diagnose. Inherent in diagnosis of mental or psychological disorders is the concept of treatment. Treatment requires knowledge of indications and contraindications for such treatment (psychotherapy). In the Association's submission, psychotherapy should require a prescription, if not performed by a practitioner with the ability to diagnose.

The Council has given careful consideration to the submissions made by the College of Psychologists of British Columbia (College) and the Association. The Council has not recommended that "psychotherapy" be made a reserved act for the following reasons:

- The risk of harm proposed is contingent upon the presence of a contraindication. The Council has considered this argument in the submissions of the College of Massage Therapists of British Columbia who sought to restrict the use of massage therapy when a patient has a contraindication to massage.

The Council concluded that the use of massage itself does not carry a significant risk of harm. In the Council's view, activities which are harmful on contingency are not properly the subject of reserved acts.

- Psychotherapy is difficult to define. The Council received submissions that over 400 types of interventions can be considered to be psychotherapy;
- Restricting psychotherapy would inhibit the practice of other counsellors or therapists;
- The reserved title "psychologist" provides protection to the public who are seeking psychotherapy ; and
- The Council has added the term "psychotherapy" to the scope of practice statement for psychologists.

B. Diagnosis

Several masters-prepared vocational rehabilitation counselors wrote to the Council because they also perform diagnosis; they are not members of a health professional regulatory body whose members are allowed to perform diagnosis. There is a movement to include masters-prepared practitioners within the College and to grant them a limited form of the reserved act of diagnosis if they are qualified and have documented credentials in this area. Qualifications for membership in a college are not properly the subject of the scope of practice review.

III. RESERVED TITLES

The Council's *Preliminary Report* recommended the reserved title "Psychologist" for psychologists.

The Council received a number of submissions from university faculty members advocating continuation of the exemption for use of the title "Psychologist" for faculty members. These professors are currently exempted from membership in the College and are able to use the title "Psychologist." The post-hearing submissions indicate that the College is considering a "non-practicing" registrant category, along the lines of similar categories employed by other colleges. This would address the issue adequately and more appropriately than continuing the exemption. For this reason, the Council does not wish to depart from its previous recommendation to remove the exemption, as the exemption is not in the public interest.

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Health Professions Council

SAFE CHOICES: A New Model for Regulating Health Professions in British Columbia Part II: Legislative Review

II. INTRODUCTION TO REVIEW PROCESS

The legislative review was conducted pursuant to the [Terms of Reference](#) issued by the Minister in accordance with section 25 of the [Health Professions Act](#), RSBC 1996, c. 183 (*HPA*).

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A. THE PURPOSE OF THE REVIEW

The [Terms of Reference](#) directed the Council to review the governing statutes for each of ten health professions.

The purpose of the review is twofold:

- a. To determine whether designation of the health profession under the *HPA* would be in the public interest or whether there are unique features of the health profession, or other relevant factors, that justify a continuing need for a separate statute.
- b. To determine what amendments, if any, are required to the current statute, rules, regulations and bylaws for each profession to provide adequately for the regulation of the profession in the public interest and to ensure that the current statute contains the *core principles* of professional regulation reflected in the *HPA* and discussed in Schedule B to the *Terms of Reference*.

The [Terms of Reference](#) and the Criteria and Guidelines which expand upon them are included as an Appendix to this report.

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B. THE BACKGROUND OF THE REVIEW

The [Terms of Reference](#) flow from several recent reports of royal commissions and government policy statements which have emphasized that an integrated approach to the delivery of health care is in the public interest. Co-ordination and co-operation amongst health care providers is of fundamental importance to such an approach. Consistency in statutory instruments is crucial to this aim.

A general policy favouring a uniform regulatory structure was referred to in the report of the Seaton Commission on Health Care in British Columbia: *Closer To Home. The Report of the British Columbia Royal Commission on Health Care and Costs (Closer to Home)*. The following excerpts are from that part of the Commission's report which deals with regulation of the health professions, on page D-30:

There is a lack of consistency among the 16 provincial acts that govern the health care professions, despite the fact that all of the colleges established under the acts have the same legislative mandate: to protect the public from preventable harm. Such inconsistency increases the likelihood of variations in judicial interpretations of the acts. Underlying this situation are persistent jurisdictional disputes and a distinct lack of co-operation among the health care professions.

...

In general, a lack of consistency characterizes the acts with respect to complaints, discipline and appeals, resulting in insufficient public accountability, no uniformity in the structure or organization of the different statutes, and an absence of common terms.

These views led the Commission to conclude that the existing [Health Professions Act](#) be repealed and the *HPA* be revised to serve as the umbrella act for regulating health professions.

The general policy of legislative uniformity is also consistent with initiatives in several other provinces -- notably Ontario, which has implemented umbrella legislation for the health professions, and Alberta, which is in the process of enacting umbrella legislation.

Alberta's *Health Professions Act*, SA 1999, c. H-5.5, or Bill 22, 1999, received Royal Assent on 19 May 1999 and is currently awaiting proclamation.

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C. THE ANALYTICAL FRAMEWORK

In reaching its conclusions, the Council considered two main directives, both of which are embodied in the [Terms of Reference](#): first, the *HPA* embodies the minimum regulatory standards which should govern all self-regulating professions; and second, designation of all health professions is the preferred option and it is for the individual profession to **justify** the need for a separate statute.

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1. The Core Principles of Professional Regulation

The Council's primary task in conducting the legislative review is to determine whether it is in the public interest that a health profession be designated under the *HPA*. The analysis of whether the professional statute contains the *core principles* of professional regulation is an important element in the consideration of whether designation is in the public interest. The extent to which a professional statute currently embodies these *core principles* is clearly one of the factors the Council must consider in making this determination.

2. The Terms of Reference

The *Terms of Reference* underscore the importance of uniformity in legislation and the general policy favouring designation. The *Terms of Reference* also refer to the desirability of minimizing the number of statutes that govern the health professions and the importance of a high degree of consistency amongst statutes. They direct the Council to consider specifically whether there are unique features of a health profession or other relevant factors that **justify** a separate statute. Thus, the onus is on the profession to establish why a separate statute is in the public interest.

One of the first clear positions which became apparent soon after the process started was the widespread opinion that designation under the *HPA* is tantamount to government "taking over" the professions.

The Council does not accept this view. The *HPA* relies on a system of self-regulation, and professions regulated under the *HPA* still have colleges and still have a broad rule-making power. Indeed, the basic structure of the *HPA* is remarkably similar to the current professional statutes. While the Council acknowledges that there is some difference between provisions of the *HPA* and the current professional statutes, the Council also stresses that the *HPA* clearly embodies a strong commitment to the principle of self-regulation. Indeed, the regulation of the actual practice of the profession by its members is left almost entirely to the profession itself.

The following discussion on the principles upon which self-regulation is founded may help erase this erroneous interpretation of the *HPA*.

It is an accepted principle that self-regulation is a privilege, not a right. Government grants a profession certain rights in return for which the profession agrees to regulate the profession in the public interest. This principle has been judicially noted in the British Columbia Supreme Court case of *Costco Wholesale Canada Ltd. v. British Columbia Assn. of Optometrists*, [1998] B.C.J. No. 646. It is the government which maintains fundamental control over self-regulatory bodies through the legislative process.

Thus, it is erroneous to consider that the *HPA* "takes over" a profession by designation. In fact, the legislature has always had the power to regulate directly and indirectly. With self-regulation, it merely delegates some authority to the profession itself. By no means is the power to self-regulate unlimited, nor is the self-regulatory body (college) autonomous.

This balance between professional self-regulation and government oversight is reflected in the *HPA*.

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D. THE PROCESS FOR THE REVIEW

The general process for the review provided for an initial meeting with the profession, preparation by the Chair of the Council of a comparative analysis of the profession's current statute with the *HPA*, discussion of the analysis with the profession, drafting of a preliminary report, roundtable discussions with representatives of the health professions under review and a final report.

Initial meetings were held with the professions in 1995. The Chair then completed his comparative analyses and circulated them to the professions under review in 1996. In 1997, the preliminary reports were drafted and sent out, and the roundtable discussions were commenced late in 1998. A separate roundtable discussion was held to discuss the changes to the *HPA*.

The roundtable discussions were completed in early 1999. The professions co-operated with the Council's requests for information and actively participated in the roundtable process.

The process was broad and inclusive, and all professionals were given wide latitude to provide their views on the issues. In addition, all health professions in British Columbia were invited to participate, as well as government agencies and departments and other interest groups. Research was conducted into the regulation of health professions in other provinces and U. S. jurisdictions.

The Chair then completed this comprehensive report, which will be submitted to the Minister.

During the legislative review process, the professions of naturopathic medicine, psychology and registered psychiatric nursing applied to be designated under the *HPA* and to repeal their profession-specific statutes. The Council was thus left with seven professions to review.

There was a notable lack of response from the professional associations representing the health profession membership. The Council prepared a preliminary analysis for each of the ten health profession statutes and sent copies to both the regulatory bodies and the membership associations. Most membership associations made no submissions and often simply agreed with little comment on the submission made by their respective regulatory body. One notable exception to this trend is in the review of the *Nurses (Registered) Act* where the Registered Nurses Association of British Columbia as well as the British Columbia Nurses' Union, not only made separate detailed submissions but often gave opposing views on issues the Council raised. The Council looked forward to this kind of discourse, which was a primary reason for the format of the legislative review process. Separate and detailed submissions from the regulatory bodies and the membership associations could also have stimulated more fruitful discussions within the Council's framework for the legislative review.

At the request of the Minister, the Council also conducted a separate consultation process on the issue of mandatory membership in professional associations. The Council contacted the health professions in British Columbia and the ministers of health of all other provinces and territories, as well as representatives of other professions, such as accountants, architects, engineers, lawyers, social workers and teachers. The Council published the survey on its website. The results of the consultation are discussed in the [mandatory membership](#) section of this report on page 76.

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III. ANALYSIS OF LEGISLATION

The Council's primary focus in conducting the legislative review is to determine whether designation of the health professions under the *HPA* would be in the public interest, and a key element of this task is to determine whether the existing health profession statutes contain the *core principles* of professional regulation reflected in the *HPA* and discussed in the [*Terms of Reference*](#).

The Council made the following recommendations in nine preliminary reports:

First, the Council recommended that seven health professions statutes be repealed and that the professions be designated under the *HPA*. They are the following acts:

- [*Chiropractors Act*](#), RSBC 1996, c. 48,
- [*Dentists Act*](#), RSBC 1996, c. 94,
- [*Naturopaths Act*](#), RSBC 1996, c. 332,
- [*Nurses \[Registered\] Act*](#), RSBC 1996, c. 335,
- [*Optometrists Act*](#), RSBC 1996, c. 342,
- [*Podiatrists Act*](#) and RSBC 1996, c. 366,
- [*Psychologists Act*](#), RSBC 1996, c. 381.

Second, the Council made a qualified recommendation with respect to the *Medical Practitioners Act*, RSBC 1996, c. 285, that it be repealed and the profession be designated under the *HPA*, provided the *HPA* is amended to include the suggested revisions discussed in the report.

Third, the Council recommended that the *Health Emergency Act*, RSBC 1996, c. 182, be retained as a separate statute.

This section of the report discusses significant issues which arose from the submissions by the health professions to the Council's consultation process. The section is organized around the five *core principles* of professional regulation described in the Council's [*Terms of Reference*](#).

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A. MANDATE OF THE REGULATORY BODY

The [*Terms of Reference*](#) emphasize two issues regarding this core principle:

- i. barriers to interdisciplinary practice are not in the public interest; and
- ii. it is important that there be a clear separation between the professional association and the regulatory body.

The following issues were raised by the Council's review of the health professions' legislation.

1. Barriers to Interdisciplinary Practice

Barriers to interdisciplinary practice were discussed by the Seaton Commission in its report *Closer to Home*, on page D-35:

In addition to broadly stated scopes of practice, there are other barriers to practice. For instance, there is no reason why a member of one profession should not be allowed to be a member of another profession. A provision in any regulation, rule, bylaw or Code of Ethics which prevents this from happening is inappropriate. It may be in the profession's interest to have such a prohibition, but it is not in the public interest.

Some of the existing professional legislation makes it an offence for a member of a college to work in association with someone who is not a member of that college. But as long as the non-member does not practice within the profession's narrow scope of practice, the commission does not believe there is any substantial reason why a member of a college should not be allowed to work in co-operation or partnership with someone who is not a member. In fact, a multi-disciplinary practice may be beneficial and should be encouraged.

The Council agrees with these comments about interdisciplinary practice and has noted in its preliminary reports that several of the profession-specific statutes contain prohibitions against interdisciplinary practice. The prohibitions usually forbid registrants of a college to practise in association with a non-registrant. Some provisions prohibit affiliation or the establishment of a partnership with non-registrants.

For example, section 93(1) of the *Medical Practitioners Act* makes it an offence to practise medicine in partnership with a non-member unless the written consent of the Executive Committee of the College of Physicians and Surgeons of British Columbia (CPSBC) is obtained. The primary concern with this section is that broadly applied, it can create unnecessary barriers to the practice of other health professions. Although the CPSBC indicated that it uses the section to ensure that its members meet appropriate standards and practise in a manner consistent with those standards, it appears that the CPSBC has adopted a broad interpretation of the section, thus creating barriers to interdisciplinary practice.

To illustrate, the CPSBC uses this section to restrict access to laboratory facilities in British Columbia. The CPSBC takes the position that diagnostic testing is the practice of medicine, requiring supervision by medical practitioners so that all diagnostic facilities are operated by physicians. In conjunction with section 93, this position allows physicians to prohibit access to the facilities, both public and private, by other health professionals. The Seaton Commission identified this practice as a barrier to interdisciplinary practice, on page C-113:

The Medical Services Commission has generally interpreted the Medical Services Act and the Medical Practitioners Act to mean that only physicians may own laboratories. But we can find nothing in the Medical Services Act to support this interpretation. A non-physician is quite capable of managing the daily operations of a laboratory, and that is, in fact, what happens at present. A pathologist must be available to provide clinical expertise as required. But we believe that laboratories are, in reality, business enterprises, and should be treated as such, rather than as medical practices.

In its *Medical Practitioners Act Legislative Review (Preliminary Report)* the Council determined that it is inappropriate to give exclusive power of governance over diagnostic facilities to medical practitioners as it has the potential to create unnecessary barriers to interdisciplinary practice. Thus, while the Council appreciates the concerns the section attempts to address, the powers this section creates and the severe remedy that may be

imposed go beyond what is necessary to address these concerns.

