



Professional Practice... in the Public Interest



**A REPORT TO THE BRITISH COLUMBIA MINISTRY OF HEALTH FROM THE
BCSLS/BCAMRT COLLEGE STEERING COMMITTEE ON THE
FEASIBILITY OF A JOINT REGULATORY COLLEGE GOVERNING THE
PRACTICE OF MEDICAL LABORATORY TECHNOLOGY AND MEDICAL
RADIATION TECHNOLOGY IN BC**

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1. List of Abbreviations

AE	Adverse Event
BCAMRT	BC Association of Medical Radiation Technologists
BCSLS	BC Society of Laboratory Science
CAMRT	Canadian Association of Medical Radiation Technologists
CIHI	Canadian Institute for Health Information
CLXT	Combined Laboratory and X-ray Technologist
CMLTO	College of Medical Laboratory Technologists of Ontario
CMRTO	College of Medical Radiation Technologists of Ontario
CSMLS	Canadian Society for Medical Laboratory Science
HPA	Health Professions Act
HPC	Health Professions Council
HPRAC	Health Professions Regulatory Advisory Council
MLA	Medical Laboratory Assistant
MLT	Medical Laboratory Technologist
MRT	Medical Radiation Technologist

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2. Executive Summary

The BC Society of Laboratory Science (BCSLS) and the BC Association of Medical Radiation Technologists (BCAMRT) have applied on several occasions over the past 14 years to the Ministry of Health to have Medical Laboratory Technologists and Medical Radiation Technologists regulated in BC. In 2005, the Ministry of Health provided grants to the BCSLS and the BCAMRT to explore a new structure for a joint regulatory college that would govern the actions of medical laboratory technologists, medical laboratory assistants, and medical radiation technologists in BC. The two professional associations combined efforts to study the issue and develop a proposal on the idea of a joint college. After extensive consultation with interested parties, the BCSLS and BCAMRT are collaborating on a proposal to establish a joint regulatory college that will govern the actions of medical laboratory technologists, medical radiation technologists, and allied subspecialties in BC. Both organizations are committed to establishing a regulatory body whose primary purpose is to protect the public. This college will be flexible in its approach to changes in the healthcare landscape and collaborative in its openness to all stakeholders.

Data from the laboratory and medical imaging departments contribute up to 80% of the diagnostic information on a patient's chart. Some of the procedures performed by medical laboratory technologists and medical radiation technologists are invasive, involving venipuncture, insertion of probes, or administration of ionizing radiation. Laboratory and Radiation procedures are used to make clinical decisions, administer treatments and or medication and therefore have a very real potential for public harm if they are not performed properly.

As scientific advances drive technology into more and more complex applications, MLT/MRTs are required to upgrade their training yet there is no current requirement for participation in continuing education. The current system is voluntary and is based on assumptions that history and good intentions will combine to avert problems. The problem with this approach is that the healthcare workplace has been subject to unprecedented restructuring and cost constraints over the past 10 years. Over the same time frame we have also seen the emergence of SARS, West Nile virus, multi-drug resistant organisms, and *Escherichia coli* contamination of water and food sources. We have also seen the implementation of new diagnostic technology and therapies that didn't exist 10-15 years ago. In the face of these challenges, many MLTs/MRTs and many health care managers are feeling pressure to do more with less. Clearly, the roadmap for laboratory and radiology/radiotherapy procedures has changed but the roadmap for safety is still firmly rooted in the past.

Governments are struggling with issues of health care sustainability. Health care managers are having to balance workloads with wait-time targets. These pressures are being felt in the face of a growing and ageing population. Employers are concerned that there will be enough adequately-trained paramedical professionals to fill current and future vacancies. The numbers of MLTs and MRTs have been declining and are expected to continue doing so. MLTs who transfer to BC from other provinces may not meet the same standards of competency. Paramedical professionals trained in other countries face a daunting challenge in getting their training recognized so they can work in the Canadian

health care environment. The fact that BC is one of the few remaining provinces in Canada without regulation means that filling vacancies and getting training recognized will be more difficult than in other provinces. Since provinces like Ontario offer incentives for continuing education, BC employers face the prospect of being unable to compete for qualified technologists. The general public is concerned that despite the importance of MLT/MRTs to healthcare, they are not regulated and therefore not accountable to the same degree as doctors and nurses. Finally, government is concerned that regulation may escalate existing barriers.

In the current environment, physicians and members of the public alike do not always know if the person performing laboratory, imaging, or radiation therapy procedures is qualified or not. Employers do not know if an MLT/MRT has ever been dismissed for cause in another province in Canada. This opens healthcare up to questions as to whether the current level of oversight is sufficient to ensure public safety and leaves the public with no recourse to address problems.

Regulation ensures that diagnostic and therapeutic procedures are performed by qualified individuals and guarantees the public's right to due process in the event of any failures in the system. In our view, the time has come to regulate the professions of Medical Laboratory Technology and Medical Radiation Technology to ensure public safety in the changing landscape of Canadian healthcare.

3. Introduction and History

This proposal represents a collaborative effort on behalf of two professional associations: the BCAMRT and the BCSLS.

The BCAMRT represents approximately 2,071 members who perform procedures in radiography (1,477 members), radiation therapy (243 members), nuclear medicine (232 members), and magnetic resonance imaging (119 members). Membership in the BCAMRT is required by many, although not all employers, and so the true figure is unknown. By mutual agreement between the BCAMRT and the CAMRT, a BC member must be registered in both professional associations.

BCSLS represents individuals who perform diagnostic procedures in chemistry, hematology, microbiology, anatomic pathology, transfusion medicine, and clinical genetics. The exact numbers of MLTs and MLAs practicing in BC is not known. Most employers require certification in the national professional association, the Canadian Society for Medical Laboratory Science (CSMLS), at the time of hiring an MLT but membership is not required subsequently. The CSMLS currently has 2,730 members in BC and the BCSLS has approximately 1,200 members. It is estimated that there are approximately 3,500 MLTs in the province and 1,500 MLAs. The fact that we do not know the true number of MLTs in the province or what their credentials are is a cause for concern.

Both the BCAMRT and the BCSLS are represented by the Health Sciences Association (HSA).

The BCSLS applied to the Health Professions Council (HPC) in 1994 to have Medical Laboratory Technology regulated under the public interest criteria of the Health Profession Act (HPA). The HPC then conducted a series of consultations with BCSLS,

other related professions, and other interested agencies and parties from 1997-1999. They also conducted their own research on the practice of MLT and its regulation in other jurisdictions. After an extensive consultation process, the HPC recommended in 1999 to the Minister of Health that a College of Medical Laboratory Technology be established to regulate both medical laboratory technologists and assistants [1]. In its report, the HPC determined that the practice of MLT met the definition of “health profession” as defined in the HPA and concluded that the practice of MLT met the basic risk of harm criteria under the act. The HPC recommended that the specific practice of phlebotomy presented a significant risk of harm and should be designated as a reserved act. The HPC further recommended that college membership should be mandatory for medical laboratory technologists and assistants employed in the public sector and that the titles of “Medical Laboratory Technologist” and “Medical Laboratory Assistant” be reserved for the exclusive use of registrants of the College (title protection).

The BCAMRT applied to the HPC to have Medical Radiation technologists regulated under the Health Professions Act in 1998. In 2002, the HPC recommended that medical imaging technologists and medical radiation therapy technologists be designated as a self-governing profession under the HPA and that medical imaging technologists and medical radiation therapy technologists be granted the reserved titles of “radiological technologist”, “nuclear medicine technologist”, “magnetic resonance technologist”, and “radiation therapist” [2]. Although not part of the original application, the Council also recommended that Ultrasonographers should be regulated as part of a College of medical imaging technology and radiation therapy because they shared a similar scope of practice with medical imaging technologists. The HPC recommended that the following reserved acts be applied to the profession: “applying a hazardous form of energy including magnetic resonance imaging, computerized axial tomography, and ultrasound for planning radiation therapy, and ionizing radiation and the administration of pharmaceuticals, physiologically active drugs or a therapeutic radioactive substance by routes including peripheral IV, intramuscular, subcutaneous, rectal, oral, injection or inhalation”.

In 2003, the Ministry invited six health technology professional associations (BCSLS, BC Society of Respiratory Therapists, Cardiology Technologists Association of BC, BCAMRT, BC Society of Clinical Perfusion, and the BC Ultrasonographers Society) to consider the concept of forming a single umbrella college of all six professional groups but this idea was rejected as unwieldy owing to the diversity of interests represented.

In 2004, the Ministry initiated discussions with BCSLS and BCAMRT on a possible joint regulatory college of these two professions. In 2005, the Ministry provided grants of \$30,000.00 each to BCSLS and BCAMRT to conduct a feasibility study on a joint regulatory body for these professions.

The BCSLS and BCAMRT subsequently met to plan an approach to studying the issue. A steering committee composed of members from the BCSLS (John Mabbott, Lynn Simpson, Pat Johnston, Cheryl Dosen and Heather Autio) and the BCAMRT (Alison Mitchell, Claire Hatch, and John French) was set up in June of 2005 to oversee research into the issues and concerns and to prepare a report to the Ministry containing recommendations for a joint regulatory college of the BCSLS and BCAMRT.

4. Objectives and Methods

This report was prepared in response to questions and concerns posed by the Ministry of Health regarding the potential regulation of Medical Laboratory Technologists (MLTs) and Medical Radiation Technologists (MRTs).

A steering committee composed of members of both the BCSLS and BCAMRT was formed in 2005. Public opinion surveys covering a random sample of BC residents across all regions of the province were conducted in July of 2005. Members of the BCSLS and BCAMRT were interviewed in a telephone survey (Mustel Group – February 2006) covering the entire province for their attitudes towards regulation in general and joint regulation in particular. A range of possible stakeholders was identified and interviews were conducted to gather input from these groups from 2005 to 2007.

A general report on the state of healthcare regulation in Canada (QSE report) was commissioned at the request of the BCSLS/BCAMRT steering committee. Recent literature and existing health professions legislation were reviewed. Regulatory bodies for MLTs and MRTs in Canada were contacted and asked to provide statistics from their databases. Personal interviews were conducted with College staff in Ontario and Alberta.

Discussions were held with representatives of the Ministry on a variety of issues relating to the joint college proposal. Finally, a report was drafted, reviewed by the Joint College Steering Committee as well as by the boards of the BCSLS and BCAMRT, and finalized for submission to the Ministry.

