

HEALTH  
PROFESSIONS  
COUNCIL

# RECOMMENDATIONS ON THE DESIGNATION OF CLINICAL PERFUSION

Dianne Tingey, Chair  
Jim Chisholm, Member  
Brenda McBain, Member

Application by the  
British Columbia Society of Clinical Perfusion

August 2002

## FOREWORD

This report is in response to an application by the British Columbia Society of Clinical Perfusion (the applicant) for designation under the *Health Professions Act* (RSBC 1996, c. 183). Under the *Health Professions Act*, the Health Professions Council is a three-person advisory body appointed by the Government of British Columbia to make recommendations to the Minister of Health Planning about the regulation of health professions. This report is the result of an investigation of the profession of clinical perfusion by a three-member panel of the Health Professions Council.

# CONTENTS

EXECUTIVE SUMMARY.....	iv
I. APPLICATION AND PROCESS OF INVESTIGATION.....	1
A. GENERAL BACKGROUND .....	1
B. PROCESS OF INVESTIGATION .....	2
II. STATEMENT OF ISSUES.....	4
III. RECOMMENDATION.....	5
IV. RATIONALE FOR THE RECOMMENDATION .....	6
A. DEFINITION OF "HEALTH PROFESSION" .....	6
B. PUBLIC INTEREST CRITERIA.....	7
1. <u>Section 5(1): Risk of Harm Criteria</u> .....	7
2. <u>Summary of Section 5(1) Criteria</u> .....	12
3. <u>Section 5(2): Discretionary Public Interest Criteria</u> .....	12
4. <u>Conclusion Regarding Section 5(1) and 5(2) Criteria</u> .....	14
C. RESERVED ACTS .....	14
 APPENDIX A: <b>Excerpt from <i>Safe Choices: A New Model for Regulating Health Professions in British Columbia</i></b>	

## EXECUTIVE SUMMARY

In its review of the application for designation of clinical perfusion, the Health Professions Council (Council) applied the Public Interest Criteria as directed by the *Health Professions Act (HPA)*. The Council reviewed the information provided by the applicant. A limited consultation was conducted but no public hearing was held for reasons that will be set out in this report.

The Council first determined that the practice of clinical perfusion meets the definition of "health profession" set out in the *HPA*. The Council recognizes that the practice of clinical perfusion requires a high degree of education, skill and training to provide a service related to treatment of individuals who are injured, sick, disabled or infirm. Therefore, clinical perfusion clearly meets the definition of "health profession".

The Council then reviewed the services provided by clinical perfusionists in light of the risk of harm criteria in Section 5(1) of the *HPA Regulation*. After reviewing the services performed and the level of independent practice, the Council determined that a significant risk of harm exists in the practice of this profession.

Next, the Council considered the supporting criteria listed in section 5(2) of the *Health Professions Regulation (HPA Regulation)*. The Council found that these criteria were the most significant in the Council's decision not to recommend designation of clinical perfusion under the *HPA*, particularly section 5(2)(g) which states:

*the likelihood that a college established under the Act would be capable of carrying out the duties imposed by the Act, having regard to factors which in the view of the council may affect the viable operation of the College.*

The factor which most influenced the Council was the small size of the profession in the province. In view of the low number of practitioners (30) in the province, it is the Council's view that the section 5(2)(g) criteria has not been met. Therefore, the Council cannot recommend designation of the profession. However, the Council believes that the safety of the public is protected to a certain extent by the certification and biennial recertification program of the Canadian Society of Clinical Perfusion. According to the applicant, this recertification is required by employers.

In order for the public to be assured of the full range of regulatory safeguards provided by a self-governing college, the applicant might consider a revised application in conjunction with other highly skilled health professions. Another option for regulation of the practice of clinical perfusionists is delegation of reserved acts from physicians to perfusionists, the model adopted in Ontario. The Council's report, *Safe Choices: A New Model for Regulating Health Professions in British Columbia*, recommended general principles be enacted to cover the delegation of reserved acts.

Therefore, the Council made the following recommendation to the Minister of Health Planning:

that the practice of clinical perfusion not be designated under the *Health Professions Act*.

# RECOMMENDATIONS ON THE DESIGNATION OF CLINICAL PERFUSION

## I. APPLICATION AND PROCESS OF INVESTIGATION

### A. GENERAL BACKGROUND

The applicant BC Society of Clinical Perfusion (BCSCP) was incorporated in August 1992 under the *Society Act*, RSBC 1996, c. 433.