The problem with section 93(1) is that it creates an outright ban, subject to limited exceptions, when less stringent measures would suffice. For example, in Alberta a physician is able to refer to a non-regulated health professional as long as no harm is caused to the patient:

A referral to a non-regulated health care provider is acceptable when the physician is satisfied that those services can reasonably be expected to benefit the patient, and not cause harm.

[College of Physicians and Surgeons of Alberta Policy. Practice in Association. Original: April 1997, updated: March 1998, section (10).]

A complete barrier to interdisciplinary practice is not in the public interest. As the Seaton Commission stated, as long as the non-member does not practice within the profession's scope of practice, there is no reason why a member of a college should not be allowed to work in co-operation with someone who is not a member.

The *Chiropractors Act* contains a provision that creates a barrier to dual licensure:

Practice

21 (1) Subject to subsection (2), a person registered as a chiropractor under this Act must not engage in the practice of the diagnosis or treatment of the human body for disease, or the causes of disease, otherwise than as a chiropractor, unless the person,

- a. first applies to have his or her name stricken from the register of members of the college, and
- b. discontinues the use of the name "chiropractor", whether by way of advertisement or in any other manner that might signify that he or she was practising as a chiropractor within the meaning of this Act.

This provision clearly restricts dual licensure as it prohibits a registrant from practising the profession other than as a registrant of the college unless the registrant has his/her name stricken from the register of members of the college or discontinues the use of the reserved title of the profession. For example, a chiropractor could not practice both chiropractic and physical therapy.

In Ontario, chiropractors are entitled to be members of other health professions, both regulated and unregulated, and the College of Chiropractors of Ontario has enacted a policy to address the regulatory issues. The policy provides, in part:

Dual registrants are required to inform the patient that the proposed treatment is outside the scope of practice of chiropractic and that the proposed treatment would not be administered in the registrant's capacity as a chiropractor;

the client/patient must understand in what circumstances he or she is receiving treatment from the dual practitioner in his or her capacity as a chiropractor, and in what circumstances he or she is receiving treatment which is outside the scope of the practice of chiropractic.

(CCO Policy: P- 018. Dual Registrants. Executive Committee, College of Chiropractors of Ontario. Approved by Council: 29 July 1995, re-affirmed by Council: 1 November 1997.)

In the *Chiropractors Act Legislative Review (Preliminary Report)*, the Council stated that allowing dual licensure and giving the British Columbia College of Chiropractors the power to regulate the matter is more in accordance with the public interest than an outright ban.

In sum, barriers to interdisciplinary practice in any form, and especially in the form of an outright ban, are not in the public interest. This is not to say, however, that individuals members can be compelled to practice with other health professionals, simply that they should not be prohibited from doing so if in their judgment the best interests of the patient would be served by so doing.

2. Relationship Between Regulatory Body and Professional Association

The Seaton Commission dealt with the issue of membership promotion and self-regulation when it recommended that "two separate bodies be created for all regulated or licensed professions so that there is a clear separation of membership promotion functions and licensing and discipline functions." The Seaton Commission felt that without this separation the public protection function of the college would become blurred with the membership promotion function of the professional association.

The Seaton Commission's views echo those of the report *Health Security for British Columbians*, Special Report: Consumer Participation, Regulation of the Professions, and Decentralization, the Report of Richard D. Foulkes (*Foulkes Report*). In a chapter on public regulation and the professions, on page 133, Chapter 3, Tome Three, Professor J.T. McLeod stated:

It is only reasonable to recognize that professions, like other groups and individuals in society, may well be expected to have certain private self-interests of their own which are not coincident with the public interest. Recognition of a degree of real or at least potential conflict between the private interest of the profession and the public interest is the root of the necessary distinction between the professional or licensing body on the one hand, whose purpose is to enforce standards of quality and service, and the voluntary association of the profession on the other hand, whose legitimate function is to advance the particular interests of the profession and its membership. This important distinction between the public function of the licensing body and the private function of the voluntary association is now widely recognized in Canada. From the standpoint of both the professions and the public, it is desirable that the separation of the two functions be kept sharp and distinct.

The Council agrees with these comments and believes it important that there be a clear separation between the professional association and the regulatory body.

The comparative analysis of the health profession statutes under review illustrated many provisions where the separation between the regulatory body and the professional association was ambiguous and sometimes non-existent. For example, the professional associations for podiatry and optometry have the power to administer the disciplinary authority of the regulatory body and are effectively performing the function of the regulatory body. The professional association for podiatry is charged both with the duty of serving and protecting the public as well as advancing the economic welfare of its members. Under the *Optometrists Act*, membership with the British Columbia Association of Optometrists is mandatory. Without membership, a person is not entitled to practice optometry. Further, the association is granted professional disciplinary powers over its members.

Another matter arising from the relationship of the regulatory body and professional association concerns college involvement in "economic" or fee-related matters of the health profession. Since health profession colleges are charged with the duty of serving and protecting the public, their participation in negotiating fee-

related matters for the health profession could be in direct conflict with their primary duty to the public.

Provisions in profession-specific statutes and regulations which set out unnecessary rules regarding premises for the practice of the profession and provide for restrictive rules regarding advertising are indicative of the regulatory body's interest in the economic affairs of its members. Economic issues affecting the members are a proper concern for the membership association whose essential role is to serve the interests of its members.

In sum, activities of a regulatory body to promote the economic, political and professional interests of its members must not compromise, and should not be seen to compromise, its ability to regulate the profession in the public interest. The *HPA* relies on a structure that prohibits the melding of roles between the regulatory body and the professional association. Thus, the concerns discussed in this section would be addressed were all professions governed under the *HPA*.

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3. Power to Approve Educational Programs

In four profession-specific statutes, the regulatory body plays some role in the approval of educational programs. Under the *Nurses (Registered) Act*, the regulatory body may make rules regarding qualifications for admission to approved schools, and the board must be satisfied as to an applicant's qualifications before she or he may be admitted to an approved school. These functions are beyond the proper scope of the mandate of a regulatory body.

The Council recognizes that the regulatory bodies are knowledgeable about the health profession and can be a valuable and primary resource in designing educational programs. Although it may be appropriate for the colleges to set admission requirements for entry to the practice of the profession and to have input on curriculum development, giving them the power to approve schools is more than the public interest requires. A regulatory body's role in "approval" of educational programs should be limited to approval for the purposes of registration. It should not be given the power to determine whether a school can exist at all. Further, while it is appropriate for a regulatory body to regulate the entry of professionals into practice, it is not necessary or desirable for the regulatory body to have such a role in the admission of applicants to educational programs.

Virtually all health professions are given the power to determine which educational programs meet their educational requirements. In many instances, the regulatory body relies on the opinions of national or international accreditation bodies. The decision as to whether a particular institution will be approved for registration purposes is clearly significant as it can affect many potential registrants and may arbitrarily limit the number of practitioners in the profession. Therefore, it is important that all health professions give careful consideration to this issue and act in the public interest, so as not to use arbitrary standards as a barrier to entry into practice. The Council also supports independent oversight in this area, and believes that rules adopted by regulatory bodies should be subject to cabinet approval.

However, the Council does not believe it is in the public interest to simply remove approval powers from the health profession colleges without ensuring that some body is responsible for approving health profession schools. The solution may be to have the health profession colleges act in an advisory capacity to government, which will have the final decision-making power.

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4. Interim/Permanent Injunction Powers

Section 52 of the *HPA* provides that a board may apply to the Supreme Court for an interim or permanent injunction to restrain a person from contravening the act, the regulation or its bylaws. The Council dealt with this issue in several preliminary reports. Naturopathic physicians, registered nurses and chiropractors offer no objection to the inclusion in their statute of an injunction power to protect the public from registrants who have violated, are about to, or currently violate the act, regulations or bylaws. This provision is an important public protection measure which should be included in a health profession statute.

In its submission on this provision, the College of Physicians and Surgeons of British Columbia raised an issue about enforcement of professional statutes. That issue is addressed on [page 62 in section V](#) of this report "Revisions to the *Health Professions Act*."

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B. REGISTRATION REQUIREMENTS FOR ENTRY INTO THE PROFESSION

Schedule B to the [Terms of Reference](#) makes three important points under this heading:

- First, natural justice and fairness must be reflected in the admission criteria and application process for newly graduated and foreign trained applicants.
- Second, there must be objective requirements for registration and accreditation of education programs.
- Third, applicants should have appropriate rights of appeal affecting registration decisions.

1. Requirement of "Good Character"

The core principle that there must be objective requirements for registration poses a significant issue with respect to the typical registration requirement of "good character" or "good moral character." A number of submissions by the health professions point out the significance of such requirements for registration with a college. For example, one health profession states in its submission:

...[T]his requirement is in the public interest. These factors impact significantly on a person's suitability to practice a health profession. Thus the mandate of regulatory bodies should include the right and ability to fully investigate and assess such matters.

Similarly, one regulatory body states that:

...[I]t is in the public interest as it establishes as paramount the principle that only persons of good character are to be registered with the College.

Essentially, the six health professions that require applicants to be of "good character" or "good moral

character" justify it as being in the public interest. The Council's initial concern was that the terms may inject a significant degree of subjectivity into the decision-making process. However, the Council recognizes the need for such provisions and is satisfied that the *core principles* of professional regulation are not violated. The concept of good character has long been recognized in the common law as an appropriate requirement for registration in professional bodies. The Council emphasizes that this discretionary power be exercised with utmost consistency and fairness.

2. External Appeal of Registration Matters

One of the *core principles* under this heading is the provision for appropriate rights of appeal affecting registration decisions. The *HPA* contains such a right under section 20(4):

A person whose application for registration as a member of a college is refused by the registration committee may appeal the refusal to the Supreme Court . . .

Six of the health profession statutes reviewed by the Council do not contain an external right of appeal, though some provide for an internal appeal, usually to the college's board. One profession submitted that an external right of appeal is an unwarranted intrusion on a regulatory body's discretion to determine who may become a member of the profession. However, the trends in recent case law indicate that courts do defer to administrative tribunals acting within their area of expertise. Further, given the serious implications of registration decisions which involve the right to practice one's profession, a health profession statute must contain an express right of external appeal from registration decisions.

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3. Registration Process

Section 20(1) of the *HPA* provides:

The registration committee is responsible for granting registration of a person as a member of its college.

Several health professions disagree with the registration process under the *HPA*. Some health professions, generally those with large numbers of practitioners, indicated that the process of registration is an administrative process which is handled by their registrar. Other, generally smaller, professions stated that their board handles all registration decisions directly, without the assistance of a committee or registrar.

Under the *HPA*, a health profession college must create a registration committee to handle all applications. During the review process, the Council was persuaded that the creation of this committee should be discretionary. For professions in which there are set mechanisms and bodies in place to handle the registration process in a competent manner or where there are very few applications for registration received, a registration committee need not be established. Further, for larger professions where the requirements for registration are so clear that they leave nothing to do for the appropriate committee but to ensure compliance therewith, the registrar can aptly handle this administrative task.

In order to address the concerns raised by the professions, the power to deal with applications for registration ought to be granted to the college boards, and provision made for delegation of that task to either a committee

or the registrar. Additional comments regarding the committee structure and the registrar's role under the *HPA* will be made in the section, "[Revisions to the Health Professions Act](#)," commencing on page 54.

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C. QUALITY ASSURANCE MECHANISMS

Schedule B of the [Terms of Reference](#) states that there should be:

- effective mechanisms for monitoring practitioner competency including the ability to set continuing education requirements, and
- a committee of the board should be responsible for reviewing standards of practice and codes of ethics.

During the review, all health professions provided information about their quality assurance mechanisms. While the programs vary amongst the professions, all have programs in place to maintain professional competence that indicate substantial compliance with this *core principle*.

For example, the Registered Nurses Association of British Columbia maintains a nurse-client relations program which seeks to prevent professional misconduct of a sexual nature. It also endorses the codes of ethics of both the Canadian Nurses Association and the International Council of Nurses and is involved in a project aimed at updating the codes of ethics. Similarly, the College of Dental Surgeons of British Columbia maintains a patient relations program, a committee with the responsibility for developing a standards of practice document, and has had an ethics committee for four decades. The College of Physicians and Surgeons of British Columbia maintains several committees committed to monitoring practitioner competence, including the Preliminary Review Committee and Sexual Misconduct Review Committee, the Ethical Standards and Conduct Review Committee, and the Committee on Office Medical Practice Assessment.

The Council was impressed by the commitment of all health professions to the task of quality assurance. All appear dedicated to maintaining high standards of excellence and ensuring public protection in the public interest. Two specific issues are worthy of comment.

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1. Continuing Education

Although some professions have mandatory requirements for continuing education, several professions indicated that mandatory education requirements were not the best means of ensuring continuing competency and quality practice. For example, the College of Physicians and Surgeons of British Columbia stated:

With respect to mandatory continuing education, there is considerable evidence that this does not significantly alter the actual performance of physicians. We would be pleased to provide copies of literature which support this view. In addition, the available mandatory continuing education does not always match the needs of the physician. Rather than mandating participation in specific medical education activities, the College has elected to do evaluations of physicians' actual performance in

practice. Programs such as the Office Medical Practice Assessment Program ... and the Triplicate Prescription Program, which monitors the use of narcotics, are examples of such evaluation of performance.

The Council agrees with these comments about mandatory continuing education and accepts that it is only part of the greater goal of ensuring quality practice. Many other mechanisms, such as those described above, are equally if not more effective in ensuring quality practice. These other mechanisms also ensure that a regulatory body can tailor the programs to match the needs of its profession. The core principle regarding quality assurance appears to recognize these other mechanisms, as it states only that there should be the ability to establish continuing education requirements, not that they should be mandatory. In the final analysis, it is up to each profession, in accordance with its public interest mandate, to determine the appropriate means of ensuring quality practice.

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2. Committee Structure

Several professions indicated that the committee structure under the *HPA* is too onerous. Section 19(1)(t) states:

A board may, by bylaw for its college, do the following:

...

(t) establish a registration committee, a quality assurance committee, an inquiry committee, a discipline committee, a patient relations committee, and other committees the board determines are necessary or advisable;...