This report outlines the current status of regulation of MLTs and MRTs in Canada, summarizes the opinions and concerns of key stakeholders, members of the general public, MLTs and MRTs, and contains recommendations for joint regulation of the two professions in BC.

This report aims to answer the following questions:

- Have different regulatory regimes hindered, maintained, or improved public safety in response to changes in the delivery of services, restructuring and standards of practice?
- How have regulatory bodies affected health care professional supply and mobility and what can be done to ensure a sufficient supply of adequately trained laboratory and radiation professionals?
- Have entry to practice requirements escalated due to regulation? If so, has this been generally recognized as being in the public interest?
- How well have regulatory bodies protected the public through the complaints and disciplinary processes? Are there better ways to handle complaints and discipline?
- How effective are quality assurance requirements in contributing to protecting public safety?
- How can a regulatory body deliver cost-effective sustainable services?
- What is the feasibility of jointly regulating MLTs and MRTs in BC?

Information on concerns among MLTs and MRTs is summarized in Section 6.

Information regarding stakeholder's concerns is summarized in Section 7.

Information on general public concerns is summarized in Section 8. Recommendations with regard to a joint regulatory college of MLTs and MRTs are provided in Section 9.

5. Background

Medical laboratory technology is the third largest health profession in BC. Only the College of Physicians and Surgeons of BC and the Registered Nurses Association of BC have more members. MLTs have completed an accredited two-year training program [three years including the practicum] and perform a wide variety of laboratory tests that assist physicians and other health professionals in diagnosing illness and treating patients. Medical laboratory technology encompasses the disciplines of anatomic pathology, clinical chemistry, hematology, blood banking, and microbiology. Within these major areas of practice, subsections and specialties have evolved in response to changing technology: eg, molecular genetics, virology, cytology, cytogenetics, and immunology.

The title MRT encompasses four different disciplines: Radiography, Nuclear Medicine, Magnetic Resonance (MRI) and Radiation Therapy, each with their own education programs. Radiography and Nuclear Medicine are diploma courses approximately 2 to 2.5 years in length. Radiation Therapy is a 33-month degree program; MRI is a post graduate diploma course as are the subspecialties of computerized tomography (CT) and mammography.

The modalities of radiography, nuclear medicine and MRI are imaging specialties which use sophisticated and highly technical equipment to aid physicians in diagnosing illness. These technologists perform a vast array of examinations including general imaging, interventional procedures, and specialty procedures involving the introduction of contrast media, biopsy collection, and injection of radioactive isotopes. Technologists are required to have current knowledge of many drugs, sterile procedures, specimen collection and initiating intravenous lines as well as maintaining quality control of their equipment and keeping up to date with rapidly-changing technical advances within their field.

Radiation therapists are responsible for planning & delivering a therapeutic dose of ionizing radiation to patients for the treatment of cancer. Radiation therapists work in collaboration with Medical Physicists and Radiation Oncologists, using information from CT, MRI, Nuclear Medicine, and other imaging modalities to visualize tumours and surrounding critical organs in three dimensions. They are also responsible for using advanced computer software to design customized treatment plans that optimize tumour dosing while sparing critical organs. Radiation therapists are responsible for ensuring accurate delivery of treatment using modalities such as state-of-the-art linear accelerators or brachytherapy afterloaders. Radiation therapists are also responsible for the physical & psychosocial care of patients in collaboration with other health care professionals.

Most MLTs and MRTs work in hospital or government laboratories, private medical laboratories, public health clinics, or blood transfusion service laboratories.

Overlapping scope of practice

In addition to individuals who work as either MLTs or MRTs, there are three other types of technologist whose scope of practice overlaps to some extent with MLTs and MRTs. These include combined laboratory and X-ray technologists (CLXTs), MLTs who are cross-trained in radiography, and Medical Laboratory Assistants (MLAs).

Combined laboratory and X-ray technologists (CLXTs) are individuals who have received 2 years of full-time training split between 1 year in radiography and 1 year in laboratory sciences. Most CLXTs practice in rural locations. Training programs exist in Alberta, Manitoba, and Saskatchewan. Members are required to undertake medical laboratory and X-ray training and pass a certification examination. CLXTs typically work in rural hospitals and health care centers, community health care centers, and medical laboratories.

The Northern Alberta Institute of Technology offers a limited training program in radiography (i.e., less than one year) for practicing MLTs. There are no BC members of BCAMRT in this category at present.

Medical laboratory assistants have completed a six-month accredited training program and are responsible for specimen collection and accessioning, initial specimen processing, performing electrocardiograms, and quality assurance activities. The Canadian Society for Medical Laboratory Science introduced an MLA certification examination in 2002. The Ontario Society of Medical Laboratory Technologists (OSMLT) has defined a curriculum and competencies for MLAs and administers a certification examination. In BC, the BCSLS has a certification program for Medical Laboratory Assistants and they also certify the college training programs for Medical Laboratory Assistants.

Regulatory Status of the Professions in Canada*Medical Laboratory Technologists:*

MLTs are regulated under legislation enacted in seven provinces as shown in Table 1.

Table 1 Provincial Regulation of Medical Laboratory Technologists in Canada

Province	Date enacted	College name	Statute	Number of members (year)
Nova Scotia	2004	Nova Scotia College of Medical Laboratory Technologists (NSCMLT)	Medical Laboratory Technology Act	510 (2007)
New Brunswick	1991	New Brunswick Society of Medical Technologists (NBSMLT)	An Act respecting the New Brunswick Society of Medical Laboratory Technologists	649 (2006)
Quebec	1973	Ordre Professionnel des Technologistes Médicaux du Québec	Codes des Professions: Medical Laboratory	4,128 (2006)

		(OPTMQ)	Technologists Act	
Ontario	1993	College of Medical Laboratory Technologists of Ontario (CMLTO)	The Medical Laboratory Technologists Act	5,939 (2005)
Saskatchewan	1995	Saskatchewan Society of Medical Laboratory Technologists	The Medical Laboratory Technologists Act	481 (2005)
Alberta	2002	Alberta College of Medical Laboratory Technologists (ACMLT)	Health Disciplines Act (1995)/Health Professions Act (2002)	1,804 (2006)
Manitoba	2007	College of Medical Laboratory Technologists of Manitoba Transitional Council (CMLTMTTC)	Medical Laboratory Technologists Act (2007)	1,104 (2007)

In five provinces, the regulatory and professional bodies are combined. In Ontario and Manitoba, the regulatory body is separate and distinct from the professional society. Two provinces (BC and Newfoundland/Labrador) are currently considering legislation.

Registration in the Canadian Society for Medical Laboratory Science (CSMLS) is voluntary. Membership with a provincial organization (i.e., either the professional association or the college) is mandatory in order to practice as an MLT in Alberta, Manitoba, New Brunswick, Nova Scotia, Ontario, Quebec, and Saskatchewan.

Medical Radiation Technologists:

MRTs are regulated in five provinces as shown in Table 2.

Table 2 Provincial Regulation of Medical Radiation Technologists

Province	Year enacted	Name	Statute	Number of members
Alberta	1985/2005	Alberta College of Medical Diagnostic and Therapeutic Technologists	Health Disciplines Act (1995)/Health Professions Act (2005)	1,865 (2006)
Saskatchewan	1987	Saskatchewan Association of Medical Radiation Technologists	The Medical Radiation Technologists Act	511 (2006)
Ontario	1991	College of Medical Radiation Technologists	Regulated Health Professions Act	5939 (2006)
Quebec	1973	Ordre des	Radiology	4,200

		Technologues en Radiologie du Québec	Technologists Act	(2006)
Nova Scotia	1989	Nova Scotia Society of Medical Radiation Technologists	Medical Radiation Technologists Act	574 (2006)

As is the case with MLTs, most of the colleges shown in Table 2 combine the roles of regulatory oversight and professional advocacy while in Ontario, the regulatory body is separate and distinct from the professional society. Ultrasonographers are not included in the Ontario legislation while Magnetic Resonance Imaging (MRI) Technologists were recently required to register with the Ontario College.

In Nova Scotia, the Nova Scotia Society of Medical Radiation Technologists has regulated the profession since 1989. There is no quality assurance program at present. The provincial association of MRTs defers to the CAMRT to determine eligibility to write the certification examination.

Registration with either a provincial licensing authority or with the Canadian Association of Medical Radiation Technologists (CAMRT) is mandatory in all provinces except British Columbia.

CLXTs

In Alberta, CLXTs are regulated by a combined college of Laboratory and X-ray Technologists (ACCLXT, established in 1987). There were approximately 300 members of the college in 2006. They are not recognized in Ontario and Quebec and are prevented from practicing by legislation. In BC, the BCAMRT provides CLXTs with a limited practice membership that provides them with liability insurance and all the other benefits of membership. There are currently 8 such members registered with BCAMRT.

MLT/Radiography Technologists

This training is not recognized by the Alberta CLXT College. BCAMRT does not offer a limited practice membership although they are eligible to join as a non-certified technician with access to continuing education but not liability insurance. Although the BCAMRT does not offer limited practice membership to MLTs who are cross-trained in radiography, it is not their intent to prevent this type of initiative.

Medical Laboratory Assistants

There is currently no legislation in Canada regulating Medical Laboratory Assistants. The Canadian Society for Medical Laboratory Science introduced an MLA certification examination in 2002. In Ontario, the practice of Medical Laboratory Assistants and Technicians is governed by the Specimen Collection Licensing Act, which specifies duties that they may perform. The Ontario Society of Medical Laboratory Technologists (OSMLT) has defined a curriculum and competencies for MLAs and administers a certification examination. In 2005, the CMLTO applied to the HPRAC to have MLAs regulated under the Regulated Health Professions Act.

In BC, the BCSLS has a certification program for Medical Laboratory Assistants and they also certify the college training programs for Medical Laboratory Assistants.

Other Issues

Labour supply

According to statistics from the Canadian Institute for Health Information (CIHI) the number of practicing MLTs in Canada decreased by 5.8% between 1993 and 2002[3]. The largest percentage decrease occurred in Alberta (-17.8%). Over this same time period, the Canadian population increased by 9.1%. When adjusted to the growth rate in the general population, the ratio of MLTs per 100,000 population nationally decreased by 13.6% from 68.2 in 1993 to 58.9 in 2002. Three provinces were below the national average- British Columbia (58.7), Ontario (57.3), and Quebec (38.3).