There is currently no legislation regulating clinical perfusion in Canada. In Alberta, perfusionists applied for self-regulation under the *Health Disciplines Act*, now replaced by the *Health Professions Act*. At that time, the Health Disciplines Board recommended that perfusionists be regulated together with another profession, noting the small number of perfusionists in Alberta. There has not been a subsequent application under the *HPA* and perfusionists are currently unregulated.

In Ontario, clinical perfusion is not a regulated health profession; however, the Ontario College of Physicians and Surgeons has adopted policies for delegation of the controlled acts which perfusionists perform. The *Regulated Health Professions Act (RHPA)* allows delegation of controlled acts in a manner similar to that recommended for reserved acts by the Council in *Safe Choices: A New Model for Regulating Health Professions in British Columbia (Safe Choices)*.

There are two perfusion training programs in Canada: The Michener Institute for Applied Health Sciences in Ontario and the University College of the Cariboo (UCC) in BC. The UCC program consists of an independent study, tutor-supported didactic portion offered via distance education, and a 48-week clinical rotation. The prerequisite for both programs is a diploma in an allied health care field (i.e., respiratory therapy, nursing, biomedical technology) or a Bachelor of Science degree in a health care field. Both training programs incorporate an academic and a practical component.

The applicant submits that over 20 institutions in the United States offer perfusion training with a range of theoretical and practical experience.

Members of the applicant must be certified or eligible for certification by the Canadian Society of Clinical Perfusion (CSCP). To receive certification, practitioners must demonstrate a firm base of knowledge in the following:

- anatomy,
- physiology,

- applied medical sciences,
- perfusion haematology,
- physiologic and hemodynamic monitoring,
- cardiovascular pathophysiology,
- perfusion technology, and
- pharmacology.

Practitioners must also complete 50 adult cardiopulmonary bypass procedures and 15 pediatric procedures to be eligible to complete an accredited program and sit qualifying exams. To maintain certification with the CSCP, a practitioner must perform a minimum of 80 cardiopulmonary bypass procedures in a two-year period as well as provide evidence of continuing education. The applicant qualifications are the same as those of the CSCP.

The applicant submits that there are 30 practitioners in BC, all of whom are members of the applicant. Membership in the applicant society is voluntary. All 30 practising clinical perfusionists are employed in hospitals as no employment opportunities exist outside of the hospital setting. Certification by the CSCP is required by all employers in B.C., according to information provided by the applicant.

The applicant is affiliated with the CSCP. The CSCP has an association with the Canadian Medical Association. A Conjoint Committee of the Canadian Medical Association and the CSCP accredits perfusionists' training programs. The CSCP is affiliated with the American Society of Extra-Corporeal Technology and the American Board of Cardiovascular Perfusion.

## **B. PROCESS OF INVESTIGATION**

BCSCP submitted an application for designation of clinical perfusion as a self-regulating health profession under the *HPA*. The application was received on March 5, 1996.

The Council conducted a limited consultation process but did not hold a public hearing. Pursuant to section 7(3)(a) of the *HPA*, the Council determined that it could reach its conclusion without a full consultation process or a public hearing.

Section 7(3)(a) of the *HPA* provides:

*On receiving an application under subsection (1), the council may*

(c) *refuse the application without investigation.*

Since the Council decided not to recommend designation of the profession under the *HPA* because of the reasons set out in this report, it saw no need to conduct a full consultation process or a public hearing.



## II. STATEMENT OF ISSUES

In accordance with the requirements of the *HPA*, the Council identified three issues involving the regulation of the practice of clinical perfusion. In assessing the public interest in the regulation of this profession, the Council considered:

- (1) whether the practice of clinical perfusion meets the definition of health profession in section 1 of the *HPA*;
- (2) the extent to which the practice of clinical perfusion may involve a risk of physical, mental or emotional harm to the health, safety, or well-being of the public according to section 5(1) of the *HPA Regulation*; and
- (3) whether designation of a college of clinical perfusion would be in the public interest having regard to the criteria of sections 5(1) and 5(2) of the *HPA Regulation*.

### III. RECOMMENDATION

The Council recommends to the Minister of Health Planning:

that the practice of clinical perfusion not be designated under the *Health Professions Act*.