The British Columbia College of Chiropractors stated that this section imposes onerous administrative structures, and the need for numerous committees when the board of their college is already responsible for matters which may fall within the mandate of such committees. For example, the British Columbia College of Chiropractors stated that its board deals directly with most quality assurance matters. The Council accepts this submission, and agrees that the legislation governing the professions must be sensitive to the administrative burden imposed on regulatory bodies. Unless there is a demonstrated need for a specific committee to deal with an issue, regulatory bodies ought not to be required to create such committees. Section 19(1)(t) appears to recognize this, as it is discretionary, and does not mandate that regulatory bodies establish all of these committees.

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D. COMPLAINTS AND DISCIPLINARY PROCESS

A review of the *HPA* and the principles outlined in schedule B to the [Terms of Reference](#) indicates that a designated health profession's complaints and discipline process must, at a minimum, incorporate the following key elements:

- i. the investigative and adjudicative bodies must be made up of different people and the bodies administered independently;
- ii. dissatisfied complainants and registrants must be afforded rights of appeal;
- iii. the process must be consistent with the rules of natural justice, and provide for proper notice of a proceeding and a right to be heard; and
- iv. the process must not be complex: complainants and registrants must understand how the process works.

Under the existing regulatory system, each health profession has its own complaints and discipline process, and wide variations exist in how disciplinary matters are addressed by the professions. The Council analyzed each profession's system in detail. While some professions generally satisfied the *core principles* set out in the *HPA* and [*Terms of Reference*](#), others fell far short. Further, virtually every profession contained some provisions which were inconsistent with the *core principles* of regulation. This section contains a summary of the significant issues raised in the Council's review.

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1. Inquiry Committee Procedures

Under the *HPA*, the inquiry committee is responsible for investigating complaints, and has the power to dismiss the complaint or order that a disciplinary committee be convened to conduct a hearing. Section 33 of the *HPA* requires that certain minimum procedures be followed by the inquiry committee including investigating a complaint, requesting the registrant who is the subject of an investigation to provide it with any information, and considering such information.

Several health profession statutes do not contain such provisions though most indicated that similar procedures are followed in practice. At least one profession objected to the inclusion of such provisions. The College of Dental Surgeons of British Columbia stated that these requirements would make the "investigating body a decision making body with all the attendant problems", and that an investigating body should not have to observe the rules of natural justice.

However, recent jurisprudence clearly indicates that even in circumstances where natural justice does not apply, procedural fairness does and there is always a duty to be fair. Further, section 33 of the *HPA* provides basic, minimum fairness requirements, and are far from onerous to apply in practice. All health profession statutes ought to contain a similar provision.

However, the Council accepts the submissions of several professions which stated that the requirement for a committee to investigate all complaints is too onerous, and that a more expeditious process is appropriate in many cases. This issue will be discussed further in section V, [*Revisions to the Health Professions Act*](#), on page 59.

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2. Right to Internal Appeal

The right to an internal appeal refers to the right of a complainant to appeal a decision to dismiss a complaint. Section 34(2) of the *HPA* provides a complainant with a right to appeal such a decision to the board of a college. Several of the existing statutes provide rights of internal appeal though some do not. The professions which do not have a formal right of internal appeal indicate that in practice complainants are entitled to request a review. No profession raised significant objections to this provision, and the Council believes that this right should be part of the legislative scheme for all health professions. The right of external appeal through the courts is not economically feasible for many complainants.

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3. Separation Between Investigative and Adjudicative Functions

The *core principles* dictate that the investigative and adjudicative bodies must be composed of different people and administered independently of each other. Several of the professional statutes contain provisions which are inconsistent with this principle. For example, one health profession statute allows the same persons who initially receive the complaint to adjudicate upon it. Another statute allows the board of the college to initiate investigations, adjourn them and suspend registrants pending disciplinary hearings. Further, the same board can review a complaint after it has been heard, and can make rules "creating discretionary powers related to the discipline and control of currently or formerly registered members". Finally, the council of one health profession's college selects from amongst itself the persons to conduct a hearing, and then determines the penalty to be imposed after the matter has been heard.

Such situations raise the potential for overlap between the investigative and adjudicative functions. Separation of these functions is not only a core principle, it is a fundamental principle of administrative law. The people hearing a disciplinary matter must have no prior knowledge of the subject matter of the complaint or investigation. This principle is embodied in part III of the *HPA* which provides that the inquiry committee is responsible for investigating complaints and the discipline committee conducts the hearings.

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4. Open Disciplinary Hearings

Section 38(3) of the *HPA* sets out the general rule that discipline hearings are open to the public. It also sets out the circumstances in which the discipline committee may conduct hearings *in camera*.

Section 38(3) of the *HPA* states:

(3) A hearing of the discipline committee must be *in public* unless

- a. the complainant or the respondent requests the discipline committee to hold the hearing *in private*, and

- b. *the discipline committee is satisfied that a private hearing would be appropriate in the circumstances.*

(4) *At a hearing of the discipline committee,*

- a. *the testimony of witnesses must be taken on oath, which may be administered by any member of the discipline committee, and*
- b. *there must be a full right to cross examine witnesses and call evidence in defence and reply.*

Sections 23(3) and 12(5)(a) to (d) of the Model Bylaws under the Health Profession Bylaws provide more detail regarding the circumstances in which the public may be excluded from a disciplinary hearing:

(5) *The board may exclude any person from any part of a meeting if it is satisfied that*

- a. *financial or personal or other matters may be disclosed of such a nature that the desirability of avoiding public disclosure of them in the interest of any person affected or in the public interest outweighs the desirability of adhering to the principle that meetings be open to the public.*
- b. *A person involved in a criminal proceeding or civil suit or proceeding may be prejudiced.*
- c. *Personal matters or property acquisitions will be discussed.*
- d. *The contents of examinations will be discussed.*
- e. *Communications with the Office of the Ombudsman will be discussed, or*
- f. *Instructions will be given to or opinions received from legal counsel for the college, board, or committees.*

Several health profession statutes contain a provision requiring that disciplinary hearings be held in the absence of the public. Generally, the professions support closed hearings on the basis of sensitivity and the fear that complainants will be discouraged from bringing forth complaints. The College of Psychologists of British Columbia makes a specific objection:

Making disciplinary hearings open to the public will be undesirable to a large number of complainants. This is especially true in the mental health area given the still common stigma of mental health problems. While 37(a) and (b) allow non-public hearings in certain cases, it should be obvious that the popular media, depending on the anticipated titillating or scandalous content of the hearing, will fight against closed hearings if there is an opportunity for an open hearing. In fact, the spectre of a public hearing in which one's mental health and/or sexual history are examined and cross-examined may lead to fewer complaints by legitimately harmed patients.

The Council appreciate the sensitivity of disciplinary proceedings, and the potential impact on people's privacy. At the same time, the Council believes it important that these hearings be open to the public in order to ensure that the process is fair and to ensure that the regulatory bodies are fulfilling their mandate to protect the public.

That said, the Council appreciates that in certain circumstances, hearings should be closed. That is the purpose of the exceptions described above. Rather than closing all hearings, the Council supports a general rule of open hearings subject to exceptions in specified circumstances.

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5. Mediation and Alternative Dispute Resolution

Section 33(6) of the *HPA* empowers the inquiry committee to take measures to informally resolve complaints. It states that the inquiry committee may "take any action it considers appropriate to resolve the matter." Section 63 of the Model Bylaws under the *HPA* sets out procedures for mediation. In addition, section 36 of the *HPA* empowers the inquiry committee to resolve matters by asking a registrant to make undertakings and consent to a reprimand.

Alternate dispute resolution (ADR) is widely accepted throughout society as a process that promotes settlement of issues without the time, expense and emotional involvement associated with traditional dispute mechanisms. In the courts, increasing recognition of the limits of ordinary litigation as a means of resolving disputes, crowded trial lists and concerns about expense and delay make litigation less attractive. Further, a general consensus appears to have developed that participants in the process appreciate the informality, efficiency and speed with which matters are resolved.

ADR takes different forms. In arbitration, a dispute is submitted to an arbitrator for a decision. Arbitration may be binding or non-binding (advisory). Mediation is also a form of ADR. It is a process for resolving disputes with the aid of a neutral third party. The third party's role is to assist the parties, privately and collectively, to identify the issues in dispute and develop proposals to resolve the disputes.

Several health profession statutes contain provisions for various forms of ADR. Other professions engage in ADR as a matter of practice. Virtually all health professions strongly support ADR. Likewise, the Council is convinced that ADR has a strong role to play in professional disciplinary matters, and broad provisions ought to be enacted in order to grant the necessary powers to the professions to engage in ADR. The Council will discuss this issue further in the section "[Revisions to the Health Professions Act,](#)" on page 62.

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6. Offences

Section 51(3) of the *HPA* prohibits prosecution of offences under the *HPA* after two years. Most health professions statutes do not contain such a provision but little objection was made to this provision. One profession submitted that a two-year limitation is inadequate because many complaints are not made within two years. However, this provision applies to offences under the *HPA*, not to disciplinary proceedings launched by a regulatory body, and the Council supports the inclusion of this provision.

Sections 13, 19 and 30 of the *HPA* create offences for practising a profession under the *HPA* when prohibited to do so, for registering or continuing to be registered as a member when not qualified to do so, and for obstructing an inspector in the lawful performance of his or her duties. Section 81 of the *Dentists Act* provides that it is an

offence for a person to give a public demonstration of skill in the practice of dentistry or to demonstrate or exhibit to the public specimens, models or examples of work. The Council recognizes that the role of a college includes regulating advertising and marketing of services. However, the Council believes that the disciplinary powers of a regulatory body are sufficient to address such matters, and that creating an offence and the stigma that goes with it is more than is necessary to regulate such matters. The offence provisions of the *HPA* adequately address the matters for which penal sanctions are appropriate.

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7. Uniform Complaint and Disciplinary Process

Quite aside from the issue of consistency with the *core principles* of regulation, another advantage of the *HPA* model is that it creates a uniform complaints and discipline process. The Council believes this to be a significant advantage over the present regulatory system. Under the existing regulatory system, each profession is governed by its own professional statute. The terminology used as well as the regulatory structures and processes created vary widely from profession to profession, especially with respect to the complaints and discipline process. This variation and resulting complexity is confusing to the public and registrants. A uniform regulatory system under the *HPA* would eliminate much of the complexity and confusion, and foster the development of a common jurisprudence for the health professions.

The Seaton Commission on page D-30 made a strong recommendation for establishing a uniform complaints and discipline process among British Columbia's health professions:

There is a lack of consistency among the 16 provincial acts that govern the health care professions, despite the fact that all of the colleges established under the acts have the same legislative mandate: to protect the public from preventable harm. Such inconsistency increases the likelihood of variations in judicial interpretations of the acts. Underlying this situation are persistent jurisdictional disputes and a distinct lack of cooperation among the health care professions.

...

In general, a lack of consistency characterizes the acts with respect to complaints, discipline and appeals, resulting in insufficient public accountability, no uniformity in the structure or organization of the different statutes, and an absence of common terms. The areas of greatest inconsistency are:

- the college's rule-making authority
- the way complaints are received and addressed,
- the requirement to report incompetent members,
- the power to discipline former members,
- the use of pre-hearing suspensions,
- the availability of judicial restraining orders or injunctions,
- the description of the acts or omissions which may lead to a disciplinary action,
- the type of disciplinary action which may be imposed,
- the awarding of costs at the end of a disciplinary hearing and the maximum amount which can be awarded,
- the procedures by which disciplinary hearings are initiated, held and resolved,
- the member's rights, such as notification of hearings and obtaining a decision with reasons,
- the procedures to address a member's failure to appear at a hearing,

- the college's powers at a hearing,
- the right of appeal, what may be appealed and the limitation period for initiating an appeal,
- the requirement that an internal review take place prior to initiating an appeal to the Supreme Court and the requirements for such review

...

The [Health Professions Act](#) has the potential to influence significantly the future of self regulation of health care professions. Under this new Act, the Health Professions Council can make recommendations to the minister concerning which groups should be granted self-regulation status, their titles, and the extent of their scopes of practice, if any. The Act could be used to create uniform legislative procedures.

In its 1995 report Principles and Recommendations for the Regulation of Health Professionals in Alberta, Alberta's Health Workforce Rebalancing Committee recommended on page 12 (recommendation 10) that,

[P]rofessional legislation should incorporate a range of structures and processes to address consumer and professional concerns about unethical or incompetent professional practice.

The Committee stated that common structures and processes be established for all regulated health professions and that the processes be as open and as transparent as possible to the complainant and to the public.

Similarly, in the United States the Pew Health Professions Commission (Pew Commission), in its report, *Reforming Health Care Workforce Regulation, Policy Considerations for the 21st Century*, Report of the Taskforce on Health Care Workforce Regulation, recommended on page 29 that, "[s]tates should maintain a fair, cost effective and uniform disciplinary process to exclude incompetent practitioners to protect and promote the public's health." It also proposed the following policy option:

Establish uniform complaints and discipline processes for all regulated health professions to ensure that all investigations of complaints are handled in an objective, prioritized, and timely manner. The concerned parties should be informed of the progress of the complaint and investigation on a regular basis.

The Pew Commission found that problems in this area fall into four categories: First, there is insufficient information dissemination to the public; second, complainants are often not informed about the progress of their complaint; third, boards are not seen as vigorously pursuing complaints of health professionals' misconduct or incompetence; and fourth, boards are often criticized for taking too long to resolve a complaint and for imposing inappropriate or ineffective sanctions.

Thus, the Seaton Commission, the Health Workforce Rebalancing Committee of Alberta and the Pew Health Professions Commission call for uniformity in the complaint and disciplinary process of health profession colleges. The Council agrees with these recommendations.

E. ACCOUNTABILITY MECHANISMS

Schedule B to the [Terms of Reference](#), under the heading, Accountability Mechanisms, states that there should be a requirement for government approval of rules or bylaws. Such a provision is embodied in section 19(3) of the *HPA*. Further, section 19(5) provides that the Minister may request a board to amend or repeal an existing bylaw or make a new bylaw for the college if the Minister is satisfied that this is necessary or advisable. Section 19(6) of the *HPA* provides that where a board does not comply with a request under section 19(5), the Lieutenant Governor in Council may amend or repeal the existing bylaw for the college or make the new bylaw for the college.