The number of MRTs in Canada increased by 3.9% between 1993 and 2002. When adjusted to the growth rate in the general population (9.1%) over this time period, the ratio of MRTs per 100,000 population showed a relative decline of 5.6%. The lowest ratio of MRTs per 100,000 population was in BC (40.4%) and the highest was in New Brunswick (62.8%).

The Vancouver Coastal Health Authority recently released a report, which concluded that by the year 2015, there will be a shortfall of 905 technologists to meet the projected workload [4].

The local trends mirror those seen at the national level. Clearly, solutions will have to be found to increase the supply of trained MLT/MRTs.

A study by the Labour Market Policy Directorate of Human Resources and Social Development Canada (2001) identified gaps in credentialing of medical laboratory and radiation technologists due to the inconsistency of regulation across Canada[5]. In those provinces where provincial regulatory bodies have been established, they work with provincial and national professional societies, educators, and governments to ensure uniformity of credentials. Each is signatory to an Inter-provincial Mobility Agreement for their profession(s) under the terms of the Labour Mobility Chapter of the Agreement on Internal Trade [6].

Public Safety

The BC Health Professions Council (HPC) concluded that both Medical Laboratory Technologists (1999) and Medical Radiation Technologists (2002) perform functions with an inherent risk of harm to the public and that as professionals they may sometimes perform delegated acts under indirect supervision.

Health professions legislation is enacted to ensure health practitioners properly self-regulate through standards of practice, continuing competence, and complaints/disciplinary processes. The expectation is one of increased public protection within an open and transparent framework of public accountability.

Another issue that encroaches on safety is the subject of timely access to medical care. Particularly in medical radiation technology, new diagnostic procedures and new treatment modalities tend to increase the demand for services.

One consequence of this is that patients may actually have to wait longer for diagnosis and treatment. At least in the eyes of patients, increasing wait times imply that patient safety is being compromised.

In a recent public audit of the Ontario Health Care system, radiation dose levels during MRI and CT procedures, particularly those administered to children, were identified as a safety issue [7]. One of the key issues that this report raised was the necessity of health care providers to work within their full scope of practice to guarantee safety. In response to this report, the Ontario government has set up committees such as a Diagnostic Imaging Safety Committee and an MRI and CT Expert Panel, which have been making recommendations to minimize radiation exposure for patients and hospital personnel. The Ontario Society of MRTs has been a participant in this interprofessional effort to establish acceptable radiation exposure levels.

The Health Professions Council (HPC) recommended in 1999 that MLTs, MLAs, and MRTs should be designated as a health profession under the Health Professions Act in order to protect the public interest [1].

The HPC concluded that employment-based supervision alone was not sufficient to protect the public safety and that in the absence of regulation, an employee who had been disciplined in one jurisdiction would be free to practice with another employer.

Foreign-trained graduates

Currently, a foreign-trained technologist is unable to work as an MLT in Canada even though they may have specialty training in one area (e.g., blood bank) until they have been certified with the CSMLS. Certification is a multi-step procedure involving a review of training and a written examination. The CAMRT is taking steps to improve access for internationally educated MRTs and MRTs who have been out of the workforce for several years (http://camrt.ca/members/AGM_Workbook/pdf/06_Annual_Report.pdf). The British Columbia Institute of Technology (BCIT), which provides training for MRTs, is developing a proposal for a bridging program for internationally educated MRTs. These measures will increase the number of qualified MLT/MRTs eligible to practice in BC and help to address projected labour shortages.

Quality assurance and accountability

All health regulatory bodies must ensure the ongoing competency and practice of their registrants. There are different approaches to quality assurance but most use a combination of several of the following:

- Voluntary or mandatory continuing education requirements
- Required hours of practice
- Specialist or advanced certification
- Random or scheduled practice reviews
- Remedial targeted practice reviews
- Self-assessments, peer reviews and mentoring
- Publication of standards, guidelines and information bulletins

- Re-examination

The main distinctions between regimes are the degree to which quality assurance initiatives are voluntary or compulsory, collaborative or directive, and remedial or sanctioning.

All regulatory bodies are required to implement complaints and disciplinary processes for registrants accused of professional misconduct or incompetence. Discipline hearings are quasi-legal proceedings, can be open to the public, and findings can be published subject to provincial and federal privacy legislation. They are expensive and can be challenged in court.

Cost Effectiveness and Sustainability

A key principle of self-regulation is that costs of administering a college are borne by professional fees charged to its members. Where the population of professionals is small, it may not be possible to create or sustain a regulatory body. Regulatory bodies for medical laboratory technologists and medical radiation technologists have existed in other provinces that have populations that are either smaller or larger than BC. Registration fees for these professions vary between \$150 and \$400, depending upon region, profession and whether the body is a combined regulatory/advocacy organization. The oldest of these colleges (the Ordre Professionnel des Technologistes Médicaux du Québec and the Ordre des Technologues en Radiologie du Québec) have been in existence since 1973 and it would appear that sustainability is not generally an issue for these professions.

Health professions regulators often work together to research and develop solutions to common problems. In Ontario the Federation of Health Regulators and in BC the Health Regulatory Organizations of BC promote good practice and provide a forum for discussion of inter-professional issues.

6. Models of Professional Regulation

There are two comprehensive models of professional self-regulation, one in the United Kingdom and the other in Ontario, that combine disparate health disciplines into an overall, coordinating self-regulating Council. These models were created to maximize the establishment of common processes, structures, and terminology and to provide a reputable and well-resourced body for the public and government to interact with.

Health Professions Council – United Kingdom

The Health Professions Council was created by the Health Profession Act of 2001 in the UK. The role of the Council is to protect the health and wellbeing of anyone using or needing the services of the 13 health professions regulated under the Act. The Council administers the registration of all of the professionals and is currently planning the implementation of a continuing professional development program in July 2006 following consultation with the registrants and other stakeholders. A random number of professionals will be audited each year to monitor compliance with the program. The Council also sets standards of professional training, performance, and conduct. A register of health professionals is maintained and action is taken if registered health professionals do not meet defined standards.

Both Medical Laboratory Technologists (ie, Biomedical Scientists) and Medical Radiation Technologists (i.e., Radiographers) are regulated under the Act. All professions pay the same fee of £60 (approximately \$150.00) per year, collected every two years. This model regulates all professionals under a single regulatory framework, presumably yielding economies of scale in the regulatory process.

Health Professions Regulatory Council – Ontario

The HPRAC is an “arms-length” agency of the Ministry of Health and Long-term Care that provides independent policy advice to the Minister on matters related to the regulation of health professions in Ontario. The mandate of the council is defined in the Regulated Health Professions Act (RHPA 1991) that applies to 23 professions in Ontario. HPRAC advises the Minister on whether to regulate or deregulate health professions and can suggest amendments to the RHPA and related profession-specific Acts and regulations. The Council may also be directed by the Minister to investigate and report on any matter pertaining to the regulation of health professions. HPRAC has a duty to evaluate and report on the effectiveness of each College’s programs related to patient relations, quality assurance, and complaints and discipline procedures with respect to professional misconduct of a sexual nature.

The seven members of HPRAC are appointed by government and may not be past or present members of the regulated health professions or public servants. In essence, HPRAC serves as an overseer of the individual regulatory Colleges, each of which functions independently. There is however, a voluntary Federation of Health Regulatory Colleges of Ontario that provides a collective voice on behalf of the regulators and is a communication channel for HPRAC when matters affecting all Colleges need to be addressed.

Impact of regulation on public safety

Patient safety is a recognized issue in health care. In a study of adverse events (AEs) in Canadian hospitals, preventable AEs associated with diagnostic procedures constituted approximately 11% of the total AEs investigated [8]. The CSMLS is very concerned about safety issues and is currently developing a position paper for public discussion. Despite general recognition that patient safety deserves attention, there are no published metrics that assess the effect of professional regulation on public safety.

Health professions legislation is enacted for the purpose of regulating practitioners through standards of practice, continuing competence, and complaints and disciplinary processes. The intent of the legislation is to increase public protection by assuring the competence of practitioners who are thereby subject to investigation in the event of any report of non-competence or professional misconduct. In most provinces, the regulatory body is governed by a board or council that includes public appointees. Public appointees may also serve on the various subcommittees (e.g., Executive, Complaints, Discipline, Fitness to Practice, Patient Relations, Quality Assurance, Registration, Member Services, and Nomination). The public gains direct access to lodge complaints about the conduct of a professional and the regulatory body is obliged to assess the complaint and determine if an investigation is warranted.

Public safety is addressed by setting standards of practice and competence for all practitioners entering the workforce. Safety is also reinforced by having a public complaints process for addressing potential safety issues as they arise. One illustrative example of misconduct that came to public attention in 1985-1990, was that of sexual abuse of patients by health professionals. This led to the inclusion of specific requirements in legislation to prevent such abuse and impose disciplinary measures. A finding of professional misconduct for sexual abuse today results in the loss of the right to practice and the public thereby benefits from the close scrutiny of health professionals. The HPRAC in Ontario prepared a report for the Ministry on the effectiveness of the complaints and discipline processes of the regulatory colleges in handling reports of sexual abuse. In this report, HPRAC observed that a large proportion of the public did not know where to file a complaint. A series of recommendations were therefore made to increase responsiveness of the college's complaints and discipline processes and to encourage complainants to come forward. The legislation exists, whether or not is actually enforced and, in this sense, acts to guarantee public safety.

In the absence of any literature regarding the impact of regulation on public safety, the number of complaints received by a regulatory body reflects the degree to which regulation is working. The actual details of complaints are not made public, however, and only the overall numbers are published.

In many cases, complaints were dismissed as being unfounded or because there was insufficient evidence to proceed further. For such reasons, the number of complaints proceeding to a disciplinary process may be a more definitive indicator.

All regulatory bodies are required to implement processes for handling complaints and disciplining members found guilty of incompetence or professional misconduct. In most cases, legislation requires information about complaints and discipline to be made public. The way in which this is done varies between provinces. For example, the largest numbers of complaints were reported to the Ontario College. One reason for this is that Ontario is the only province to have regulatory colleges for Medical Laboratory Technologists and Medical Radiation Technologists that are separate from the respective professional societies.