## IV. RATIONALE FOR THE RECOMMENDATION

In order to proceed under section 10 of the *HPA* to recommend the designation of clinical perfusion, the Council must determine that the applicant's profession comes within the definition of "health profession" as set out in section 1 of the *HPA* and that designation is in the public interest pursuant to section 5 of the *HPA Regulation*.

### A. DEFINITION OF "HEALTH PROFESSION"

Section 1 of the *HPA* defines a health profession as:

*. . . 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.*

Clearly, this is an extremely broad definition that encompasses many health related services.

Clinical perfusionists prepare and operate the heart-lung machine to provide cardiopulmonary support for a patient undergoing cardiac or non-cardiac surgery. In general, they operate extracorporeal circulation equipment during any medical situation where it is necessary to support or replace the patient's cardiopulmonary/circulatory function and ensure proper management of physiologic functions. In addition to cardiac surgical support, perfusionists administer under prescription various medical gases, anesthetics, drugs, blood products and solutions; manage induced hypothermia and hemodilution; provide perfusion services during implantation of ventricular assistance devices, intra-aortic balloon procedures, liver transplantation, longterm pulmonary support, chemotherapeutic limb perfusion, hemoconcentration, autotransfusion and blood salvage.

In the Council's view, a high level of skill and judgment is required to perform this service which is provided to persons who are undergoing a critical medical procedure. As a result, the Council is satisfied that the profession of clinical perfusion meets the definition of "health profession".

## B. PUBLIC INTEREST CRITERIA

When examining an application for designation the Council considers the public interest criteria set in section 5(1) and (2) of the *HPA Regulation*. The section 5(1) criteria relate to risk of harm and must be considered by the Council while the section 5(2) criteria are discretionary and may be considered by the Council.

### 1. Section 5(1): Risk of Harm Criteria

Section 5(1) of the *HPA Regulation* states:

*5.(1) For the purposes of s.10(1) of the Act, the Council must consider the extent to which the practice of a health profession may involve a risk of physical, mental or emotional harm to the health, safety or well being of the public, having regard to*

- (a) the services performed by practitioners of the health profession,*
- (b) the technology, including instruments and materials, used by practitioners,*
- (c) the invasiveness of the procedure or mode of treatment used by practitioners, and*
- (d) the degree to which the health profession is*
  - (i) practised under the supervision of another person who is qualified to practise as a member of a different health profession, or*
  - (ii) practised in a currently regulated environment.*

**Section 5(1)(a), (b) and (c): the services performed by practitioners of the health profession, the technology, including instruments and materials, used by practitioners, and the invasiveness of the procedure or mode of treatment used by practitioners**

The applicant states that clinical perfusionists provide the following services which involve invasive technology:

*Preparation and Operation of -*

- Heart Lung machines.
- Cardioplegia solution and topical cooling systems.
- Extracorporeal solution and topical cooling systems.
- Extracorporeal haemoconcentration.
- Extracorporeal circuit drug administration.
- Extracorporeal circuit blood +/- blood products administration.
- Extracorporeal circuit crystalloid +/- colloid administration.
- Heparin/Protamine assays.
- Activated clotting times.
- Physiologic monitoring - temperature, blood gas electrolytes, haematocrits, oximetry.
- Autotransfusion systems (CATR).
- Rapid infusion devices.
- Blood salvage systems (Cell Saver).
- Intra-Aortic Balloon pumping.
- Extracorporeal supported angioplasty (CPS).
- Ventricular assist devices (LVAD, RVAD, Bi-VAD).
- Left heart bypass systems.
- Extracorporeal membrane oxygenation (ECMO).
- Veno-veno bypass systems.
- Isolated limb perfusion systems.
- Pacemaker implantation.
- Set-up and insertion of invasive monitoring.
- Trans-esophageal ECHO.
- Quality assurance and quality control.
- Research, development and assessment of new devices, equipment and techniques.
- Instruction, training and development within the Perfusion Training Programme.
- Administrative duties with regard to departmental demands.