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1. Cabinet Approval of Rules

Section 19(3) of the *HPA* provides that a regulatory body's rules do not take effect until they are approved by cabinet. Before addressing the concerns raised, the Council will provide some background regarding the principles of self-regulation.

It is well established that self-regulation is a privilege not a right. Government grants a profession certain rights, such as the exclusive right to use a title or perform certain services, in return for which the profession agrees to regulate the profession in the public interest. As the Seaton Commission stated on page D-29:

The purpose of regulating members of a profession is to protect the public from preventable harm. The privilege of self-regulation 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.

Self government is simply a delegation by the state of its regulatory authority in the professional sphere. (Emphasis added)

In the Supreme Court decision of *Costco Wholesale Canada Ltd. v. British Columbia Association of Optometrists*, [1998] B.C.J. No. 646, Mr. Justice Lowry emphasized the public nature of a regulatory college's rules:

The rules are not merely private and non-governmental in nature, but have a direct and indirect public dimension in carrying out the government's regulatory scheme.

In that decision, the Court struck down various rules under the *Optometrists Act* as being in violation of the *Canadian Charter of Rights and Freedoms*. The nature of the relationship between self regulatory bodies and the state was also addressed in the Foulkes Report on page 136:

Thus it is clear that the principle of state primacy over professional decisions has been understood and established over a considerable period of time. In this manner it has been established that the state has not only a continuing and lively interest in the regulation of professions, but that the state has merely delegated to the professions the power of self-government as long as that power is exercised in a manner consistent with the public interest. The state has not abdicated its ultimate authority, but has established the primacy of public legislation over the private regulatory arrangements of the professions.

The government maintains fundamental control over self-regulatory bodies through the legislative process through which it can make, amend or repeal a statute. The government can, at any time, change the regulatory structure. Further accountability mechanisms are frequently enacted through provisions requiring open meetings, public membership on boards and committees, the duty to submit an annual report and review by the ombudsman.

The ability to review and scrutinize regulatory instruments is simply another means by which government supervises the grant of self-regulation.

The Foulkes Report discussed the general issue of accountability on page 135 to 136 and stated:

[M]ost jurisdictions not only insist that professional law must be public law, as passed by the legislature and reflecting public policy, but also insist that any bylaws, rules or regulations under professional statutes be reviewed by public authorities and if necessary revoked and repealed by the state. For example, since 1948 the Province of Saskatchewan has written into law the provision that any bylaws, rules or regulations passed by the governing council of a profession must be submitted to the Department of the Provincial Secretary within thirty days of being made, and that these bylaws, rules and regulations may be reviewed by the Legislative Assembly. If these supplementary regulations under the Act are found by the legislature to be beyond the power of the professional body, or to be prejudicial to the public interest, they may be revoked and repealed.

The Foulkes report commented on the lack of a mechanism for reviewing professional rules and regulations in British Columbia on page 40, Part Two:

[A]lthough there can be no doubt that the legislature has the power to amend professional statutes, at present there is no effective agency able to perform a careful, continuous, and detailed review of such statutes and professional regulations.

This led the committee to recommend the creation of a tribunal to scrutinize regulations and revoke such regulations if necessary.

A provision requiring government approval of rules or bylaws is very common in professional legislation. In addition to the *HPA*, which already applies to several professions, section 5 of the *Medical Practitioners Act* states:

(1) The council of the college must govern, control and administer the affairs of the college, and without limiting those powers, may make rules as follows:

...

(4) A rule under subsection (1) has no effect until it is approved by the Lieutenant Governor in Council.

The *Dentists Act* contains a similar provision in section 28:

(1) The council may make rules for the governing of the profession of dentistry, the college and registrants and for the carrying out of this Act.

(2) No rule comes into force until approved by the Lieutenant Governor in Council.

Section 9 of the *HPA* currently applies to the several professions governed under the *HPA* many of which have a long history of self-regulation. Virtually all health professions' rules are subject to cabinet approval.

One exception is the *Nurses (Registered) Act (NRA)*. Under the current *NRA*, the Registered Nurses Association of British Columbia (RNABC) is granted a broad rule-making power. Under section 9, the RNABC has the power to make rules "[f]or the better administration of [the] Act," and for many specific matters, including

- "curricula and standards of schools of nursing";
- "qualifications for admission to an approved school of nursing"; and
- "registration of persons wishing to become registered nurses."

Pursuant to section 9(5) only the rules related to licensed graduate nurses and to the curricula and standards of schools of nursing are subject to cabinet approval. Thus, at present the RNABC has a very broad, unfettered rule-making power.

The RNABC indicates its preference for the current process for rule approval under the *NRA* and its strong opposition to the *HPA* process:

Requiring government control over every substantive structural or process decision is the antithesis of self governance and undermines the concept of professional responsibility and accountability which is at the heart of any profession. Society does not look to professionals as a department of government, but as the repository of skills that are exercised independently of bureaucratic and political influence. A government's role must be limited to ensuring that the professions meet certain minimum standards of accountability, but that does not include "second guessing" every decision of the profession relating to its processes and standards of practice and ethics, in respect of which government has no particular expertise. It is the practising professionals themselves who are the best judge of what the practice standards should be.

...

Having the authority to make rules is obviously in the public interest. Creating impediments to the rule making authority is not in the public interest and in the absence of evidence that the authority is being abused, it should not and need not be changed.

The ability of cabinet to approve professional bylaws is widely recognized. As the various excerpts above indicate, all professional statutes are public statutes and represent the delegation of state powers to independent self-regulatory bodies. They are not primarily for the benefit of the professions but, rather, embody the public interest, and their provisions can have a profound impact on the public. Therefore, the Council supports a requirement for cabinet approval of professional bylaws. That said, the Council sees merit in the RNABC's submission that not every procedural or structural matter need be approved by cabinet. Many administrative and internal issues, such as voting procedures for college elections, banking and financial matters and appointment of officers can properly be dealt with in the absence of cabinet approval. Another issue raised by the professions was the considerable time it takes to receive approval of bylaws or rules. The Council will provide further details on these issues in the section, "[Revisions to the Health Professions Act,](#)" on page 56.

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2. Cabinet Rule-Making Power

There was widespread opposition to section 19(6) of the *HPA*, which provides that cabinet may make rules for a health profession. The professions contend that this power is contrary to the principle of self-regulation because it is inconsistent with the notion that expert delegates should formulate rules on professional ethics and practice standards. The professions also state that the provision is contrary to the concept of self-regulation because the Lieutenant Governor in Council should only be vested with a supervisory function in the form of his or her ability to refuse or approve rules of a health profession college.

The medical practitioners summarized the concern as follows:

In our respectful view, the Lieutenant Governor in Council should not be given the absolute right to impose a rule unilaterally. The concept of self-governance is that rules (and by extension, standards and ethics) are passed by peers and, accordingly, are entitled to some considerable degree of deference by the courts.

It is our view that the strength and success of self-governance rests with the independence of the profession and to the extent it is weakened or eroded, so too is the credibility of self-governing bodies. There must of course be accountability and, in our view, this is provided for in the M.P.A. At present, section 4(2) of the M.P.A. provides that the Council of the College may make Rules with respect to any of the areas itemized in section 4(2)(a)-(k) of the M.P.A. Pursuant to s.4(5) of the M.P.A., a Rule has no effect until it is approved by the Lieutenant Governor in Council. To this extent, therefore, there is a review process in place.

The existing M.P.A. provides adequate checks and balances in terms of its committee structure. There is one-third public representation on committees and Council. In addition, there are annual reports by the College to government and the requirement that the Lieutenant Governor in Council approve any changes to the Rules. The government retains control over amendments to the M.P.A. In addition, with respect to the College's procedures, the College is now subject to the jurisdiction of the Office of the Ombudsman.

Given the above, it is our submission that the H.P.A. provision which gives the Lieutenant Governor in Council the power to amend the College Rules is neither required nor acceptable.

The Council recognizes the important distinction between approval of bylaws by cabinet and by the legislature or some other independent agency. Further, the bylaw-making power set out in section 19(6) of the *HPA* is clearly a greater power than the power to review and scrutinize regulations.

Although a provision like section 19(6) of the *HPA* does not appear in any of the individual profession-specific statutes, section 19 currently applies to the several professions governed under the *HPA*, many of which have a long history of self-regulation.

A similar provision is contained in section 63 of the *Pharmacists, Pharmacy Operations and Drug Scheduling Act*. The Lieutenant Governor in Council recently exercised its powers under this section on the issue of releasing prescription information for commercial purposes. The College of Pharmacists had proposed that

prescription information must not be provided to a third party for any purpose other than patient care without the fully informed, written consent of the pharmacist, patient and prescriber. The Minister's main concern was that with the release of such information under any circumstances, drug companies would be able to target sales presentations to physicians. After negotiations with the college, the Minister recommended to the Lieutenant Governor in Council that release of information for commercial purposes be prohibited. As a result, the Lieutenant Governor in Council passed a new bylaw which effectively overrode the College of Pharmacists' position.

A provision like section 19(6) of the *HPA* has been in place in Ontario for over twenty five years. Under the *Ontario Health Disciplines Act*, SO 1974, c. 47 (*HDA*), which was enacted in 1973, most of the health professions' regulation-making power was subject to ministerial review and cabinet approval. In addition, the *HDA* also gave the minister the power to review and make, amend or revoke regulations. Section 3 stated:

3.--(1) It is the duty of the Minister to ensure that the activities of health disciplines are effectively regulated and co-ordinated in the public interest, to have appropriate standards of practice developed and ensure that these are maintained and to ensure that the rights of individuals to the services provided by health disciplines of their choice are maintained and to these ends to,

c. review proposals by a Council for changes in legislation or regulations of concern to that Council;

....

e. request a Council to make, amend or revoke regulations respecting any of the matters specified in its applicable Part...

...

(2) Where the Minister requests in writing that a Council make, amend or revoke a regulation under clause (1) (e) and the Council has failed to do so within sixty days after the request, the Lieutenant Governor in Council may make the regulation, amendment or revocation specified in the request.

The successor legislation to the *HDA*, the *Regulated Health Professions Act*, RSO 1991, c.18 (*RHPA*) contains similar provisions. Section 95 of the *RHPA* contains an extensive list of a regulatory body's rule-making powers which are subject to cabinet approval. Section 5(1)(c) of the *RHPA* provides that the minister may, "require a Council to make, amend or revoke a regulation under a health profession act or the *Drug and Pharmacies Regulation Act*."

The medical practitioners refer to the Ontario case of *Szmuilowicz v. Ontario (Minister of Health)* (1995), 24 O.R. (3d) 204, Ontario Court, (General Division), Divisional Court, and submit that the case illustrates the difficulties which arise when regulations are enacted by government rather than by a self-regulating body.

In that case, the Ontario minister of health asked cabinet to pass a regulation making it an act of professional misconduct for a physician to charge a block or annual fee for all uninsured services a physician may provide to a patient. The College of Physicians and Surgeons of Ontario (CPSO) had earlier refused to make such a regulation. The CPSO challenged the regulation in court, and it was struck down.

The basis for the decision was that the government had exceeded its regulation-making power. The statutory

provisions in question, though not identical to section 19(6) of the *HPA*, were very similar in that they granted the Lieutenant Governor in Council the power to make regulations which the CPSO refused to make. The court determined that the Lieutenant Governor in Council's power was not unfettered. Rather, the power must be exercised with due regard for the purpose and intent of the statute. In *Szmuilowicz*, the court found that the government's purpose in enacting the regulation-to ensure accessibility and prevent abuses of "extra-billing"-was not consistent with the purposes of the *Medical Practitioners Act*. A key factor in the court's decision was the extensive evidence that the profession did not consider block billing to be professional misconduct.

The court discussed the limits of ministerial rule-making power and stated:

When the Minister sees fit to override a determination made by a self-governing body of professionals authorized by the legislature to determine such issues, the views of the self-governing body of the profession should be taken into consideration by the court in determining whether the Minister pushed the definition of "professional misconduct" beyond permissible limits, given that the term is peculiarly defined by the standards of the profession...

The court found in this case that the minister must be careful not to overstep the limits of his or her rule-making power, but the rule-making authority itself was not put in question.

The College of Physicians and Surgeons of British Columbia submits that this case illustrates the difficulties that can arise when the government attempts to define what is ethical. Clearly, the court in *Szmuilowicz* was not satisfied with the government's views on the issue of block billing, and the government was specifically rebuked for ignoring the views of the CPSO. The Council believes that the important principle to be extracted from this case is that the powers created by such a section are not unfettered but must be exercised having regard to the purpose of the statute and only after considering the regulatory body's position on the issue. In short, government cannot override a professional college's views on an issue without good reason. Thus, the case provides an important series of checks on the cabinet's rule-making power and demonstrates the court's willingness to intervene when the cabinet fails to accord appropriate deference to a professional college.

Thus, judicial review as applied in the *Szmuilowicz* case simply provides for another safeguard for the health professions, namely the courts' willingness to review the minister's discretion in making rules for a health profession college. Clearly, the minister's rule-making power is not unfettered.

While the professions recognized and accepted that the legislature has ultimate supervisory control over the professions since it can amend statutes, they felt that granting rule-making authority to the government of the day created a potential for improper political interference. The Council believes these concerns to be overstated. The Ontario government has had the rule-making power for 27 years, and the Council is aware of only one instance of its use, and that was in the *Szmuilowicz* case. There, the court overturned the ministry's attempt to impose a bylaw and set out specific limits on the rule-making power of the minister. It is important that government maintain ultimate supervisory authority over the powers it has delegated to the professions. In the Council's view, the order-in-council process required to make a rule or bylaw, along with the ability to seek judicial review of such decisions, provides a sufficient check on the exercise of governmental powers under this subsection.

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3. Public Access to Register and Bylaws

The issue of public access to the college register and bylaws was considered in a number of preliminary reports. Section 22 of the *HPA* provides for open access to the register. Objections were made to this provision because present registers of health professions contain various personal information of registrants, such as home phone numbers and addresses. The Council understands the privacy concerns but is of the view that such issues can be addressed through the design and operation of the register. It is important that a regulatory body keep a publicly available and up to date record of members' names and business addresses, as well as their registration status. The Council will suggest an amendment to this provision in the section on "Revisions to the *Health Professions Act*," below.