Complaints and disciplinary cases for Medical Laboratory Technologists in different provinces are shown in Table 3.

Table 3 Complaints and disciplinary cases – Medical Laboratory Technologists

Year	Province	# Complaints	# Discipline cases	Outcome
2000	Ontario	4	5	1. Sexual abuse; registration revoked. 2. Failure to maintain standard of practice; 3 weeks suspension and a \$250.00 fine. 3. Incompetent; one-week suspension, \$100.00 fine, and no longer allowed to practice immunohematology. 4. Unprofessional conduct; errors made due to medical condition, required to practice

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				under supervision. 5. Theft of money from purse in laboratory; one-month suspension and ordered to take an ethics course.
	Quebec	1	0	N/A
2001	Ontario	0	4	1. Transfusion science errors; one-month suspension, course, and \$250.00 hearing costs. 2. Laboratory errors; three weeks suspension, courses in histology, immunohematology, specimen collection, and ethics required, \$1,000.00 fine. 3. Discrepancies in quality assurance documentation; oral reprimand, \$100.00 fine and member required to report to the college on the importance of honest communication with College. 4. Allegation of professional misconduct; member resigned.
	Quebec	0	2	1. Temporary suspension. 2. Practice restrictions
2002	Ontario	0	2	1. Laboratory errors; one week suspension or completion of courses in specimen collection and problem solving, \$100.00 fine and \$400.00 costs.
	Quebec	3	1	Suspension and fine.
2003	Ontario	0	2	1. Disgraceful, dishonorable, or unprofessional conduct; reprimand, two-week suspension or completion of course on boundaries, \$3,000.00 costs.
	Quebec	1	0	N/A
2004	Ontario	0	0	N/A
	Quebec	7	0	N/A
	Nova Scotia	1	0	N/A
200-2004	Alberta	13	3	Reprimands, required courses, fines, costs.
	Saskatchewan	8	4	4/4 referred for discipline (no details available)
N/A = not applicable				

Complaints and disciplinary cases among Medical Radiation technologists in Ontario for 2000-2004 are shown in Table 4.

Table 4 Complaints and disciplinary cases (Ontario) - Medical Radiation Technologists

Year	#Complaints	#Discipline hearings	Outcome
2000	6	1	Professional misconduct - negligence: two-month suspension, reprimand
2001	0	1	Non-compliance with quality assurance program requirements; suspension and \$2,000.00 costs, member resigned
2002	9	1	Payroll record mismanagement; one-year suspension and reprimand
2003	10	0	N/A
2004	10	1	Decision issued in 2005
N/A = not applicable			

The Nova Scotia Society of Medical Radiation Technologists reports that they have received 3 complaints between 2000 and 2004. None of the complaints proceeded to disciplinary hearings. One fitness-to-practice case was also reported in this period. The outcome is unknown.

In Ontario, public complaints are handled by the Complaints Committee of the College. In addition to public complaints, the Regulated Health Professions Act in Ontario requires an employer to report (a) the dismissal of a member for reasons of incompetence or professional misconduct, (b) any case of a member having limitations placed on their practice by an employer, and (c) failure to comply with the requirements for quality assurance. These mandatory reports are reviewed by the Executive Committee of the College and not by the Complaints Committee. The College of Medical Radiation Technologists of Ontario (CMRTO) does not publish information about mandatory reports. The College of Medical Laboratory Technologists of Ontario (CMLTO) does publish limited information on mandatory reporting, however, and the number of cases reported to the Executive Committee of the CMLTO in 1998, 1999, and 2004 was 19, 12, and 26, respectively.

Overall, there were significantly more complaints and discipline proceedings for MLTs in Ontario. Information on complaints and discipline for MRTs in other provinces could not be obtained for comparison but these numbers follow a trend in that the higher the profile of the profession and the greater the contact with the public, the more complaints are likely to be received.

The fact that complaints and disciplinary proceedings appear to be highest in Ontario may be due to the fact that the Ontario legislation places a greater onus on the colleges to protect the public. Ontario is the only province to separate the regulatory college from the professional societies for both MLTs and MRTs. The colleges undertake public awareness campaigns through the Federation of Health Regulatory Colleges and there is also a mandatory reporting requirement in the Ontario legislation. Employers are required to report the dismissal of an MLT if it is for incompetence or negligence.

In BC, with our strong union environment, most dismissals for cause have a privacy clause attached so there is no way that a new employer would know of the dismissal unless the employee chose to disclose it.

In addition to specific measures enacted through legislation, there are also professional measures that, while they are outside of the legal framework of regulation, may also act to protect the public interest. Health professions have adopted Codes of Ethics to guide practice in the public interest. Quality assurance programs are another avenue for protecting the public interest. These programs require participation in continuing education and sometimes include competence assessment or peer review. In theory, health professionals who participate in such programs should have a reduced risk of error. The problem with a voluntary approach, however, is that individuals and employers may not wish to invest to update their skills and knowledge even though they might be among those who would benefit the most from it.

Scope of Practice

Legislation limits the health profession to varying degrees. Some statutes limit the use of title only, while others specify the tasks or activities the health professional may or may not perform. The Ontario Regulated Health Professions Act lists thirteen controlled acts; each regulated profession is permitted to perform one or more of the controlled acts. A 2003 review of this legislation noted that this model has encountered problems due to its rigidity. Other provinces used delegated or licensed acts models.

There are three approaches to regulation: licensure, certification, and registration. Licensure creates a professional monopoly, giving the practitioner exclusive right to practice in addition to title protection. Certification is achieved through title protection, is less restrictive, and recognizes individuals who have met predetermined qualifications set by a regulatory agency. Registration is the least restrictive and provides essentially a roster of practitioners.

Title protection is the most common form of regulation today, combined with some form of assigning responsibility for tasks that present a particular risk of harm to the public. These restricted, reserved, or controlled acts (terminology varies according to the specific statutes) have generally replaced the former delegated acts, reflecting the independence of the various health professions.

Title protection allows a profession to articulate its scope of practice and the standards required for practice. Practice may include acts that present a risk of harm and this is usually specified in legislation. The emphasis of any professional legislation should be on the accountability of the professional. Health professionals are expected to meet and maintain standards of practice and it is the job of the regulator to ensure that this happens. This is achieved by a number of means:

- Subject-specific certification- eg, MLT/MRTs practicing in one specialty only
- assigning controlled or reserved acts to a profession or to individual practitioners
- quality assurance programs for continuing professional development
- mandatory reporting of incompetence or professional misconduct by employees
- complaints, discipline, and fitness to practice processes

- public reporting of compliance to the various requirements

7. Laboratory and Radiation Professionals: Issues and Concerns

BCSLS and BCAMRT commissioned the Mustel Group, a professional market research and public opinion firm, to survey the opinions of BCSLS and BCAMRT members about establishing a joint regulatory body for their professions [see Appendix: Future Regulation and Licensing of Diagnostic and Treatment Professionals. Mustel Group, February 2006]. In this survey, which was conducted in December 2006, most (94%) of members surveyed were trained in Canada and most (69%) were principally trained in BC. Fifty-four percent of members were 45 years old or older. A large proportion of members expressed concerns for public safety in the face of increasing workloads and technological sophistication. Regulation was seen as a route to standardize job skills and quality control across the province and ensure that individuals graduating from educational training programs or moving to BC from other provinces or countries have the necessary expertise to perform the work.

Many members were in favour of continuing education requirements although they were opposed to the idea of being periodically re-examined in order to maintain their licensing.

Most members were aware that medical laboratory technologists, medical laboratory assistants, and medical radiation technologists are currently regulated in other provinces.

Some of the possible advantages of regulation in BC that members identified include accreditation of educational qualifications, standardization of job skills and quality control measures, and raising the standards of practice in the workplace.

On the other hand, members are concerned that regulation might increase the cost of education, lead to increased entry-to-practice requirements, and limit the ability of professionals from other provinces or countries to work in BC.

Overall, one-half of the combined membership of the BCSLS and BCAMRT supported the creation of a joint regulatory college and there was strong support (66% overall) for the idea of regulation by the profession. Almost 60% of total members were opposed to the idea of establishing a combined college covering all diagnostic services. A high level of support (74%) exists for including medical laboratory assistants in the joint regulatory college. Only 11% of total members were opposed to regulation.

Medical Laboratory Assistants

The majority of laboratory staff performing phlebotomy are MLAs. The general public and, to some extent, other health care colleagues, tend to view all laboratory staff as one entity and do not understand the inherent safety risks associated with phlebotomy. Phlebotomy errors can cause serious harm to patients, either by direct injury or by improperly collected blood specimens that can lead to erroneous laboratory results. Employers appear to be increasing the scope of duties and responsibilities of MLAs.

As the laboratory workforce ages, younger and less-experienced MLAs are having to fill the gaps and in this environment, appropriate supervision may be lacking. Because of the inherent risks of phlebotomy, it is essential to establish quality control standards for the practice. Four provinces (Alberta, Saskatchewan, Ontario, and New Brunswick) are at various stages of working toward some form of regulation of MLAs.

The BCSLS views the current situation where MLAs do not have national standards of training, practice, or competence as an anomaly that is not consistent with public protection. MLAs are the primary interface between the laboratory and the public in specimen collection centres, point-of-care settings, and long-term care facilities. Under the current state of affairs, a member of the public who experiences a misadventure at the hands of an MLA does not have any recourse to a public complaints and disciplinary process.

Patient safety is such a concern that the CSMLS is drafting a white paper entitled “The Laboratory’s Role in Patient Safety” that will be completed in August of this year. This report will address the important role that MLAs play in the laboratory.

8. Stakeholders: Issues and Concerns

Interviews with stakeholders such as senior human resources staff, diagnostic service managers, and government managers were conducted between November 2005 and July 2007 by members of the BCSLS/BCAMRT Joint College Steering Committee.

Government representatives

- Bruce Deacon, Manager, Research Initiatives, Research and Innovation, BC Ministry of Advanced Education
- Daryl Beckett, Director of Professional Regulation, BC Ministry of Health
- Lorne Klippert, MD, Consultant, BC Ministry of Health
- Jan Rossley, Legislation and Regulation Division, BC Ministry of Health

Jan Rossley stated that government wanted to devote attention to bringing recognized regulators under the act (Health Professions Act?) but were finding that this was proving to be demanding in terms of finding staff to deal with new legislation and regulations. For this reason, government was having to prioritize their efforts but were looking at reserved actions for different professional groups sometime in 2007/2008. Although the Federal government holds a position of influence in some matters of policy, the delivery of services falls under provincial jurisdiction. There will need to be some coordination of policy between the two levels of government. The Federal government tends to favour umbrella organizations because these are felt to be more cost-effective and efficient. The public does not readily distinguish between different health care professions and may find a single umbrella organization for the health care professions to be more accessible.