With respect to risk of harm, the applicant states:

*The practice of clinical perfusion is required in order to facilitate Cardio-Pulmonary bypass and therefore provide the conditions necessary to allow the appropriate cardiac repair and/or cardiac support. By the very nature of such an invasive technique, there is obviously great potential for risks to the patient and it is only by the constant vigilance, expertise and knowledge of the Perfusionist that any adverse sequelae may be avoided.*

*There are an infinite variety of such risks, ranging from possible cardio-pulmonary bypass circuit contamination, inappropriate drug administration, erroneous blood administration, arterial air embolus, etc. Any and all such risks will certainly result in varying degrees of harm to the patient with case*

*scenarios ranging from extended stays in cardiac surgery ICU to varying neurological deficits to ultimately patient death.*

The Registered Nurses Association of BC (RNABC) in its submission states:

*... [M]any of the listed activities are procedures that require the specialized skills of surgeons (e.g., inserting an intra-aortic balloon pump, veno-veno bypass, starting ECMO on a child, doing angioplasty). The role of the clinical perfusionist in these activities appears to be one of providing assistance to the surgeon.*

*... In all settings which were surveyed, perfusionists are responsible for the preparation and operation of the heart lung machine and assume a role similar to the circulating nurse when assisting the anaesthetist to start a procedure. Nurses reported that most physiological monitoring is done by the anaesthetist; however, the clinical perfusionist works collaboratively with the anaesthetist to interpret the data.*

**Section 5(1)(d)(i): the degree to which the health profession is practised under the supervision of another person who is qualified to practise as a member of a different health profession**

The applicant states that clinical perfusionists regularly make a variety of independent judgments concerning the management of cardio-pulmonary bypass. It further states that clinical perfusionists enjoy a significant amount of autonomy with regard to the running of the heart/lung machine. Finally, it states that over-all management of the patient is achieved by "*continuous liaison between the Perfusionist, the Anesthetist and the Surgeon*".

The RNABC in its submission states:

*Nurses reported that clinical perfusionists require patient-specific orders from either the anaesthetist or the cardiovascular surgeon in order to initiate some of their activities (for example, heart bypass or administration of blood). In some settings standing orders or protocols also provide direction for parts of the perfusionist's practice (e.g., when to add medication or run blood gases)*

...

While it appears the decision to initiate certain procedures which involve reserved acts is made by a physician, the Council explored further whether clinical perfusion is practised under supervision or delegation from physicians.

In May 2001, the Council wrote to the College of Physicians and Surgeons of Ontario (CPSO) asking the following:

*It is the Council's understanding that much of the practice of clinical perfusion is independent. The Council is interested in ascertaining the amount and type of supervision that physicians provide for clinical perfusion practice. Is there a delegation or transfer of function from physicians to clinical perfusionists, an unregulated profession? If so, are there policies or protocols in place for such delegation? The Council has been informed that the Ontario College of Physicians and Surgeons has set up procedures for delegation from physicians to clinical perfusionists within the hospital setting. The Council would appreciate receiving information about such programs.*

CPSO states:

*In the Ontario context, therefore, the delegation of the necessary controlled acts by physicians to clinical perfusionists is regulated through legislation and policy. It is not tied to the question of whether or not clinical perfusion is a self-regulating profession.*

...

*... The CPSO's delegation policy sets out the procedures for proper delegation within the legislative framework.*

*... [T]he CPSO has not specifically addressed the procedures for delegation from physicians to clinical perfusionists in the hospital setting; rather, such procedures would be covered under the general delegation policy.*

*According to the policy on the Delegation of Controlled Acts, the physician must, in most cases, establish a physician-patient relationship before delegating any controlled act. The controlled act or acts to be delegated must then be identified. A physician may only delegate a controlled act that he or she is competent to perform and which forms part of his or her regular practice.*

*... in the hospital setting, the responsibility for ensuring the competence of the delegate falls to the institution rather than the individual physician.*

*The physician delegating the controlled act should ensure there is proper supervision of the delegation, so that the act is performed properly and safely. What constitutes 'proper supervision' will depend on the circumstances. The delegating physician is responsible and accountable for the **delegation** of the controlled act. He or she is also responsible for the **performance** of the controlled act, unless the delegate is a regulated health*

*professional who is already authorized under his or her governing legislation to perform the controlled act being delegated.*

RNABC in its submission states:

*Nurses reported that perfusionists are never left alone in the operating room with a patient on bypass; the surgeon and anaesthetist direct the practice of the perfusionist until the patient is off the pump. ... None of the nurses who were contacted were aware of a formal delegation or transfer of function process from physicians to clinical perfusionists.*

Within this setting, the applicant states that clinical perfusionists consult with the attending operating room physicians, cardiac surgeon and anaesthetist. They are not, however, supervised in their operation of the heart lung machine.