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F. THE HEALTH PROFESSIONS ACT BYLAWS

The *Terms of Reference* direct the Council to conduct a comparative analysis of the *HPA* with each professional statute, along with any relevant rules, regulations or bylaws, in order to ensure that they contain the core principles of professional regulation. The *Terms of Reference* also indicate that the *HPA* embodies those core principles of professional regulation which the Minister considers are desirable or essential for regulating the profession in the public interest.

In the initial phase of the review process, the Council also considered the *HPA* draft bylaws. These bylaws are distributed to newly designated professions as a guide for drafting bylaws for their new regulatory colleges. Several questions in the Council's comparative analysis referred to the draft bylaws. The Council informed the professions that although the bylaws were not legally binding, they reflected the ministry's view of provisions which were desirable for regulating a profession in the public interest.

During the review process, the original draft bylaws were substantially rewritten and many provisions were removed and some added. This complicated the Council's process as its initial questions referred to the original draft of the bylaws. The revisions also underscored the fact that the bylaws were not legally binding and subject to modification, making it somewhat difficult to assess which bylaw provisions embody *core principles* of professional regulation.

Nonetheless, many provisions appear in both versions of the draft bylaws and are also consistent with the *core principles* discussed in the *Terms of Reference*. The Council felt it important to note where provisions in the various health profession statutes could be considered inadequate, incomplete or missing having regard to the draft bylaws. The Council has decided to include its account of such provisions in this separate section in order to reflect the fact that the bylaws have a different legal status than the *HPA*.

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1. Open Board and Committee Meetings

Bylaw 11(2), now bylaw 12(4) of the *HPA*, states that "...the meetings of the board must be open to registrants and to the public." Further, bylaw 12(4), now bylaw 23(3), states that "...meetings of a committee must be open to registrants and to the public."

The Council received objections to the requirement of open board, committee and panel meetings. One membership association expressed concern about telephone conferences and meetings of committees such as an education committee or a legislative and government affairs committee whose subject matters are not necessarily matters for public dissemination. Some regulatory bodies stated that keeping committee meetings open to the registrants and the public will unduly disrupt and delay the proceedings and constrain the candor of the discussion. One regulatory body submitted that openness concerns are already addressed, since the public may have copies of the minutes of its board subject to the *Freedom of Information and Protection of Privacy Act*, RSBC 1996, c. 165. Another health profession college contended that the public is sufficiently represented through the one-third public representation on its board and disciplinary committee hearings.

The Council previously [indicated its support for public disciplinary hearings](#) on page 29 above. Similarly, the Council believes that, as a general rule, meetings of the board, the registration and inquiry committees should be open to the public subject to the exceptions set out in bylaws 12(5)(a) to (d). To the extent that other research or policy committees may be established, the Council believes that their meetings need not necessarily be open to the public.

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2. Public Membership on Committees

HPA bylaws 14(2), 15(2), and 16(2), 17(2), 18(2) and 19(1) provide that the registration, discipline, inquiry, quality assurance, patient relations and executive committees must have at least one-third public membership. Most professions objected to this provision on the basis that the issues under consideration are best judged by a panel of peers and that significant delays may occur in seeking public members for panels. In the Council's view, public membership on major committees is an important public accountability measure and should be included in the professional statute.

3. Mandatory Liability Insurance

HPA bylaw 97 provides for mandatory liability insurance. Virtually all health professions agreed on the importance of this provision. However, one college suggested that the standard amount of \$1 million be omitted, as different health professions require different coverage. The Council notes however that the \$1 million requirement is stated as a minimum requirement for liability insurance coverage.

4. Discipline Committee Records

HPA bylaws 65 and 66 provide that the registrar must keep records of the results of all investigations of the inquiry committee and all decisions of the discipline committee. The bylaws further provide that the discipline committee must record and transcribe its hearings, that the board must publish a notice on the disciplinary proceedings and that the registrar must notify the colleges or associations responsible for the regulation of the profession in other jurisdictions if the proceeding resulted in a limitation or suspension of a registrant's practice. The only comment the Council received suggests that there should be a discretion extended to the health profession colleges not to disclose discipline decisions and records thereof in certain circumstances.

The Council accepts this suggestion but stresses that any discretion be confined to well-defined circumstances. In this regard, Schedule 2 of the Regulated *Health Professions Act* of Ontario, which is the Health Professions Procedural Code, sets out procedural rules applying to all health professions in Ontario. Section 56 provides for the publication of the Discipline Committee's decisions:

56.(1) The College shall publish a panel's decision and its reasons, or a summary of its reasons, in its annual report and may publish the decision and reasons or summary in any other publication of the College

(2) In publishing a decision and reasons or summary under subsection (1), the College shall publish the name of the member who was the subject of the proceeding if,

(a) the results of the proceeding may be obtained by a person from the register;
or

(b) the member requests the publication of his or her name

(4) The College shall not publish the member's name unless it is required to do so under subsection (2)

Further, section 23(3) of the Ontario Health Professions Procedural Code states:

(3) A person may obtain, during normal business hours, the following information contained in the register:

1. Information described in clauses (2) (a) to (c)

2. Information described in clause (2) (d) relating to a suspension that is in effect

3. The results of every disciplinary and incapacity proceeding completed within six years before the time the register was prepared or last updated,

i. in which a member's certificate of registration was revoked or suspended or had terms, conditions or limitations imposed on it, or

ii. in which a member was required to pay a fine or attend to be reprimanded or in which an order was suspended if the results of the proceeding were directed to be included in the register by a panel of the Discipline or Fitness to Practise Committee

3.1 For every disciplinary proceeding, completed at any time before the time the register was prepared or last updated, in which a member was found to have committed sexual abuse, as defined in clause 1 (3) (a) or (b), the results of the proceeding....

These provisions may serve as a blueprint for similar provisions in the *HPA* which the Council believes should distinguish between a disclosure by the Inquiry Committee and disclosure by the Discipline Committee. The Inquiry Committee is, for the most part, an investigative body, and its proceedings precede the laying of formal charges. However, decisions of the Discipline Committee should generally be available to the public

G. CONCLUSIONS FROM COMPARATIVE ANALYSIS

In the preceding section, the Council has discussed generally the issues raised by the Council's comparative analysis of the health profession statutes. Volume II contains detailed reports for each individual profession regarding their particular statute.

The comparative analysis indicated that the professions under review fell into two distinct categories. The first group consisted of those professions whose statutes were so deficient when compared with the minimum requirements set out in the *HPA* and the core principles that there was little reason to consider trying to amend the statute so as to make it acceptable. These statutes are the *Optometrists Act* and the *Podiatrists Act*.

The second group consisted of professions whose statutes by and large met the standards set out in the *HPA* and the core principles. In some cases these statutes contained provisions that are in the public interest but are not contained in the *HPA*. These statutes are the *Chiropractors Act*, the *Dentists Act*, the *Nurses (Registered) Act* and the *Medical Practitioners Act*.

As noted above, however, the comparative analysis is only part of the legislative review process. The other concerns are the desirability of minimizing the number of statutes that govern health professions and the onus on the professions to justify the need for a separate statute. These latter concerns are addressed in the next section of this report, "Designation under the [Health Professions Act](#)".

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IV. DESIGNATION UNDER THE *HEALTH PROFESSIONS ACT*

A. POLICY FRAMEWORK

In considering the issue of whether a profession should be designated under the *HPA*, the Council was directed to consider not only the comparative analysis but also the general policy that designation is the favoured option and that a profession must justify a continuing need for a separate statute. The Council would like to expand on this important issue.

Under the existing regulatory system, each profession is governed by its own professional statute. The terminology used, as well as the regulatory structures and processes created, vary widely from profession to profession, especially with respect to the complaints and discipline process. This variation and resulting complexity is confusing to the public and registrants. A uniform regulatory system under the *HPA* would eliminate much of the complexity and confusion and foster the development of a common jurisprudence for the health professions.

Several recent reports of royal commissions and government policy statements in several provinces have emphasized that an integrated approach to the delivery of health care is in the public interest. Co-ordination and co-operation amongst health care providers is of fundamental importance to such an approach, and a uniform regulatory structure enhances the government's ability to apply health care policy consistently.

One policy initiative for which co-ordination and consistency is particularly relevant is the scope of practice review process the Council recently completed. The ministry requested that the Council review the scopes of

practice of the existing professions with a view to implementing a new regulatory framework for health professions in British Columbia. The key elements of the new framework are broad, non-exclusive scope of practice statements and narrowly defined reserved acts. Reserved acts are those elements of a profession's scope of practice which present such a significant risk of harm that they should be reserved to a particular profession that is qualified to perform them. The new system will create shared scopes of practice, and it is likely that many of the reserved acts will be shared amongst particular professions. A uniform regulatory structure would ease the implementation of the new model of professional regulation.

A general policy favouring a uniform regulatory structure was referred to in the report of the Seaton Commission on Health Care in British Columbia. The [relevant excerpts from that report](#) are set out on page 11 of this report.

The Seaton Commission concluded that the existing health professions acts be repealed and the *HPA* be revised to serve as the umbrella act for regulating health professions.

The general policy of legislative uniformity is also consistent with initiatives in several other provinces—notably Ontario, which has implemented umbrella legislation for the health professions, and Alberta, which is in the process of approving umbrella legislation. The Council agrees with these statements about the desirability of uniformity in legislation and accepts that, as a general rule, designation under the *HPA* is the preferred option. This general policy favouring designation is embodied in the Terms of Reference which refer to the desirability of a "high degree of consistency between statutes" and of "minimiz(ing) the number of statutes that apply to the governance of health professions." Indeed, the Terms of Reference and attached criteria and guidelines make it clear that the Council is to consider whether there are unique features of the profession or other relevant factors that justify a need for a separate statute.

However, the Council again emphasizes that although the policy preference is for uniform legislative structures, the *HPA* model still embodies a strong commitment to self-regulation through the "college" system of regulation.

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B. THE PROFESSIONS' SUBMISSIONS

All of the health professions subject to the Council's legislative review opposed designation under the *HPA*. Most health professions voiced strong objections while a few conceded to the possibility that designation under the *HPA* and the repeal of their profession-specific statute may be beneficial to their profession. Towards the completion of the process, almost all professions appeared to accept the notion of uniform legislation and indicated that they would be willing to accept designation under the *HPA* so long as all professions come under that statute and provided that certain suggested changes were made to the *HPA*. The following are some of the objections to designation the professions raised during the review process.

1. Tradition and Jurisprudence

Some health professions argue against designation under the *HPA* by asserting a long history of regulation. One health profession feels that inclusion under an umbrella act such as the *HPA* would be "a slight on (the health profession's) individuality, uniqueness and historical right to self-regulation."

All the larger health profession colleges advance the argument that designation of their profession under the *HPA* would erase valuable existing jurisprudence about their profession. They believe the jurisprudence is

evidence of a "proven track record and considerable judicial comment of weighty precedential value." One health profession opposes designation under the *HPA* by arguing that, "(n)early 100 years of innovation and evolution in the provisions ... would be lost with no appreciable advantages to the public."

Despite requests for additional information, the Council was not provided with specific examples of precedents that would be lost and the effect that would have on the colleges' processes. Further, decisions by the courts in respect of interpretation of the statute and in particular interpretation of procedural provisions, rarely assess the merits of the provisions. Rather, such decisions take the provisions as granted and simply determine whether they have been applied properly.

In sum, the Council does not believe that tradition and decades of self-regulation are adequate reasons for continuing separate health profession statutes. The Council has already explained that the *HPA* still embodies a commitment to self-regulation. Thus, there exists no such "historical right to self-regulation." Similarly, the arguments about the existing body of precedent under a health profession statute do not justify the retention of a separate statute. No submissions were presented which supported the proposition that significant judicial precedent would be rendered inapplicable and there seems no rational reason why it should.

2. Size and Complexity

Most health professions contend that the *HPA* was enacted to deal with new and emerging professions that need an initial regulatory framework. They state that the *HPA* was not meant to apply to traditional health professions with a sizable membership and a sophisticated regulatory framework that has served the public interest for many years.

While the initial focus of the *HPA* was new and emerging professions, nothing in the *HPA* restricts its application to new professions. Further, the Terms of Reference clearly indicate that the government is contemplating uniform legislation for the health professions, and it has directed the Council to use the *HPA* as its template for assessing the quality of the existing professional statutes. Finally, the Seaton Commission stated on page D-30:

The commission recommends that ... the existing health care profession acts be repealed and a revised [Health Professions Act](#) become the umbrella act for regulating all health care professionals ...

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3. Uniqueness

The Council encountered many declarations of "uniqueness" by the health professions. One health profession claims a unique philosophy which would be lost under the *HPA*, while another lists a number of factors that make it a unique profession, including size, efficient rule-making structure and policy framework. Other health professions simply declare their uniqueness and assert that designation under the *HPA* will destroy their unique characteristics.

The Council acknowledges that each health profession is unique. However, the Council asked each health profession to explain how their uniqueness justifies the retention of separate health profession statutes. None of the health professions claiming uniqueness described specifically how such unique factors support the

continuing need for a separate statute.

The only health profession that presented convincing arguments of uniqueness was emergency medicine. Emergency medical assistants (EMAs) are not self-regulated but, rather, regulated by government. Further, there is only one employer for EMAs, a government body, not a private institution. Training for EMAs is job-specific and standardized because it is provided by only one facility. Also, registration criteria are not as relevant for EMAs, as hiring and licensing takes place only to fill a vacancy. Finally, in Ontario, which has adopted umbrella legislation for health professions, ambulance services continue to function under separate legislation.

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C. CONCLUSIONS

In terms of the Council's analysis of the individual statutes in light of the core principles, the professions fall into two distinct categories so far as the quality of their legislative schemes is concerned

The first group consisted of professions whose statutes were so deficient when compared with the minimum requirements as set out in the *HPA* and the core principles that there was little reason to consider trying to amend the statute so as to make it acceptable. This group includes Optometry and Podiatry.

Therefore, the Health Professions Council recommends that the *Optometrists Act* and the *Podiatrists Act* be repealed and those professions designated under the *Health Professions Act*.

The second group consisted of professions whose statutes, by and large, met the standards set by the *HPA* and which presented valid concerns with respect to uniform legislation. These concerns were largely focused on the notion that uniform legislation which does not include all professions is not an improvement over the present regulatory model. Further, several of these statutes contain provisions that are definitely in the public interest but are not contained in the *HPA*. To simply designate these professions without making changes to the *HPA* would be contrary to the public interest. Thus, although none of the professions provided a persuasive submission that their profession was so unique as to justify a separate statute, they did present compelling reasons why, at the present time, designation under the *HPA* was not in the public interest and it would be appropriate to retain their separate statutes.