Ms. Rossley stated that government is open to new approaches to regulation so long as these fit the needs of different populations and service configurations. One approach may be to ask health authorities to regulate certain professions but she admitted that there is no universal model in mind. In considering the need for a new regulatory body, government would consider input from existing professional groups who are organized, able to engage with government, sufficiently funded, and will not create problems for other regulatory bodies already in existence.

Jan Rossley, Daryl Beckett, and Dr. Klippert expressed the concern that professional bodies tend to escalate entry-to-practice credentials, which raises costs of educating professionals and restricts the supply of qualified labour. Regulatory bodies should focus on patient safety first and discuss raising credentials with government in order to assess their impact on the educational system and the supply of new labour. Similarly, integration of internationally-trained professionals should be a high priority in order to sustain health care in general and the professions specifically. Government prefers that assessment of skills and knowledge be based more on competency rather than paper-based examinations.

Government believes that quality assurance and scope of practice guidelines should be determined in discussion with existing regulators, professional associations, and employers in order to establish best practices that are flexible and robust.

Fees should not be so high as to discourage new members from entering the market but in some cases, such as midwives, subsidies may be necessary because of the strategic potential for rural communities.

Mr. Beckett and Dr. Klippert both expressed an interest in alternative models of self-regulation, particularly ones that were based on interprofessional collaboration and cooperation. Both felt that employers should be more involved in supervision of quality standards and be more accountable for public safety. They further stated that current regulatory practices minimize the role of employers and prevent them from adopting best practices in their own service area. Both expressed the view that different approaches might be required in rural communities compared to urban areas. Mr. Beckett expressed the concern that adding regulatory bodies might overburden the system with legislation and carried the potential for disputes between regulators over scopes of practice that could be debilitating to the system. Mr. Beckett and Dr. Klippert felt that regulators are not good at working with employers to ensure the quality of the skills of professionals. Both expressed the view that although disciplinary processes are similar between regulatory bodies, they do not share these functions, often citing specialization and privacy concerns. Since many of the legal and policy issues are similar between professional groups, cooperation in this area might lead to greater transparency and avoid duplication.

Non-governmental stakeholders

Interviews were conducted with the non-governmental stakeholders listed in Table 5

Table 5. Individuals on this list were provided with a background document to familiarize them with the issues and subsequently interviewed over the telephone or in person using a standardized questionnaire. Copies of the background document and the questions asked are provided in Appendix 1.

Table 5 Non-governmental Stakeholders

Organization	Name	Organization	Date interviewed
BC Children's and Women's Hospital	Catherine Halstead, MD	Head, Division of General Laboratory Services	June 29, 2007
	Nancy Kotani	Corporate Director, Strategic and Process Initiatives	June 29 and July 3, 2007
Vancouver Island Health Authority	Gordon Hoag, MD	Medical Director	June 25, 2007
	Pamela Ganske	Laboratory Manager	
	Debra Cain	Manager, Laboratory Licensure and Training	
Fraser Health Authority	Marc Pelletier	Vice-president, Clinical Support	June 26, 2007
	Judy Newman	Director, Laboratory Services	
	Arun Garg, MD	Medical Director, Laboratory Services	
	William Dow, MD	Director, Medical Imaging	
Northern Health Authority	Ken Winnig	Director of Diagnostic Services	June 26, 2007
Interior health Authority	Martin Woods	Head, Laboratory Redesign	June 26, 2007
MDS Metro Laboratories	Nigel Banks	Vice-President, Human Resources	June 26, 2007
	Norma Page	Director, Analytical Services/Operations Manager	
BC Biomedical Laboratories	Barbara Wong	Director, Human Resources	July 3, 2007
	David Chow	Manager, Microbiology	
College of Medical Radiation Technologists of Ontario	Linda Gough	Registrar and Executive Director	June 21, 2007

Organization	Name	Organization	Date interviewed
BC Cancer Agency and BC Center for Disease Control	Catherine Syms	Director, Risk Management	June 21, 2007
Diagnostic Accreditation Program	Sharmen Lee	Executive Director	June 29, 2007
Health Employees Union	Marcy Cohen	Research and Policy Director	July 4, 2007

The questions broadly concerned the effect of regulation on public safety; labour supply, mobility, and credentials; quality assurance and accountability; and cost effectiveness and sustainability. Interviewees were also asked for their general opinion on the proposal to establish a joint college of MLTs and MRTs. An overall summary of opinion across the participants as well as highlights of key differences between them is provided below.

Among Health Authorities in different regions of the province, responses were generally supportive of joint college regulation. In general, the responses to questions were fairly consistent between interviewees. Most felt that regulatory bodies were meeting the expectation of protecting public safety and most also felt that regulatory bodies should be required to provide evidence of this. Dr. Gordon Hoag (Medical Director, Vancouver Island Health Authority) suggested that standards and quality of practice should be more rigorous as there have been situations across Canada where the colleges have not fulfilled expectations. Catherine Syms (Director of Risk Management for the BC Cancer Agency and BC Centre for Disease Control) suggested including patients in discussions of how a college can improve safety. Martin Woods (Director of Diagnostic Services, Interior Health Authority) suggested that a peer-review process between provinces might fulfill this need. The College of Registered Nurses of BC has built standards around disclosure into their standards of practice similar to the Law Society of BC. Dr. William Dow (Director of Medical Imaging, Fraser Health Authority) stated that they were experiencing major challenges with workforce sustainability and need a mechanism to introduce changes to scope of practice involving multiple entry levels and standards. Dr. Catherine Halstead (Head of General Laboratory Services, BC Children's and Women's Hospital) stated that safety in a hospital setting was a complex issue that involves several levels of oversight, some internal to the institution and some external. She felt that competency was best addressed through self-regulation but acknowledged that there are other problems that need to be addressed at a system level. In regard to continuing education, she felt that this should be mandatory rather than voluntary.

Most interviewees felt that regulation did not restrict the supply or mobility of MLTs or MRTs and most felt that they did not impede workforce restructuring or innovation. Catherine Syms quoted an example of physicians blocking the introduction of nurse practitioners and she also noted that insurers sometimes stipulate what a college member may or may not do. The Vancouver Island Health Authority representatives felt that

regulation needs to be flexible to allow for innovative workplace practices, such as molecular diagnostics, and not unreasonably limit scope of practice.

Several interviewees felt that it was not reasonable to oblige foreign-trained technologists to re-train, particularly in times of labour shortages. Catherine Syms felt that a regulatory college should help with evaluation of foreign-trained technologists.

Dr. Halstead stated that budget pressures force institutions to employ personnel who get paid less and this carries a risk of compromising quality to meet budget targets. She felt that regulatory bodies can be useful in setting standards in this environment even though this might increase costs. A new regulatory college in her view should be open and flexible in the definition of competencies and job descriptions. She also noted that because standards differ between provinces, technologists can be certified in a province where standards are lower, obtain some work experience, and then move to another province. National standards would level the playing field in this regard; a view that was echoed by Sharmen Lee (Executive Director of the Diagnostic Accreditation Program) who noted that national standards would have to account for the fact that scope of practice for different professions is sometimes different between provinces. Sharmen Lee felt that while regulatory bodies could impede workforce restructuring or innovation, this can be overcome if they recognize that requirements and standards change over time and scope of practice be defined according to the patient's best interests. Standards should not be arbitrary but should be set in partnership with other experts including educators, institutions, and provincial and national associations.

Colleges generally have a process for demonstrating competency. Sharmen Lee felt that rather than using a one-time certification approach, competency assessment should be an ongoing process and adapt to changing circumstances. She also felt that while competency standards should be mandatory, the best way to ensure a stable labor force is to avoid sanctions and focus on continuous improvement. Quality assurance programs should be creative and open to other stakeholders.

Several interviewees pointed out that in BC, an employer has little way of knowing if a technologist had been dismissed in another jurisdiction for competency-related issues. The Fraser Health Authority representatives asked how much overlap there would be between the Health Authorities and the college in regard to quality assurance, and workplace standards and controls. Most felt that the current complaints and discipline processes were effective and that it was desirable to follow a standardized approach across the different colleges. Many felt that the challenge to transparency is to strike a balance between the public's right to know and the privacy of the member. In Ontario, complaints are reviewed by a complaints committee and very few of them progress to a disciplinary hearing. In BC, the College of Nurses investigates all complaints and this has led to investigating complaints that have little merit. Involving patient advocates before a complaint is made to the college was suggested as a way to resolve issues. Catherine Syms suggested that complaints and discipline processes could be improved by subscribing to a philosophy such as "Safer Health Care Now" and adopt similar standards around disclosure, education, and training. Standards for credentials, education, and quality assurance should be set nationally.

Most interviewees felt that a joint regulatory college of MLTs and MRTs was desirable and that it should include CLXTs and other cross-trained technologists. Some suggested that a combined regulatory body might reduce costs by sharing processes and administrative structure. Linda Gough (Registrar, CMRTO) pointed out that a challenge in forming a joint college might be in coping with many different disciplines and levels of practice. Martin Woods pointed out that the costs of incompetence and the risks to public health outweigh the costs of maintaining a regulatory body.

Catherine Syms pointed out that while there needs to be independent people on the college hearing committees, it is also important to have content experts. Several interviewees suggested that the costs of regulation should be partly borne by government since the HPA is a government initiative. On the subject of a joint college, she suggested that standards of practice and responsibilities should be clearly defined, particularly where there is cross-over between the disciplines, such as CLXTs. If not clearly defined, this could be confusing to the public and create concerns over liability.

Several stakeholders either had reservations to components of the college questionnaire or were resistant to the college idea in its entirety. Nancy Kotani (Corporate Director, Strategic and Process Initiatives at BC Children's and Women's Hospital) was opposed to the idea of establishing a joint regulatory college of MLTs and MRTs because she felt that it would escalate costs and would not measurably improve quality of care. She felt that the effect of regulation of other professional groups such as nurses, has been to increase educational requirements and this has been largely responsible for the current labour shortage.