In the Council's opinion, the role of the perfusionist is that of a highly trained technical expert who functions as an independent member of the surgical team. It is doubtful that an anaesthetist or cardiovascular surgeon could be expected to directly supervise the operation of the heart-lung machine and it seems clear that the surgeon and anaesthetist rely on the perfusionist to competently perform to the level of his or her advanced training.

**Section 5(1)(d)(ii): the degree to which the health profession is practised in a currently regulated environment.**

As previously stated, the profession of clinical perfusion is not self-regulated anywhere in Canada. All 30 practising clinical perfusionists in BC work in hospitals because no employment opportunities exist outside the hospital setting. In the Council's view, institutional or administrative structures cannot generally be relied upon to regulate professional practice and standards. The administrative structure of the institution does not exist to supervise the professional practice of independent health professionals. A health care professional can only be supervised in his or her practice by another qualified health care professional.

## **2. Summary of Section 5(1) Criteria**

The Council is satisfied that there is risk of harm in the practice of clinical perfusion, particularly in the light of the invasive nature of the services performed, the equipment employed, and the amount of independent practice with regard to the operation of the heart/lung machine.

In the Council's view, the risk is managed to a limited extent through the certification and recertification process provided by the CSCP. All employers require CSCP certification. However, employer-monitored certification is generally not sufficient in and of itself to protect the public from incompetent, unethical or impaired practice of a certified individual.



At a minimum, certification provides some evidence of competency. Certification is only one aspect of competency assurance. However, without monitoring by a regulatory body with the power and authority to set standards of practice, and review members' competency, discipline its members, and remove a member found unsuitable to practise, the public has no independent assurance that health professionals are subject to uniform standards of practice which apply across employment situations.

In addition to certification requirements, it appears that clinical perfusionists work very closely with cardiovascular surgeons and anaesthesiologists who, if they do not directly supervise, collaborate with clinical perfusionists and order initiation of procedures requiring reserved acts.

Clinical perfusion clearly meets all the section 5(1) mandatory criteria that address risk of harm for designation as a health profession under the *HPA*. However, the Council went on to consider the section 5(2) criteria. Consideration of these section 5(2) criteria are not required, but can raise issues which impact on successful college operations. In all previous applications, the Council's practice has been to review these section 5(2) factors. It will be shown that one of the section 5(2) factors, section 5(2)(g), was significant in the Council's decision not to recommend designation of clinical perfusion.

### **3. Section 5(2): Discretionary Public Interest Criteria**

Section 5(2) of the *HPA Regulation* states:

- (2) *The Council may also consider the following criteria:*
- (a) *the extent to which the health profession has demonstrated that there is a public interest in ensuring the availability of regulated services provided by the health profession;*
  - (b) *the extent to which the services of the health profession provide a recognized and demonstrated benefit to the health, safety or well being of the public;*
  - (c) *the extent to which there exists a body of knowledge that forms the basis of the standards of practice of the health profession;*
  - (d) *whether members of the profession are awarded a certificate or degree from a recognized post-secondary educational institution;*

- (e) *whether it is important that continuing competence of the practitioner be monitored;*
- (f) *the extent to which there exists within the health profession recognized leadership which has expressed a commitment to regulate the profession in the public interest;*
- (g) *the likelihood that a college established under the Act would be capable of carrying out the duties imposed by the Act, having regard to factors which in the view of the council may affect the viable operation of the college;*
- (h) *whether designation of the health profession is likely to limit the availability of services contrary to the public interest.*

The applicant has provided the curriculum outline for the University College of the Cariboo clinical perfusion program. The program is accredited by the Canadian Medical Association. The Council is satisfied that there is a uniform body of knowledge that forms the basis of standards of practice of the profession of clinical perfusion. Perfusionists are awarded a diploma from one of two programs in Canada.

The applicant has represented the profession since 1992. The services of perfusionists provide a recognized and demonstrated benefit to the health of the public. Clearly, there is need for monitoring continuing competency in any profession where there is a risk of harm to the public. There is no indication that designation would limit availability of services. The applicant indicates there are only 30 practitioners of clinical perfusion in the province. The Council notes that the number of practitioners is extremely small when compared with membership in other self-regulating professions. While the applicant proposes to use lay persons and students of perfusion for board and committee membership in a college of clinical perfusionists, the Council is of the view that membership of this size is not sufficient to support the operation of a college.