This second group includes Chiropractic, Dentistry, Medicine and Registered Nursing, all of which would have difficulties operating under the *HPA* as it currently stands. Each of them has a statute which meets the required standards of the *HPA*, and the public interest does not favour designation under the *HPA* unless various concerns with the provisions with the *HPA*, as it applies to the professions, are addressed. Those concerns are discussed in the following section of this report, "[Revisions to the Health Professions Act,](#)" on page 54.

Therefore, the Health Professions Council recommends that the *Chiropractors Act*, the *Dentists Act*, the *Medical Practitioners Act* and the *Nurses (Registered) Act* be repealed and those professions designated under the *Health Professions Act* as soon as revisions are made to the *Health Professions Act* to reflect the unique features of those professions.

As discussed on [page 51](#) only emergency medical assistants were able to convince the Council that the public interest is best served if they continue to be regulated under their *Health Emergency Act*. The Council was generally not persuaded that any other profession had provided sufficient rationale.

Therefore, the Health Professions Council recommends that the *Health Emergency Act* not be repealed, and the profession of emergency medical assistance not be designated under the *Health Professions Act*.

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V. REVISIONS TO THE *HEALTH PROFESSIONS ACT*

Several of the Council's preliminary reports contained a separate section addressing suggested revisions to the HPA. For the most part, these represent either deficiencies in the *HPA* or provisions in other health profession statutes which represent an improvement of the *HPA*. The suggestions were made by several professions and represent areas in which the *HPA* should be changed in order that the present regulatory colleges may better protect the public interest. There are other areas in which changes to the *HPA* should be considered. These include changes with respect to the "reserved acts model" as described in the Terms of Reference and the issue of mandatory membership. Finally, the Council will also make recommendations about changes to the *Health Emergency Act*. These include changes with respect to the "reserved acts model" as described in the Terms of Reference and the issue of mandatory membership.

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A. CRITICISMS OF THE *HEALTH PROFESSIONS ACT*

1. The Registration Process and the Registrar's Duties and Powers

Section 20(1) of the *HPA* provides that the Registration Committee is responsible for granting registration to applicants. The Council received useful criticism of this provision. The Registered Nurses Association of British Columbia (RNABC) believes its model to be more effective than the one found in the *HPA*. The RNABC utilizes three entities in the registration process: a registration committee, a membership review committee and a board of examiners. However, most applicants are registered through a simple administrative process carried out by the registrar upon satisfaction of the applicable rules. The RNABC submits that it cannot possibly review all applications by way of the *HPA* process because of the number of applicants.

Similarly, the College of Dental Surgeons of British Columbia (CDSBC) states that registration is generally an administrative task which can be handled by the registrar. The requirements for registration are explicitly set out in the *Dentists Act Rules*, and applicants who meet the requirements are registered. Only in non-standard situations is the registration committee required to deal with an application.

The Council agrees that for larger professions such as registered nursing, dentistry, psychology and medicine, a committee need not consider every application. It is evident that the criteria for registration are widely known and transparent, leaving nothing for the appropriate committees to ensure compliance with. In these

circumstances, each application need not be reviewed by a registration committee.

Therefore, the Health Professions Council recommends that section 20 of the *Health Professions Act* be modified to provide for a more flexible registration process, which would allow the registration committee to delegate approval of applications to the Registrar

2. The Complainant as a "Party" to a Disciplinary Hearing

A pressing concern amongst the health professions is section 38(2) of the *HPA* which provides that the complainant in a disciplinary matter may appear as a party. Many professions objected to this provision. For example, the College of Dental Surgeons of British Columbia states:

A disciplinary hearing in this regard is akin to a criminal trial. In a criminal trial the victim is not a party; the only parties are the Crown and the accused.

That is because the Crown is the party aggrieved by the breach of the Criminal Code and the party with the obligation to enforce the Criminal Code. Those are not the roles of the victim. While it is important that the Court in criminal matters hears from the victim during sentencing as to impact, the victim should otherwise be a witness and not a party.

The same applies to disciplinary hearings. It is the duty and obligation of self regulating professions to prosecute members who act inappropriately on behalf of the public as a whole. It is the profession that is aggrieved by a breach of the professional standards of the profession because it brings the profession into disrepute. People who complain to the College are important to that process as they initiate the investigation, but thereafter, a complainant should only be a witness to the College's disciplinary actions. There is a very real possibility that if a complainant is given party status at a disciplinary hearing their focus will not be on protection of the general public, but on their own interest. A disciplinary hearing may be used by a complainant as an examination for discovery in aid of a civil action against the member.

The British Columbia College of Chiropractors states:

The purpose of appeal rights and hearings in professional regulation is to provide the member and college with the ability to address errors of law, jurisdiction, natural justice or fundamental misapprehension of evidence at the first instance. As a witness, the complainant is not a party to the discipline process and as such does not have any appeal rights.

The Registered Nurses Association of British Columbia, the British Columbia Nurses' Union, as well as the College of Physicians and Surgeons of British Columbia make similar comments about this issue.

The Council agrees with these submissions. Although the complainant plays an important role in the discipline process, the regulatory body is responsible for prosecuting the complaint, and a complainant should not be a "party" to the proceeding. It is important that the focus of disciplinary hearings remain professional standards and the public interest, and that the process not become a substitute for personal actions in the courts. Nonetheless, the Council believes that the *HPA* and the core principles indicate the importance of involving the complainant in the process. In particular, complainants should have the right to appear at disciplinary hearings.

Therefore, the Health Professions Council recommends that the *Health Professions Act* be amended to remove the right of the complainant to appear as a party.

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3. Appeal Right from a Decision of the Discipline Committee

Section 40 of the *HPA* provides that any person "aggrieved or adversely affected" by a decision of a discipline committee has a right to appeal the decision. The Council agrees with the submission of the British Columbia College of Chiropractors that the term "aggrieved or adversely affected" contained in section 40 of the *HPA* may be too broad and may encompass persons who ought not to be entitled to an appeal.

Therefore, the Health Professions Council recommends that section 40 of the *Health Professions Act* be amended to restrict the right of appeal to the parties in a disciplinary hearing

4. Cabinet Approval of Bylaws

The Council has previously discussed the issue of cabinet approval at length in the section, "[Accountability Mechanisms](#)," on page 35. After reviewing the legislation and the insightful comments by the health professions in their submissions, the Council is of the view that many matters of professional governance are routine and need not be subject to heightened scrutiny, as they do not raise issues of concern to the public. Such matters are administrative and would include voting procedures for college elections, banking and financial matters and appointment of officers.

The Seaton Commission recommended that not all rules need be approved by cabinet. In its chapter on professional regulation on page D-31 it stated the following matters need not be subject to cabinet approval:

- i. adopting a college seal;
- ii. executing documents;
- iii. approval of banking and finance;
- iv. selecting committees and procedures for election to committees;
- v. regulating meetings of the college and its committees;
- vi. appointing officers and the delegation of college powers to those officers;
- vii. prescribing forms for internal use;
- viii. arranging for indemnity insurance;
- ix. regulating membership fees; and
- x. authorizing grants

Similarly, Ontario's Regulated *Health Professions Act* (RHPA) provides a useful guide in sections 94 and 95 of the Procedural Code to matters which should be subjected to additional scrutiny. Section 94 sets out the matters not requiring cabinet approval. The Council agrees that not all matters relating to a regulatory body need be subject to cabinet approval and that the report of the Seaton Commission and section 94 of the RHPA provides a useful guide in this regard.

Therefore, the Health Professions Council recommends that section 19 of the *Health Professions Act* be revised to create a category of matters for which cabinet approval is not necessary.

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5. Delay in Rule Approval

Another issue related to section 19 of the *HPA* is delay in the rule approval process. Section 19(7) states:

(7) A bylaw may not be made, amended or repealed under subsection (3) or (6) unless notice of the proposed bylaw, amendment or repeal is given to the college of each health profession prescribed for the purposes of this subsection.

- a. at least 3 months before the bylaw, amendment or repeal comes into force, or
- b. within a period, shorter than that set out in paragraph (a), that the minister specifies as appropriate in the circumstances.

This is the only provision in the *HPA* that touches on the issue of the time for approval of bylaws. Many professions have expressed serious concern regarding the amount of time it takes for rules, regulations and bylaws to be approved. The Council accepts this concern. Lengthy delays inhibit regulatory bodies' ability to regulate and are not in the public interest. Some professions suggested that a provision be enacted stating that rules proposed by regulatory bodies automatically take effect within 90 days of submission, unless the government indicates, in writing, specific objections to the rules. While the Council is not prepared to recommend the adoption of such a provision, the issue of delay in bylaw approval should be addressed in some manner.

Therefore, the Health Professions Council recommends that the Minister of Health and Minister Responsible for Seniors take steps to address the issue of delay in the bylaw approval process.

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6. "Professional Misconduct", "Conduct Unbecoming" and "Sexual Misconduct"

There are several references in the comparative analysis to the terms "professional misconduct" and "conduct unbecoming." Neither the *HPA* nor the current draft bylaws use the term "conduct unbecoming." However, the *HPA* refers, for example in section 33(4)(c), to professional misconduct.

In his book, *The Regulation of Professions in Canada* (Carswell, 1994), James Casey notes that both terms are well recognized in the law of professional regulation. Professional misconduct has been generally accepted to relate to conduct while actually engaged in the practice of the profession, while conduct unbecoming relates to conduct not in the course of the practice of the profession. The Council accepts that in some cases conduct

occurring outside the practice of one's profession may be cause for disciplinary proceedings by a professional college. In such cases, however, the conduct must be relevant to a member's suitability to practice the profession.

Therefore, the Health Professions Council recommends that disciplinary provisions of the *Health Professions Act* be clarified to ensure that they encompass both "professional misconduct" and "conduct unbecoming."

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7. Reporting and Investigation Requirement of Investigative Committee

In the course of the legislative review process, the Council has determined that the initial intake process for complaints under the *HPA* ought to be clarified. Section 33 of the *HPA* appears to provide that all complaints must be investigated.

Many professions found this requirement too onerous. One college states that it employs an intake person for all complaint matters, and this person is responsible for screening complaints. The college states that in 1995, of 133 specific concerns received, only 30 resulted in formal complaints. Another college states that it receives approximately 1400 phone complaints and 400 written complaints each year, and that it is simply not possible for a committee to fully investigate all complaints. It also states that its registrar is successful in mediating many of the complaints.

The Council agrees that a requirement that all complaints be investigated by the inquiry committee is not an effective use of a health profession college's complaints and disciplinary processes. The College of Physicians and Surgeons of British Columbia states that under the *Medical Practitioners Act*, the registrar has the power to resolve "minor" complaints.

In the Council's view, the *HPA* does not intend that the inquiry committee must conduct an investigation in all cases but intends that some matters could be resolved by the registrar. For example, the *HPA* provides that the registrar is an inspector, pursuant to section 27(2) of the *HPA*. Pursuant to section 32(2), the registrar is mandated to deliver to the inquiry committee a copy of the complaint, an assessment thereof and any recommendations for the disposition of the complaint. The *HPA* intended that the registrar would be able to deal with minor complaints summarily, and the inquiry committee would only need to conduct an investigation in cases where the registrar refers the matter to that committee. The Council agrees that a registrar or other designate can play an invaluable role in the initial handling of complaints. In short, the Council supports an enhanced role for the registrar in dealing with complaints in the first instance.

The *HPA* should be amended to clearly provide for an initial summary review process by a designated staff person such as the registrar. That person should be empowered to dismiss the complaint where the matter is beyond the mandate of the regulatory body or where the matter is trivial, frivolous or vexatious. However, the Council believes that any summary review process must provide that decisions to dismiss complaints are subject to an internal right of appeal to either the board of the health profession college or the inquiry committee.

Therefore, the Health Professions Council recommends that the *Health Professions Act* be revised to include provision for a summary review process for complaints and a related provision for an internal appeal from a dismissal of a complaint through the summary review process.

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8. Written Reasons for Disciplinary Orders

Section 39(2) of the *HPA* provides that an order of the discipline committee on a hearing must be in writing and delivered to the respondent and the complainant, if any

The College of Dental Surgeons of British Columbia makes a good point about the section. It submits that a simple order is not enough and that, generally, the common law requires that reasons be provided. The Council agrees that written reasons are an important aspect of the discipline committee's function and notes the comments of Madame Justice L'Heureux-Dubé in the recent case of *Baker v. Canada (Minister of Citizenship and Immigration)*, [1999] 2 S.C.R. 817:

Reasons, it has been argued, foster better decision making by ensuring that issues and reasoning are well articulated and, therefore, more carefully thought out. The process of writing reasons for decision by itself may be a guarantee of a better decision. Reasons also allow parties to see that the applicable issues have been carefully considered, and are invaluable if a decision is to be appealed, questioned, or considered on judicial review. ... Those affected may be more likely to feel they were treated fairly and appropriately if reasons are given. ...

The Council agrees with these views.

Therefore, the Health Professions Council recommends that the *Health Professions Act* be amended to include a requirement that discipline committees issue written reasons for decisions made during disciplinary hearings.