Opinion among private laboratories tended to be conservative and it was here that the greatest differences of opinion compared to other respondents were observed. Nigel Banks (MDS Metro Laboratories) expressed concerns about added costs to technologists and employers and that the added bureaucracy of regulation might exacerbate labour shortages. According to Sharmen Lee, however, a regulatory body might make it easier for foreign-trained professionals to be qualified and eliminate a situation observed in the private sector where 'qualified but not registered' professionals were employed. She felt that regulation was a means to eliminate barriers rather than creating them. Norma Page (Director, Analytical Services, MDS Metro Laboratories) stated that laboratory science in BC is a medical practice, unlike other provinces, and that this serves the same purpose as having a college. Representatives from MDS Metro Laboratories were concerned about litigation resulting from college complaints and disciplinary processes. They felt that patient complaints are best handled by bringing them to the attention of senior management at MDS Metro. Nigel Banks (Vice-president of Human Resources at MDS Metro Laboratories) expressed the view that hospitals and private clinics are sufficiently covered by the Diagnostic Accreditation Program (DAP) and College of American Pathologists (CAP) and they therefore they are not yet convinced of the need for a provincial regulatory college. Dr. Gordon Hoag however, felt that while there was some overlap with the DAP, this did not negate the need for a college as the college serves a different purpose. Similarly, representatives from the Fraser Health Authority suggested that while there might be some overlap with the DAP, a college could still provide a useful oversight as long as there was a clear distinction made between licensure and accreditation to avoid duplication. They pointed out that DAP applies only to the

operation of a business or facility and not necessarily the competence of individuals. While the MDS Metro representatives expressed reservations about the effect that a college might have on their business, they acknowledged that the reasons behind a college are laudable and that if it came to pass, they were prepared to work with the college in an advisory capacity. Overall, they are concerned that the college may limit the ability of private laboratories to meet patient and business needs at the same time.

Barbara Wong (Human Resources Advisor for BC Biomedical Laboratories) stated that they were not convinced of the value of a college for MLTs and questioned whether there was adequate support for this. She felt that their participation in the DAP was appropriate regulation for their workplace but that medical supervision requirements of the DAP should be strengthened and that the BCSLS should lobby the DAP to make these changes. In contrast, Sharmen Lee (of the DAP) felt that the lack of a regulatory college for technologists made it impossible for the DAP to mandate standards of practice for the MLT and MRT professions. Ms. Wong felt that the CAP quality assurance program was a better way to promote public safety than professional self-regulation. She felt that regulatory bodies restrict the supply or mobility of technologists because they impose provincial entry requirements and fees, something that even MLTs perceived as being inconvenient and bureaucratic. She felt that CSMLS was the appropriate national certification body for MLTs and MLAs. She felt that the Joint Medical Laboratory Advisory Committee was an appropriate body to make recommendations on education and that the prior learning assessment process of CSMLS for foreign credential recognition was sufficient to address foreign-trained technologists. In her view, education standards and competency requirements should be set under medical direction and that industry and educational institutions should work collaboratively to implement the standards. She felt that the complaints and discipline processes of colleges were not effective in protecting the public. She feels instead that a total quality system needs to be implemented across other organizations because it can identify causes and solutions. The focus should be on continuous improvement rather than assigning blame. She felt that any new regulatory body might require non-value-added work, such as assessing credentials that have already been recognized by CSMLS or the employer and that it may delay accreditation or complaint resolution and discipline. This would likely be associated with extra costs that ultimately would have to be borne by the taxpayers. She also added that they are very concerned about delegated supervision for venipuncture.

While some of Ms. Wong's concerns appear valid, the majority of interviewees felt that these concerns could be addressed as the Joint College evolves and as the regulations are enacted.

Unions

In BC, the MLTs and MRTs are represented by the Health Sciences Association (HSA), MLAs are represented by the Hospital Employees Union (HEU), and MDS Metro employees are represented by the BC Government Employees Union (BCGEU).

Marcy Cohen, Research and Policy Director for the HEU, said that while they cannot take an official position at this time on a Joint Regulatory College of MLTs and MRTs, they are willing to take a collaborative approach to this initiative. They would first like to

consult more with their members, examine the research, and ensure that alternatives have been considered. Ms. Cohen offered the following general opinions on the questions that were posed. HEU believes that public safety issues are systematic issues rather than individual employee issues and that colleges should focus on system improvements and best practices rather than individual continuing education and discipline. She felt that while colleges can determine competencies, they do not necessarily deliver training, which creates a disconnect. In that regard, HEU is concerned that private training colleges that provide training for MLAs are not operating to the same standards as public institutions. HEU feels that competencies and training standards should be established through a collaboration between employers, employees, government, unions, and the professional associations. They are concerned that MLAs voices will not necessarily be heard in a joint college composed of MLTs, CLXTs and MRTs. HEU wishes to lessen the “turf wars” that have developed over roles and responsibilities. They foresee a potential problem with a joint college that represents members from several different unions and suggest that this needs to be well thought out. HEU wants to see good training standards, good entry-to-practice requirements, and more focus on improving practice and feels that employees must be involved in the process. They are not opposed to discipline but feel that it should be a last resort when other means have been exhausted. Cost and sustainability are an issue as MLAs are paid less than MLTs and MRTs and HEU wonders how balance and affordability will be considered. For foreign-trained technologists, HEU supports offering bridging and ESL programs to make it easier for them to enter the workforce. HEU are less supportive of subject-specific certification and favour a more generalist approach.

The Health Sciences Association of BC [HSABC] represents over 4100 MLTs and MRTs in the province. There is anecdotal evidence that HSABC has been reasonably supportive of regulatory colleges and regulation in general in the past. A recent grievance procedure launched by HSABC referred to the role of regulatory colleges and the unions support for such a role.

The new President of HSABC, Reid Johnson, was engaged in a very brief telephone conversation about the joint college proposal. He stated that he was intrigued by the concept of the “joint” college and was willing to have further discussion about it. Unfortunately, he was leaving on summer vacation and would not be available until his return some time in mid July. He asked one of his senior staff to respond to the request for HSABC input on regulatory colleges and regulation in general.

The following response was received on July 11, 2007:

Dear Malcolm Ashford

Thank you for sending me your questionnaire and survey regarding the establishment of a joint regulatory college. HSA seldom takes a position on matters internal to the governance or scope of a regulatory college. Our interest would be in those areas where the interests of our members would be affected by the actions of the college. You have asked if we are in favour of creating a new joint regulatory college for MLTs and MRTs. We do not have a position on this issue. However, thank you for contacting us and we are willing to be contacted in future on matters that may have an impact on our members.

Yours truly

Maureen Headley

HSABC

9. General Public: Awareness and Concerns

In July 2005, the Mustel Group conducted a telephone survey of public awareness of regulation of health professionals. Five-hundred individuals who were randomly selected from geographically diverse areas of the province participated in the survey [see Appendix: Public Opinion Survey – Mustel Group2005.pdf]. Fifty-one percent of subjects were from the Vancouver area, 21% from the southern interior region, 11% from the south coast and Vancouver Island, 9% were from the capital region, and 8% were from the north coast or northern interior region. Overall, the survey showed that public support for regulation of laboratory technologists and radiation technologists was strong. Ninety-four percent of respondents correctly believed that doctors and nurses were already regulated and 80% correctly believed that pharmacists were regulated but more than 75% of respondents incorrectly believed that laboratory technologists and radiation technologists were regulated. When informed that laboratory technologists and radiation technologists were not regulated, 66% of respondents said they were concerned about this lack of regulation.

The most common (ie, cited by 13-21% in any response category) reasons for respondents being concerned included (a) “that standards are necessary to ensure quality and accuracy” (24.6%); (b) “because standards are needed” (16%); (c) “to ensure that MLT/MRTs are supervised and accountable” (16.5%); (d) “because MLT/MRTs perform an important service that affects the lives and health of patients” (16%); and (e) “to ensure that MLT/MRTs are properly trained” (14%). By comparison, of the respondents who were unconcerned about the lack of regulation, 12.6% said that this was because MLT/MRTs have completed training school or had credentials, 11% said that this was because MLT/MRTs work under regulated professionals, 6% said that this was because MLT/MRTs do not have the same level of responsibility as doctors, 6% said that this was because MLT/MRTs are regulated by their employer, and 3% said that this was because there is already too much regulation. Of the subjects who were concerned about the lack of regulation, 83% felt that laboratory technologists and radiation technologists should be regulated. Those who were concerned also believed that regulation would improve accountability, training, and qualifications within professions. When asked what type of regulation they would prefer to see, 51% were in favour of self-regulation, 21% were in favour of government regulation, 19% were in favour of regulation by employers, and 5% were in favour of no regulation. Responses were also summarized by geographic region, gender, age, family status, education, and household income and the responses were fairly consistent across all categories.

When asked if MLT/MRTs should be regulated or the situation was fine as is, 69% of respondents answered that MLT/MRTs should be regulated.

10. Recommendations

The challenge in British Columbia lies in designing a regulatory framework that encompasses the need for public protection, without having three separate regulatory agencies, as in Alberta.

We propose that a Joint Regulatory College for MLTs, MLAs, CLXTs and MRTs be established in British Columbia.

There is a high level of concern amongst members of the general public that MLTs and MRTs are not currently regulated and many of the individuals surveyed felt strongly that such regulation is needed. The BCSLS and BCAMRT represent the interests of many MLTs, MLAs and MRTs currently practicing in BC. Members of both organizations expressed strong concerns about the potential effects of technological change and workplace restructuring on public safety. Overall support for a regulatory body amongst the memberships of these two professional organizations was high – i.e. 68% of BCSLS and BCAMRT members combined were either supportive of or at least not opposed to the notion of being regulated while 31% were opposed. Within each professional association, 80% of BCSLS members were either supportive or not opposed while 19% were opposed and 57% of BCAMRT members were either supportive or at least were not opposed while 41% were opposed. The largest influence behind a member supporting the idea of a regulatory college or not was cost. Support for the college tended to rise once the issue of cost was addressed. Most of the members expressed a desire to see a self-regulation model. Although the survey included only members of the BCSLS and BCAMRT and therefore did not sample non-members, we feel that this sampling of member's opinion reflects that of MLTs/MRTs at large. We also believe that with an effective communication strategy to explain the college to members and non-members alike, this good basis of support can be strengthened and we are confident that a joint regulatory college of these two professions has a high likelihood of ongoing support from practicing MLTs and MRTs.