In light of its review of materials submitted in support of the application, the Council is of the view that a self-regulatory college is not a viable option for this profession.

#### **4. Conclusion Regarding Section 5(1) and 5(2) Criteria**

The Council has reviewed the information gathered during the investigation according to the public interest criteria of section 5(1) and (2) of the *HPA Regulation*.

The Council found that the profession clearly met the section 5(1) (a) to (d) risk of harm criteria. However, in the Council's view, it would not be in the public interest to designate the profession of clinical perfusion under the *HPA*.

The Council notes the size of the profession (30 members) and does not view designation under the *HPA* as viable due to the small number of practitioners in BC.

Several allied health professions, including the applicant, have discussed the possibility of an umbrella health professional college under the *HPA*. Establishment of such an umbrella college could make a health profession with a small number of members, such as the applicant, more viable.

However, in light of the reasons identified in the previous paragraphs, the Council has concluded that designation of clinical perfusion should not be recommended at this time.

**The Council recommends that the profession of clinical perfusion not be designated as a health profession under the *Health Professions Act*.**

### C. RESERVED ACTS

The Council's primary mandate in considering applications for designation is to determine whether a profession should be designated under the *HPA*. In previous reports the Council has recommended against designation, and where the Council has found a significant risk of harm in the practice of the profession which is not sufficiently addressed under the current structure for governance or practice of the profession, it has gone on to consider other regulatory options.

It is of concern to the Council that the practice of this profession requires certain invasive procedures and the performance of other reserved acts. The Council has investigated the practice of perfusionists in other provinces. In Ontario the *Regulated Health Professions Act (RHPA)*, SO 1991, c. 18, provides for delegation of controlled acts, and in the case of perfusionists, model protocols have been developed which allow cardiovascular physicians to delegate controlled acts to perfusionists.

The Ontario *RHPA* sets out a regulatory scheme which is very similar to that contained in *Safe Choices*. Under *Safe Choices*, reserved acts can only be performed by regulated health professionals to whom they have been granted. The Council is not recommending designation for clinical perfusionists and therefore, cannot recommend granting reserved acts to them.

In the absence of designation as a health profession under the *HPA*, then another alternative mechanism to allow for the safety of the public is to have delegation protocols in place for those reserved acts which perfusionists perform. The applicant has stated that at the present time there are no protocols in place.

The following excerpt from the Clinical Perfusion newsletter was submitted by the applicant. It provides useful information about the history of clinical perfusion regulation in Ontario:

### **CONTROLLED ACTS**

*One of the challenges we have facing us as a health profession is the fact that certain parts of our daily routine may fall under provincial health legislation. These acts are generally delegated to various regulated health professions that are covered under the legislation.*

*Usually there is some sort of provision that will allow one of these regulated health professions to delegate these controlled or delegated acts to other groups who are not part of that regulated health profession. In some cases there can be fines levied against persons who carry out these acts that are not covered by regulation or by delegation from the appropriate regulating body.*

...

*... Perfusionists in Ontario have the controlled acts they need to perform their daily routine delegated to them via the College of Physicians and Surgeons.*

...

*The key elements to the requirement in the Ontario Model are that the Medical Advisory Council of the Hospital are informed in writing by the Chief of Cardiac Surgery that this delegation was taking place and that the Surgeon in charge of the given case would take responsibility for the delegation of the controlled act. Policies and procedures covering the given controlled act also need to be in place. In Ontario, the administration of a substance by injection or inhalation need to be outlined with policies and procedures.*

The Council's *Safe Choices* recommended that certain principles be adopted for delegation of reserved acts. These principles, if adopted by the College of Physicians and Surgeons of British Columbia, could cover the delegation of the reserved acts performed by perfusionists. The delegation principles are appended to this report as Appendix A.

If the reserved acts system set out in *Safe Choices* is adopted by the Minister of Health Planning, the Council recommends that delegation protocols which meet the principles recommended in *Safe Choices* be implemented. This should involve representatives of the applicant and of the College of Physicians and Surgeons of BC as its members,

cardiovascular surgeons and anaesthetists, are the health professionals who are responsible for delegating reserved acts.

**Excerpt from Safe Choices:**  
**A New Model for Regulating Health Professions in British Columbia**  
**Supervised Acts**

**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.

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.**

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.