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9. Particulars of Evidence

Section 37(1)(b) of the *HPA* requires that particulars of evidence be included in the notice of citation for a disciplinary hearing

Several professions indicated that this requirement is not practical. For example, the College of Physicians and Surgeons of British Columbia states:

Evidence continues to be gathered following the issuance of charges and we perceive procedural difficulties with continued amendments to the charges issued. In our view, it is

appropriate for a disciplinary charge to allege the elements of the offence but not all of the evidence to be led in support of the charge. Counsel for the College are directed to give disclosure of "particulars", including witness statements, documents, etc. either concurrently with the charge or within a short period after its issuance. There is no question that the accused member is entitled to the process but rather to the legislative requirement that particulars of any evidence form part of the charge or citation

The Council agrees with the criticism that the requirement in section 37 of the HPA regarding particulars of evidence may impair the disciplinary process. However, the Council believes that it is important that the citation include a copy of the charging document. Further, this matter raises the important issue of disclosure of evidence which is not dealt with thoroughly in the HPA. In the Council's view, a fundamental requirement of a fair disciplinary process is that members be apprised of the evidence in support of disciplinary charges at a reasonable time prior to the hearing. Such a provision is embodied in section 42 of Ontario's Health Professions Procedural Code which provides:

(1) Evidence against a member is not admissible at a hearing of allegations against the member unless the member is given, at least ten days before the hearing,

- a. *in the case of written or documentary evidence, an opportunity to examine the evidence;*
- b. *in the case of evidence of an expert, the identity of the expert and a copy of the expert's written report or, if there is no written report, a written summary of the evidence; or*
- c. *in the case of evidence of a witness, the identity of the witness*

This provision provides a good model for a similar process which should be included in the professional statute

Therefore, the Health Professions Council recommends that the *Health Professions Act* be amended to adopt a provision similar to section 42 of Ontario's Health Professions Procedural Code which provides that:

(2) Evidence against a member is not admissible at a hearing of allegations against the member unless the member is given, at least ten days before the hearing,

- a. ***in the case of written or documentary evidence, an opportunity to examine the evidence;***
- b. ***in the case of evidence of an expert, the identity of the expert and a copy of the expert's written report or, if there is no written report, a written summary of the evidence; or***
- c. ***in the case of evidence of a witness, the identity of the witness.***

10. Mediation and Alternative Dispute Resolution

Section 36 of the *HPA* provides for resolving disciplinary matters through the use of registrant's undertakings or upon consent. Section 33(6) empowers the inquiry committee to take measures to indirectly resolve complaints. Several professions submitted that while they strongly support the principle of resolving matters without a hearing, this section was not clear enough or broad enough in scope. The Council agrees and is of the view that the undertakings permitted should be expanded to include such matters as "the requirement to consent to a psychiatric assessment or other medical examinations, to take counseling with a psychologist or psychiatrist, to attend educational or remedial programs, etc., " and believes the *HPA* should be amended to include a wider scope for alternative dispute resolution.

Therefore, the Health Professions Council recommends that the *Health Professions Act* be revised to include specific provisions for fostering use of alternative dispute resolution, including mediation.

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11. Power of Interim/Permanent Injunction

Section 52 of the *HPA* provides that a board may apply to the Supreme Court for an interim or permanent injunction to restrain a person from contravening the act, the regulation or its bylaws. The College of Physicians and Surgeons of British Columbia states that the provision creates grounds for suspicion of "turf protection" and that the provision may be seen as "self serving."

The Council agrees that the issue of enforcement, particularly in regard to performing services which should only be carried out by registered health professionals, needs to be clarified. In the Council's view, enforcement of proceedings regarding improper performance are best left to the discretion of the attorney general, as has been the practice with respect to unregistered persons practising medicine. However, the Council sees no reason not to include the power to see injunctions in professional legislation, so that the professions can seek remedies against persons contravening their rules, regulations or bylaws.

Therefore, the Health Professions Council recommends that the Attorney General be given the authority to enforce the provisions prohibiting persons from performing services which should only be done by registered health professionals.

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B. REVISIONS FROM HEALTH PROFESSION-SPECIFIC STATUTES

In this section the Council reviews several sections from some of the individual statutes the adoption of which would result in significant improvements to the *HPA*.

1. Limited Registration (*Dentists Act*)

Section 26(5)(b) of the *Dentists Act* provides that the College of Dental Surgeons of British Columbia may grant limited registration where a person is the subject of a proceeding in B.C. or elsewhere which could result in suspension or limitations on the person's licence. The College of Dental Surgeons of British Columbia points out that this provision is necessary in order to deal with persons changing jurisdictions once disciplinary proceedings against them have been commenced. This provision is an effective public safety measure and the Council recommends that it be incorporated into the HPA.

Therefore, the Health Professions Council recommends that the *Health Professions Act* be revised to adopt a provision similar to section 26(5)(b) of the *Dentists Act* which provides:

If, after giving the applicant an opportunity to be heard, the council determines that at the time of the application an investigation, review or proceeding is taking place in this or any other jurisdiction which could result in the suspension or cancellation of the applicant's authorization to practise dentistry in that jurisdiction, the council may refuse to grant registration or grant registration for a period or subject to other terms and conditions.

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2. Registrants' Reporting Requirements (*Dentists Act* and *Medical Practitioners Act*)

Article 5.05(e) of the *Dentists Act* Rules provides that members must report to the registrar immediately if they believe a current or former registrant has committed certain specified acts, including any contravention of the *Dentists Act* or its rules. Section 63 of the *Medical Practitioners Act* creates a duty upon registrants to report other registrants. It provides:

(1) A registered member must report to the registrar the condition of any person registered under this Act whom the member, on reasonable grounds, believes to be suffering from a physical or mental ailment, emotional disturbance or addiction to alcohol or drugs that, in the member's opinion, if the person continues to practise medicine or surgery, might constitute a danger to the public or be contrary to the public interest.

An earlier version of the *HPA* Bylaws contained a similar provision but it does not appear in the current version of the *HPA* Bylaws. Such a requirement is in the public interest and ought to be included in the professional statute.

Therefore, the Health Professions Council recommends that the *Health Professions Act* be revised to adopt a provision similar to article 5.05(e) of the *Dentists Act Rules* which provides:

Reporting actions of registrants. Members must advise the registrar without delay if they have reasonable grounds to believe that a current or former registrant:

- i. has contravened the act or a rule made under it;
- ii. has failed to comply with a limitation, term or condition imposed under the act or the rules;
- iii. has been convicted in Canada or elsewhere of any offence that, if committed by a registrant, would constitute conduct unbecoming a registrant or unprofessional conduct;
- iv. has incompetently practised dentistry or carried out the duties and procedures delegated to him as a registrant;
- v. has engaged in conduct unbecoming a registrant;
- vi. has engaged in unprofessional conduct;
- vii. has failed to comply with an agreement that is binding on him under section 4.1(3) of the act; or
- viii. is suffering from a physical ailment, emotional disturbance or an addiction to alcohol or drugs that impairs his ability to practise dentistry or carry out the duties and procedures delegated to him

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3. Peer Assessment (*Medical Practitioners Act*)

Section 51 of the *Medical Practitioners Act* and Part XII of the *Medical Practitioners Act Rules* set out provisions for investigating the skill and knowledge of a registrant and for peer assessment of medical office practice. The Council supports the need for such processes and believes they can be an important part of a quality assurance program. However, the Council is concerned that the current process under the *Medical Practitioners Act*, and in particular section 51 of the *Medical Practitioners Act*, provide remedial jurisdiction to the College of Physicians and Surgeons of British Columbia which is essentially disciplinary in nature, without also affording sufficient procedural protection to the member under investigation. Although the Council supports the basis for this provision, there should be rules regarding the use of information gathered during such a process, as well as general procedural safeguards for the member should a regulatory college wish to proceed with disciplinary matters upon completion of such process.

Sections 79.1 to 83 of the Ontario Health Professions Procedural Code create a process of quality assurance under which members must participate in programs designed to evaluate their "knowledge, skill and judgment." However, section 83 provides restrictions on the use of information gathered during such process:

83.(1) Except as provided in this section, the Quality Assurance Committee and any assessor appointed by it shall not disclose, to any other committee, information that,

(a) Was given by the member; or

(b) Relates to the member and was obtained under section 82

Exception if member gave false information

(2) Information described in subsection (1) may be disclosed for the purpose of showing that the member knowingly gave false information to the Quality Assurance Committee or an assessor.

Referrals to Executive Committee

(3) If the Quality Assurance Committee is of the opinion, based on an assessment, that a member may have committed an act of professional misconduct or may be incompetent or incapacitated, the Committee may disclose the name of the member and allegations against the member to the Executive Committee.

Use in other Committees

(4) Information that was disclosed contrary to subsection (1) shall not be used against the member to whom it relates in a proceeding before the Discipline or Fitness to Practise Committees.

In this way, members are assured that the process, which they can be compelled to participate in, remains focussed on quality assurance and voluntary participation, and not formal disciplinary proceedings.

Therefore, the Health Professions Council recommends the adoption of a peer assessment program similar to that described in section 51 of the *Medical Practitioners Act*, but only if restrictions on use of information gathered during such a process, such as those set out in section 83(1) to 83(4) of Ontario's Health Professions Procedural Code, are included.

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4. Stay of Penalty Pending Outcome of Appeal (*Medical Practitioners Act*)

Section 71(4) of the Medical Practitioners Act provides that the executive committee may stay the operation of any penalty or punishment imposed pending the outcome of an appeal. No such provision is provided for in the HPA. The College of Physicians and Surgeons of British Columbia argues that the discretion is exercised sparingly and never where there is any threat of danger to the public. It states:

The discretion to grant a stay can be used to extract agreements and undertakings from a member and to elicit commitments on early appeal dates and interim restrictions on practice which, in our view, may not otherwise be able to be imposed.

The Council accepts that such a provision is in the public interest, particularly as it lessens the chance for lengthy court proceedings.

Therefore, the Health Professions Council recommends that the *Health Professions Act* be revised to provide a provision similar to section 71(4) of the *Medical Practitioners Act* which provides:

The executive committee may, on the terms it sees fit, stay the operation of any punishment or penalty imposed on a person appealing under this section until the outcome of the appeal, and may require the giving of reasonable security for its costs of the appeal and payment of a fine already imposed as a condition of granting the stay.

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5. Special Deputy Registrar (*Medical Practitioners Act*)

The *Medical Practitioners Act* provides for the appointment of a special deputy registrar, under section 21, who is primarily responsible, under section 65, for receiving and investigating written complaints about sexual misconduct. The appointment of a special deputy registrar, whose responsibility is to recommend actions to be taken by the sexual misconduct review committee respecting complaints on sexual misconduct, is another important complaint and disciplinary process that serves the public interest and ought to be included in the professional statute.

However, the Council recognizes that, for some professions, allegations of sexual misconduct may not be the type of concern that warrants creating a new position within the regulatory body. This may be so, for example, where a profession has virtually no historical incidence of such misconduct. In these professions, the regular complaint and discipline process can be used should such a case arise. Therefore, the Council recommends that the provision should include power to exempt professions from this provision where a profession has very little historical incidence of sexual misconduct.

Therefore, the Health Professions Council recommends that the *Health Professions Act* be revised to include a provision similar to section 21 of the *Medical Practitioners Act* which provides:

Special deputy registrar 21 (1) The council must designate a person appointed under section 20 (3) as the special deputy registrar.

(2) The special deputy registrar must

(a) receive and investigate complaints of sexual misconduct made to the college;

(b) on completion of an investigation of a complaint of sexual misconduct, review the findings of the investigation and recommend the action the sexual misconduct review committee should take under section 28 (2) (d); and

(c) perform other duties as directed by the sexual misconduct review

committee or the registrar

(3) With the prior approval of the sexual misconduct review committee, the special deputy registrar may authorize an inspector to complete an investigation under this section under the supervision of the special deputy registrar.

(4) The special deputy registrar may attempt to resolve a complaint of sexual misconduct informally if the complainant consents and

(a) the circumstances warrant informal resolution of the complaint in the opinion of the special deputy registrar, or

(b) a direction has been made under section 28 (2) (d) (iii) to make the attempt.

6. Committee Legal Assistance (*Medical Practitioners Act*)

Section 67(2) of the *Medical Practitioners Act* empowers the council of the College of Physicians and Surgeons of British Columbia, the executive committee or inquiry committee to employ, at the College of Physicians and Surgeons of British Columbia's expense, legal or other assistance for the conduct of an inquiry or hearing. The Council believes that this provision is an important discretionary power which enhances the quality of the hearing process and recommends its inclusion in the HPA.

Therefore, the Health Professions Council recommends that the *Health Professions Act* be revised to include a provision similar to section 67(2) of the *Medical Practitioners Act* which provides:

On an inquiry or hearing, the council, executive committee or inquiry committee may employ, at the college's expense, the legal or other assistance it thinks necessary or proper.

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7. Summary Membership Termination

Section 35 of the *HPA* states that the board of a college may take any action it considers appropriate to protect the public, including suspending a registrant pending an investigation or hearing by the discipline committee. Section 35 of the *HPA* does not require that any prior notice be given to the registrant. While the Council accepts that a formal hearing requirement may not be appropriate, given the nature of the power and the matters in issue regarding section 35 of the *HPA*, the Council believes that natural justice requires that a registrant be given the opportunity to respond to the allegations. The Council recognizes, however, that there may be certain extreme cases involving substantial risk to the public where the powers need to be exercised without any prior notice to the registrant. Where action is taken without notice, the registrant would, of course,

still be entitled to challenge the decision through the appeal process set out in s. 35(2) of the HPA.

Therefore, the Health Professions Council recommends that section 35 of the *Health Professions Act* be amended to add a duty to notify a registrant as well as provide an opportunity to respond to the allegations prior to action being taken under the section, with an exception for cases involving substantial risk to the public, in which case action may be taken without prior notice to the registrant.

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8. Discretionary Reinstatement (*Medical Practitioners Act*)

Under section 62 of the *Medical Practitioners Act* and rule 176 of the *Medical Practitioners Act Rules*, the College of Physicians and Surgeons of British Columbia has the discretion to grant reinstatement to a member who has been erased from the register. A previous version of the *HPA Bylaws* contained a similar provision but it does not appear in the latest version. The Council is of the view that this is a positive rule and recommends its incorporation in the HPA.

Therefore, the Health Professions Council recommends that the *Health Professions Act* be revised to include a provision similar to section 62 of the *Medical Practitioners Act* which provides:

Reinstatement of entry in register

62 (1) If the council directs the erasure from the register of a person's name or of another entry, that person's name or entry must not be again entered on the register except by direction of the council or by order of the Supreme Court or of the Court of Appeal on an appeal.

(2) If the council thinks fit, the council may direct the registrar to restore to the register a name or entry erased from it, with or without payment of a registration fee, and the registrar must restore it

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9. Termination or Refusal of Registration (*Medical Practitioners Act* and *Dentists Act*)

Sections 50(1) and (3) of the *Medical Practitioners Act* provide that:

(1) A person who has been convicted of an indictable offence by a court in British Columbia or elsewhere is not entitled to be registered and the council may erase the person's name from the register.

...

(3) The registration of a person must not be refused and the name of a person not be erased for a conviction for a political offence or for an offence that ought not, in the council's opinion, either from the nature of the offence or from the circumstances under which it was committed, to disqualify the person from practising under the Act.