Most of the stakeholders that we consulted with felt that a regulatory college would not impede workplace changes and several felt that it would assist with evaluating credentials of foreign-trained graduates and thereby could have a positive effect on labour supply.

The college should establish competency standards that harmonize with those in other provinces and close the backdoor that currently allows technologists to transfer into BC from jurisdictions with lower requirements.

Based on long-term experiences in other provinces, a college would be sustainable if based on reasonable member fees.

Seventy-four percent of BCSLS members were in favour of including Medical Laboratory Assistants in a regulatory college and this proposal therefore includes Medical Laboratory Assistants in the Joint College of MLTs and MRTs to ensure a uniform and reasonable standard of competency and quality assurance for MLAs in BC. Regulation will define the scope of practice for MLAs and ensure that all MLAs are competent to perform the duties encompassed within the scope of practice.

Similarly, the BCAMRT also propose that CLXTs and MLTs with radiography training be regulated under the college and that the two professions jointly develop standards of practice for CLXTs.

For MLTs, foreign-trained graduates are currently required to obtain their CSMLS certification before being eligible to work in BC. We propose that the joint regulatory college would be empowered to grant them temporary or provisional licenses to practice in their specialty while working towards their CSMLS general certification. This measure will increase the number of qualified MLTs eligible to practice in BC and help to address projected labour shortages.

In order to facilitate the creation of such a regulatory college, we propose to establish a joint working group of the BCSLS and BCAMRT that will have the following mandate:

- to work with the Ministry on drafting joint bylaws and policies for the proposed regulatory college following the established processes
- to inform members of both professional associations as well as practicing non-members about the procedures involved in setting up a regulatory college
- to explain to the memberships what is required of them in setting up a regulatory college (ie, costs, responsibilities, and role of the college as opposed to the professional organizations)
- to act as an advisory group that will work with other stakeholders (ie, employers, other health profession regulatory colleges, health authorities, unions, etc.) to enhance collaboration on issues affecting inter-professional practice
- to effectively address all issues and concerns that have been identified in consultations with stakeholders – i.e. cost /sustainability, entry-to-practice guidelines, workplace flexibility, inter-professional collaboration, internationally trained professionals etc.

The BCAMRT and BCSLS have been informing their memberships, through their respective websites and annual meetings, of the issues involved in setting up a regulatory college. While we feel that there is good support behind the idea of a joint college, much work remains to be done in identifying the details and explaining them to our members as well as those who are not current members.

The joint steering committee has consulted with key stakeholders about the implications of a joint college and will develop a stakeholder communication strategy to formalize these consultations going forwards.

11. Scope of Mandate

The mission of the college is to protect the public via self-regulation of the practices of the professions of medical laboratory and medical radiation technology.

The college will protect the public by setting standards of practice for the profession, by setting entry to practice requirements for medical laboratory/radiation technologists [in collaboration with the appropriate government ministries and employers] and ensuring the continued competence of MLT/MRTs, and by addressing concerns from members of the public through the complaints and discipline process.

Registration with the college will be a mandatory requirement to practice in BC. All MLT/MRTs will be required to successfully complete an approved program in medical laboratory/radiation technology, successfully complete an approved national examination and meet other requirements as defined by the registration regulations prior to receiving a certificate of registration. There will also be an approved process for evaluating Internationally Trained Professionals.

The college would work with the Ministry and the BCSLS/BCAMRT working group to draft bylaws for the college.

12. Governance Structure

The college would likely be composed of a governing council made up of a mix of professional and public members appointed by the Ministry, and several subcommittees designated by the college (e.g. registration, quality assurance, standards of practice, complaints and discipline). The specific structure would be decided on once the actual college bylaws are in place.

The steering committee understands that the roles of the college and the professional association are different. The two professional associations (BCSLS and BCAMRT) will continue to serve their memberships in areas such as professional practice, career guidance, and continuing education as well as responding to specific requests for information from the college on any matters affecting public safety as well as occasionally advising the college on other matters relevant to professional practice. Our interest is to maintain a transparent and collaborative working relationship with the college.

13. Draft Bylaws

Bylaws governing the proposed College would be drafted in consultation with the Ministry. The Steering Committee will identify a lawyer who is experienced with this type of legislation and can assist the working group in drafting bylaws.

14. Draft Policies

Policies concerning the following issues will be developed in consultation with the Ministry, the College Board, BCSLS, and BCAMRT:

- Code of Ethics
- Standards of Practice
- Competency Framework
- Quality Assurance Programs
- Complaints and Discipline

Code of Ethics and Competency profiles could be drawn from existing provincial and national professional associations. Quality assurance and scope of practice guidelines would be determined in discussion with existing regulators, professional associations, and employers in order to establish best practices that meet the needs of each group and as well as the general public.

15. Draft Proforma Budget

REVENUE	AMOUNT	PERCENTAGE of TOTAL
MLTs 3500 @ \$300	\$1,050,000	54.5%
MLAs 1400 @ \$200 ^a	280,000	14.5%
MRTs 2000 @ \$300	600,000	31.0%
Total Revenue	\$1,930,000	100%
Less: allocated to BCSLS / BCAMRT \$300,000/\$200,000	\$500,000	25%
Net Revenue to College	\$1,430,000	75%
EXPENSES		
Salaries and benefits (see note below)	\$ 680,000	47.5%
Governance – Board /Council	107,250	7.5%
Communications	35,750	2.5%
Committees	35,750	2.5%
Continuing Competence	60,000	4.0%
Professional Fees – Legal, Audit & IT	75,000	5.0%
Conduct / Discipline	107,250	7.5%
Miscellaneous – including contribution to Capital	72,000	5.5%
General operating expenses	257,000	18.0%
Total Expenses	\$1,430,000	100%
Surplus [Deficit]	\$ 0	0
^a MLAs would be offered a rate that is scaled to their median annual salary to keep College membership affordable		

Note: The Salaries and benefits budget is made up of the following:

- One CEO / Executive Director to oversee the entire Joint College
- Two Registrars, one for each discipline
- Four departmental /functional staff, two for each discipline
- Two Administrative staff, one for each discipline
- Benefits and allowances for all

Total - 9 staff. (This compares to 11 staff between two smaller colleges in Alberta.)

16. Licensure Fees and Start-Up Costs

An Annual Licensure Fee will be paid by each MLT, MLA, MRT and CLXT to the Joint Regulatory College. A portion of this fee (approximately 25%) will be allocated to the appropriate Professional Association /Society (BCSLS or BCAMRT) to assist the organizations in fulfilling their mandates. A one-time registration fee may also be charged by the College that would assist the College in off-setting considerable capital costs at the outset.

Start-up costs associated with the College will be covered under an agreement between the BCSLS and BCAMRT as follows: \$100,000 cash to be provided as interest-free loans (one half from each association) and \$150,000 in operating lines of credit (one half from each association) for a total of \$250,000 cash. These start-up expenses will then be repaid to the two professional associations from fees collected by the College over time.

17. Continuing Consultation

We believe that a key element is to establish effective partnerships with different stakeholders in the health care arena. Health care is an evolving workplace and we feel that the way forward is to maintain an open attitude and be a part of a collaborative structure. The BCSLS and BCAMRT are committed to maintaining this kind of working relationship between the two professional associations, the joint college, and other stakeholders. We recognize that good communication is vital to maintaining a productive relationship with all parties in the health care workplace and we welcome the openness that a regulatory college would provide. This will be realized by establishing a joint working group of our two professional associations whose mandate will be to meet formally and informally with all interested stakeholders to discuss issues of mutual interest. We will collaborate with other national and provincial organizations to develop best practices and address emerging priorities. We will work with hospitals, employers, unions and health authorities on matters of inter-professional practice.

18. Summary

Based on our research into regulation of MLTs and MRTs in other provinces in Canada, consultations with stakeholders, and the support from members of the BCSLS and BCAMRT, we feel that regulation of these professions in BC is feasible and necessary to ensure public safety. In our consultations with stakeholders, while we do not claim that it is exhaustive, it is at least representative of the landscape and we are encouraged that the opinions we encountered for the most part dovetailed with our aim to bring regulatory oversight to our professions in BC.

There is some opposition or uncertainty among the private laboratories and while they raise some valid points, these may be to some extent more specific to their workplace rather than being generalizable to the health care workplace as a whole. They also represent under one-third of the Laboratory professionals in B.C.

We note that strong support for the College was voiced by the DAP who are responsible for accreditation of diagnostic services in BC and that at the union level, while no official position was taken, there is support in theory for the college and a desire to participate in the process. We therefore think that opinions towards the college proposal are generally favourable and we are committed to continuing the consultation process to make it a reality.

19. Bibliography

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20. Appendix

Background Research Documents

Regulation of Healthcare professionals – a Report to the British Columbia Society for Laboratory Science and the British Columbia Association of Medical Radiation Technologists. QSE Consulting, September 2005.

Future Regulation and Licensing of BC Diagnostic and Treatment Professionals. The Mustel Group Report, February 2006

Pubic opinion survey – Mustel Group.pdf

Stakeholder Consultations

Stakeholder Briefing Document June 15, 2007.doc

Stakeholder Questions 2007.doc

Individual Stakeholder interviews:

MDS Metro

Vancouver Island Health Authority

Fraser Health Authority

Northern Health Authority

Interior Health Authority

College of Medical Radiation Technologists of Ontario

BC Cancer Agency and BC Centre for Disease Control

BC Children's and Women's Hospital

Diagnostic Accreditation Program

Health Employees Union

BC Biomedical Laboratories

Stakeholder Briefing: Joint BCSLS- BCAMRT Regulatory College Proposal

Key Issues

Some key issues have been raised about regulating laboratory and radiology professionals in BC. The research will address these and other issues that can be usefully discussed before establishing a new regulatory body.

Changing Standards

Like many other areas of health care, MLTs and MRTs are subject to changing processes, technology, and advances in scientific knowledge. Diagnostic services have been the focus of unprecedented restructuring efforts throughout the Canadian health care system for more than a decade. Consequently, standards of practice have changed as well. Have different regulatory regimes hindered, maintained or improved public safety in response to these changes?