A similar power appears in section 50 of the Nurses (Registered) Act which provides that a nurse's membership may be terminated summarily and without a hearing upon conviction of an indictable offence

The Council believes that section 50 of the *Medical Practitioners Act* is a valuable measure to deal with members and/or applicants who have been convicted of indictable offences

Therefore, the Health Professions Council recommends that the *Health Professions Act* be revised to include a provision similar to section 50 of the *Medical Practitioners Act* which provides:

(1) A person who has been convicted of an indictable offence by a court in British Columbia or elsewhere is not entitled to be registered and the council may erase the person's name from the register.

..

(3) The registration of a person must not be refused and the name of a person not be erased for a conviction for a political offence or for an offence that ought not, in the council's opinion, either from the nature of the offence or from the circumstances under which it was committed, to disqualify the person from practising under the Act.

The Council is of the view that these provisions are an important safeguard for the public and recommends that the *HPA* be amended to include this section. However, the Council believes it important that such provisions apply only to offences that are relevant to a member's suitability to practice.

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C. OTHER ISSUES

1. Name of the Regulatory Body

Currently, the regulatory body for optometry and podiatry is called the "Board of Examiners." For registered nursing, the body is called the "Registered Nurses Association of British Columbia". The *HPA* embodies the traditional name for regulatory bodies, namely "college," while membership organizations are usually identified as "associations." The Council supports the need for uniform terminology.

Therefore, the Health Professions Council recommends that all regulatory bodies be called "colleges." This will require changes to the legislation governing registered nursing, optometry and podiatry.

2. Access to the Register of Members

The Council discussed above, on page 43 the [requirement of public access](#) to the register and bylaws of a college in section 22 of the HPA. Clearly, the purpose of providing such public access to the register is not for the disclosure of the members' private information but, rather, for the public to verify which members of a health profession are in good standing.

In some cases, however, a member of a college may not have a business address so that the register contains only the member's personal address. In Ontario, the provisions dealing with access to a college registry provide the college with the discretion not to disclose a member's address or phone number where there are reasonable grounds to believe that disclosure may jeopardize the member's safety.

Therefore, the Health Professions Council recommends that section 22 of the *Health Professions Act* be amended to provide discretion not to disclose a member's address or phone number where there are reasonable grounds to believe that disclosure may jeopardize the member's safety.

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D. REVISIONS TO IMPLEMENT THE HEALTH PROFESSIONS COUNCIL'S RESERVED ACTS MODEL

In its report on the scope of practice review, the Council discussed legislative changes to the *HPA* that would need to be enacted should the government adopt the new regulatory model which is based on descriptive scope of practice statements, reserved acts and reserved titles.

The legislative changes are the enactment of: a list of reserved acts; a provision which sets out the duties of a health professional and his or her regulatory college when delegating a reserved act, a general risk of harm clause to ensure accountability for the performance of health services by unregulated providers and a provision which provides for exceptions to the general prohibition against performing reserved acts.

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VI. CHANGES TO THE *HEALTH EMERGENCY ACT*

The Council concluded that the profession of emergency medical assistance should continue to be regulated under the *Health Emergency Act*. The Council does, however, have concerns regarding some provisions of the *Health Emergency Act* which relate to quality assurance mechanisms and the complaint and disciplinary process, and therefore makes the following recommendations:

Therefore, the Health Professions Council recommends that the *Health Emergency Act* be amended to include sections 16(2)(d), 16(2)(f) and bylaw 18 of the *Health Professions Act* which provide:

16(2) A college has the following objects:

(d) to establish, monitor and enforce standards of practice to enhance the quality of practice and reduce incompetent, impaired or unethical practice amongst registrants;

(f) to establish, for a college designated under section 12 (2) (h), a patient relations program to seek to prevent professional misconduct of a sexual nature

Patient relations committee

18. (1) The patient relations committee is established consisting of [6] persons appointed by the board.

(2) The patient relations committee must include at least [2] public representatives, at least 1 of whom must be an appointed board member.

(3) The patient relations committee must

- a. establish and maintain procedures by which the college deals with complaints of professional misconduct of a sexual nature,
- b. monitor and periodically evaluate the operation of procedures established under paragraph (a),
- c. develop and coordinate, for the college, educational programs on professional misconduct of a sexual nature for members and the public as required,
- d. establish a patient relations program to prevent professional misconduct, including professional misconduct of a sexual nature,
- e. develop guidelines for the conduct of registrants with their patients, and
- f. provide information to the public regarding the college's complaint and disciplinary process

(4) For the purposes of this section, "professional misconduct of a sexual nature" means

- a. sexual intercourse or other forms of physical sexual relations between the registrant and the patient,
- b. touching, of a sexual nature, of the patient by the registrant, or
- c. behaviour or remarks of a sexual nature by the registrant towards the patient;

but does not include touching, behaviour and remarks by the registrant towards the patient that are of a clinical nature appropriate to the service being provided

Prior to the enactment of this provision, both the Emergency Health Services Commission and the Emergency Medical Assistants Licensing Board should be consulted about which body is best able to fulfill the duties required by these programs

Therefore, the Health Professions Council recommends that the provisions in the *Health Emergency Act* dealing with the complaints and discipline process be amended to ensure that the investigative and adjudicative functions are entirely separate, and that complainants are afforded a right of internal appeal regarding dismissed complaints.

Therefore, the Health Professions Council recommends that the *Health Emergency Act* be amended to provide for a general rule that disciplinary hearings are open to the public, subject to the list of exceptions set out in bylaw 12(5)(a) to (d) of the *Health Professions Act Bylaws*

Therefore, the Health Professions Council recommends that the following *Health Professions Act* provisions be added to the *Health Emergency Act*:

1. section 33(4) which deals with the inquiry committee's power to take any action it considers appropriate to resolve a complaint, including mediation;
2. section 36 which provides that the inquiry committee may resolve complaints by way of registrants' undertakings or consents;
3. section 37 which describes the contents of a citation;
4. section 38 which sets out the procedure for a discipline committee hearing; and
5. section 40 which provides for an appeal by a person aggrieved or adversely affected by a decision of the discipline committee

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VII. MANDATORY MEMBERSHIP

In June 1998, the Minister requested that the Council address an additional issue in its legislative review. The issue was whether it is in the public interest for members of a regulated health profession to be required to belong, or to pay dues, to a professional association. The Minister noted that the Ministry has generally not been supportive of mandatory membership because it denies freedom of choice and because there is no apparent public interest that would be served.

As background, the Council notes that the issue of professional promotion and self-regulation was addressed by the Seaton Commission when it recommended that, "two separate bodies be created for all regulated or licensed professions so that there is a clear separation of membership promotion functions and licensing and discipline functions." The Seaton Commission felt that without this separation the public protection function of the College would become blurred with the membership promotion function of the professional association. However the issue of mandatory membership was not specifically addressed.

In September 1998 the Council conducted a survey on the issue of mandatory membership. The Council contacted the health professions in British Columbia and the ministries of health of all other provinces and territories, as well as other professions, such as accountants, architects, engineers, lawyers, social workers and teachers. The Council received a substantial number of responses that provided various arguments supporting or opposing a requirement for mandatory membership.

The vast majority of professions surveyed indicated that there is no legislative requirement for mandatory membership in a professional association. As far as health professions in British Columbia, only the Podiatrists Act and the Optometrists Act require that practitioners belong to the professional association. In addition, registrants of the College of Dental Surgeons of British Columbia (College) are required to pay a license fee to the College, a portion of which is used to provide funding for the professional association for dentistry. The College makes a grant to the association pursuant to section 85(2) of the *Dentists Act*.

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A. ADVANTAGES OF MANDATORY MEMBERSHIP

The primary argument in favour of mandatory membership was that it improves the financial viability of the association, particularly in professions with a small membership base. Several respondents felt that in the absence of a viable professional association, pressure may mount on the regulatory body to undertake the role of the association and in turn, undermine the regulatory body's role in serving the public interest. Other respondents submitted that since all members of the profession benefit from the association's activities, for example in negotiating fee agreements with government or third party payers, all members should share in its funding.

Many other submissions were made about the benefits of membership in a professional association, though these submissions did not relate directly to the issue of mandatory as opposed to voluntary membership. These included the comments that a membership association:

- enhances educational activities and promotes research ventures;
- provides a facility for continuing education, and public information dissemination;
- would be in a position to advocate in support of the economic interests of members;
- is more proactive in government/media relations than the regulatory body which must be careful and circumspect in its public statements;
- provides a vehicle for exchanging information, mentoring and educational activities;
- provides greater opportunity to inform members of legislative and legal changes relevant to their practice standards, and to receive regular information concerning findings pertaining to their area of specialty;
- may provide liability insurance for the protection of the public.

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B. DISADVANTAGES OF MANDATORY MEMBERSHIP

Those who felt it undesirable to have mandatory membership argued primarily that it violates a professional's right of freedom of association under the Charter of Rights and Freedoms. Another common submission was that mandatory membership may result in a blurring of the respective roles of professional association (promoting professional interests) and the regulatory body (serving the public interest). Some of the other submissions opposed to mandatory membership stated that it would result in increased fees, and that confusion may arise about which professional association a member will be forced to join. Although in some professions there is clearly one dominant association, in others, there may be several groups competing for membership.

The Council accepts that professional associations can provide services that are in the public interest, such as providing continuing education programs and advocating health policies and programs. However, while it may be desirable for practitioners to belong to professional associations, it is not in the public interest to require them to do so. Making membership compulsory infringes on members' freedom of association, and has the potential to raise the perception that the activities of the regulatory body and professional association are not truly separate. The Council agrees with the views of the College of Dental Technicians of British Columbia when it states:

We do not feel that a college should encroach on personal freedoms. A registrant should have the freedom to choose for themselves whether an association provides the components that will make membership a pleasant and valuable experience. we also feel that as the interests of the associations are not necessarily related to licensure and competency issues, it would be inappropriate and at odds with the regulatory role, to require membership.

Public trust and confidence in the self-regulating process is reinforced with a clear separation of the regulatory body and professional association. Further, the Council sees little distinction between mandatory membership and mandatory dues. The system described by the College of Dental Surgeons still restricts members' freedom of association since it is the College that selects the association that receives the grant. This raises the perception that the duties of the regulatory body are not entirely separate from the activities of the professional association.

After carefully considering the responses, the Council concludes that it is not in the public interest for members of a regulated health profession to be required to belong, or to pay dues, to a professional association.

Therefore, the Health Professions Council recommends the repeal of any provision in any professional statute, rule or regulation that requires members of a regulated health profession to belong, or to pay dues, to a professional association.

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VIII. OVERSIGHT OF COLLEGES

One significant issue which has only recently been drawn to the attention of the Council is the necessity of some process to ensure the accountability of the regulatory colleges themselves.

The mandate of all the colleges is to regulate their separate professions in the public interest. Elsewhere in this report the Council has made recommendations regarding such matters as barriers to interdisciplinary practice. Not all the professions will agree with the approach taken by the Council. To the extent such recommendations, if enacted, are ignored, the public interest is not going to be served.

Differences may well arise between professions on a variety of issues, some of which will undoubtedly have an impact on the public interest.

The Council has concluded that some process must be put in place to deal with inter-professional complaints and to provide general oversight of the regulatory colleges' performance. This function could well fit in with the recommendations in the Scope of Practice Report for an [ongoing review of the Reserved Acts List](#) [Part I, Volume 1, Section IV.C.5(a), page 62].

Therefore, the Health Professions Council recommends a process be established by the Minister of Health and Minister Responsible for Seniors for the Health Professions Council to provide ongoing review and oversight of the regulatory colleges.

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IX. FINAL WORD

The HPA embodies the framework for a new model of self-regulation for health professions. It recognizes the value of making more choices available to the public in determining its health care needs while at the same time ensuring that the choices are within safe parameters.

However, the new model does not apply equally to those professions which are not designated under the HPA. This has been the primary task of the legislative review: to determine whether it is in the public interest to bring all, some or none of the self-regulating health professions under the one umbrella statute.

The history of self-regulation has a long and generally meritorious tradition in this province, as elsewhere in Canada. It has taken the form of a statute, enacted by the legislature, enabling a regulatory body to be established for the actual governance. The regulatory body has various names—the College of Physicians and Surgeons, the Board of Examiners in Optometry—but in whatever guise, the function is essentially the same. The regulatory body is made up almost entirely of members of the profession (with lay members now mandated), and its main task is to set the entrance qualifications, standards of practice, bylaws and rules of practice and disciplinary mechanisms. In day to day practice, the members rarely have need to refer to their governing statute; the rules of their regulatory body determine what they do and how they do it.

Despite the lack of interaction between the members and their statute, certain professions have attached a significance to having their own statute, with their own professional name, which far exceeds the intended purpose. In any event, perpetuating the dual system of having some professions regulated pursuant to

individual statutes and others pursuant to the *Health Professions Act*, can only entrench the impression that some professions are more recognized than others. This flies in the face of the implicit objective of eliminating the concept of a hierarchy among the professions.

While all professions proclaim support for the team approach to the provision of health care, in practice many professions complain that some professions consider themselves more equal than others.

Apart from the fact that regulation pursuant to a single universal statute has been recommended by previous studies of the delivery of health services (see the Seaton Commission report, for example), and despite the fact that it is the declared choice of government, there are other reasons:

- It is the current trend. Alberta is instituting such a plan and Ontario has had it in place for a number of years without apparent deplorable effects, at least none that have been pointed out to the Council despite invitations to those opposed to such a plan do so, while other provinces have such a system under active consideration;
- All newly recognized health professions are designated as such under the HPA;
- Some of the professions operating under their own statutes have requested designation under the HPA;
- It ensures that all self-regulated professions are subject to the same law so that judicial interpretations will apply to all;
- Most significantly, it removes the appearance that some professions are superior to others and thereby 'merit' their own statute.

During the public hearing into the scope of practice of the nursing profession, the Council was reminded of the early motto of one of the most highly regarded nursing schools in the country: "I see and I am silent." That is a sad commentary on attitudes towards a noble and humanitarian profession. Hospitals did work in those days, but to subscribe to the philosophy of "if it ain't broke don't fix it," which several professions suggested as a good reason to retain the present system, would be perpetuating the same attitudes today. The system has progressed since then, to the benefit of the public. The Council believes the recommendations in this report will continue that progression.

Appendix A: TERMS OF REFERENCE AND GUIDELINES

Last Revised: March 08, 2002