Entry-to-Practice Requirements

Most demographic data indicates that there will be a shortage of MLTs and MRTs, over the next decade and beyond. Canadian educators are not graduating enough professionals to fill the projected gap. Internationally trained professionals often find that their credentials and work experience are not recognized here, making it difficult for them to pursue their careers in Canada. At the same time scientific advances and new technology are requiring professionals to be more skilled than ever before. There is a concern that self-governing professional regulatory bodies may adopt more and more rigorous educational requirements that could further restrict MLT and MRT supply. Have regulatory bodies exacerbated supply problems by escalating entry-to-practice requirements? What can be done to ensure that there are enough adequately trained professionals?

Complaints/Disciplinary Process

All self-regulating professional bodies in Canada are expected to have a process for members of the public to make complaints about an individual's professional practice. If found culpable, a regulated professional faces disciplinary measures that are determined by other members of their profession. How well have these processes worked to protect the public? Is the public concerned about professional bias in the decisions of regulators or about insufficient disciplinary consequences? If so, what can be done to ensure the public's trust?

Quality Assurance Requirements

Health regulatory bodies are charged with the responsibility to develop policies and maintain programs and processes to ensure the quality of services provided by health professionals and their accountability to the public. Licensure and renewals requirements, standard of practice, codes of ethics, continuing competency requirements, incapacity assessments and other measures are used often in conjunction with complaint/disciplinary processes. How effective are these measures in protecting public safety?

Cost-effectiveness and Sustainability

A virtue of self-governing professional regulatory bodies is their self-financing. Members of the profession pay compulsory fees to the regulator. They do so in order to ensure the standards of their profession are sufficient to protect the public and that there is a level playing field for all members of their profession. Would it be more cost-effective to provide regulation differently? Are there too many overlapping regulatory regimes? If so, are there indirect costs to the public and how can they be minimized? Are some regulatory bodies unsustainable?

Methodology for Feedback

Stakeholder Interviews

Laboratory and radiology professionals across the country have recognized for many years that regulation is undertaken “in the public interest.” The general public is made up of people who rely on diagnostic services to enhance their access to and experience with health care in BC. However, there are many health care stakeholders who have views about regulation that need to be taken into account before deciding on the specific form or model of regulation needed.

We thank you for participating in these interviews that will garner the information and feedback that we need to move forward with our proposal to the provincial government for a joint regulatory college.

*BCSLS
BCAMRT*

BCSLS - BCAMRT Joint Regulatory College

Research Project

Stakeholder Questions:

1. Public Safety

The BC Health Professions Council (HPC) concluded that both Medical Laboratory Technologists (1999) and Medical Radiation Technologists (2002) perform functions with an inherent risk of harm to the public and that as professionals they often do so independently of medical or other administrative supervision.

Health professions legislation is enacted to ensure health practitioners properly self-regulate through standards of practice, continuing competence, and complaints/disciplinary processes. The expectation is one of increased public protection within an open and transparent framework of public accountability.

- a) Are BC health regulatory bodies generally meeting this expectation? If not, why not? What more can be done to ensure they do?
- b) Are there better ways to improve public safety than through professional self-regulation? Are there examples?
- c) Are recent changes to the Health Professions Act sufficient to improve professional accountability? If not, what more needs to be done?
- d) Should health regulatory bodies be required to provide specific evidence of protecting the public safety? If so, are there examples of good practice or ideas?

2. Labour Supply, Mobility & Credentials

A study by the Labour Market Policy Directorate, HRSDC (2001) identified the existence of partial barriers to professional credentialing of medical laboratory and radiation technologists due to the inconsistency of regulation across Canada. Where they exist provincial regulatory bodies work with provincial and national professional societies, educators and governments to ensure uniformity of credentials. Each is a signatory to an Inter-provincial Mobility Agreement for their profession(s) under the terms of the Labour Mobility Chapter of the Agreement on Internal Trade.

- a) Is there any evidence that regulatory bodies restrict the supply or mobility of medical or radiation professionals?
- b) Is there a better way of ensuring national standards for credentials?
- c) Are there other barriers that should be considered? For instance, access to education programs? Improved foreign credential recognition?

- d) Do regulatory bodies negatively impact workforce restructuring or innovative workplace practices?
- e) Increasing entry-to-practice education requirements is sometimes cited as professional protectionism. Who should set education standards?

3. Quality Assurance & Accountability

All health regulatory bodies must ensure the ongoing competency and practice of their registrants. There are different approaches to quality assurance, but most use a combination of several of the following:

- Voluntary or mandatory continuing education requirements
- Required hours of practice
- Specialist or advanced certification
- Random or scheduled practice reviews
- Remedial targeted practice reviews
- Self-assessments, peer reviews and mentoring
- Publication of standards, guidelines and information bulletins
- Re-examination

The main distinctions between regimes are the degree to which quality assurance initiatives are voluntary or compulsory, collaborative or directive, and remedial or sanctioning.

- a) To what extent should health regulatory bodies be required to use a particular approach?
- b) Should other health stakeholders be involved in the development and implementation of regulators' QA programs?
- c) To what extent should the primary focus of programs be improving the practice of individual registrants or screening out incompetent registrants?

All regulatory bodies are required to implement complaints and disciplinary processes for registrants accused of professional misconduct or incompetence. Discipline hearings are quasi-legal proceedings, can be open to the public, and findings can be published subject to provincial and federal privacy legislation. They are expensive and can be challenged in court.

- a) How effective are such processes in protecting the public?
- b) How can complaints and disciplinary processes be improved?
- c) Should all provincial health regulators use the same or a similar approach?

4. Cost Effectiveness & Sustainability

A key principle of self-regulation is that professional fees fund the operation of the regulatory body. Where a small population of professionals exists it may not be possible to create or sustain a regulatory body. However, individual regulatory bodies for medical laboratory and radiation technologists already successfully exist in most part of the country with smaller and larger populations than in BC. Registrants fees for these professions vary between \$150 and \$400 depending on region, profession and whether the body is a combined regulatory/advocacy organization. It appears that sustainability is not an issue for these professions. Is cost effectiveness?

It appears that regulatory bodies are generally well managed. Health professions regulators often work together to research and develop solutions to common problems. In Ontario there is a Federation of Health Regulators and in BC the Health Regulatory Organizations of BC exists to promote good practice and as a discussion forum.

- d) Are there other costs/benefits for health stakeholders that should be taken into account?
- e) Are there potential benefits of combined regulatory bodies?
- f) Has increased public representation escalated costs? Who should bear their costs?

5. Summary Questions

Given that many health professions are currently self-regulated and given that changes have been made to the HPA and the regulations of some colleges are being brought into line with these changes, what would be your concerns, if any, about creating a new, joint health regulatory body for MLTs and MRTs.

Is there any other issue that you would like to raise?

Generally speaking, are you in favour of creating a new, joint regulatory college for MLTs and MRTs?

Thank you very much for taking the time to answer these questions and for assisting the BCSLS and the BCAMRT in this exciting initiative.

Stakeholder Interviews

MDS Metro

Vancouver Island Health Authority

Fraser Health Authority

Northern Health Authority

Interior Health Authority

College of Medical Radiation Technologists of Ontario

BC Cancer Agency and BC Centre for Disease Control

BC Children's and Women's Hospital

Diagnostic Accreditation Program

Health Employees Union

BC Biomedical Laboratories

Nigel Banks, Vice President, Human Resources
Norma Page, Director, Analytical Services
MDS Metro Laboratory Services [Private Employer]

MDS Metro believes that the reasons for setting up the College are very laudable and if the College is inevitable MDS Metro would work with the College in an advisory sense. However, having said that, they also believe that hospitals and private clinics are already covered, in a regulatory sense, by the DAP and CAP. They are not yet convinced of the need for a College and have some concerns if it came about. The College may limit the ability of the Private Labs to meet both the patient needs and the business needs at the same time. Private Labs require flexibility and may need to do things differently than what the College might dictate. For example they may need a Lab Technician function which is somewhere between a Lab Technologist and a Lab Assistant. The College may not see such a need. Things like subject specific certification are no longer available but that may make a lot of sense in some larger private labs where individual techs do only very specific work and do not need to be generalists.

They feel the industry does not need another bureaucracy to make life difficult. There are also concerns around cost escalation for both Technologists and employers. Bureaucracy makes things even more difficult during times of a labour shortage. We don't need barriers to entry to profession or to recognizing and accepting Internationally Trained Professionals.

From the perspective of public protection, if a patient has a problem they have immediate access to senior management in the private labs and their issue can normally be dealt with. MDS Metro still needs to understand and see the value in the College.

Norma Page made the point that Laboratory Science in BC is a Medical Practice, unlike other provinces, and that makes BC different. The legislation and regulations are different and they believe that serves the same purpose as having a College to regulate the profession. In Ontario a lab is not a medical practice and does not have the same structure as in BC.

Litigation, resulting from the Colleges complaints and disciplinary processes would be a concern for private employers.

All of these things and others would have to be addressed and resolved to their satisfaction before MDS Metro would be supportive of a College.

MDS and BC Bio combined see 70% of the provinces outpatients per year [2.8 million].

Combined they also represent approximately one-third of the provinces MLTs and MLAs.

Dr. Gordon Hoag, Medical Director
Pamela Ganske, Laboratory Services Manager.
Debra Cain, Laboratory Licensure/ Training
Vancouver Island Health Authority

Most laboratories in BC's Regional Health Authorities do operate under strict medical supervision. Lab Technologists and Radiation Technologists also do have the expertise to self-regulate.

Dr. Hoag believes that, generally speaking, BC's existing Regulatory Bodies are meeting expectations, particularly in protecting the public interest and this should be key. He also believes that we still need even more rigorous standards and quality of practice needs to be ensured. There have been some situations across the country where Colleges have not done the job on occasion.

We need a joint College to be formed to direct and control the duties of technologists. The College must clearly define roles within what can be a "fuzzy" scope of practice at times, e.g. point of Care. There are gaps in defining roles of techs and obstacles are created by the unions. If there is a violation of standards the college must become the punitive side of the profession. The College is the needed controller.

Colleges should be required to provide evidence of protecting the public interest so that faith and trust in the system can be maintained.

Internationally-trained health professionals are a major problem and could be one of several answers to our labour shortage issues. They need to be able to effectively challenge the process and the Act or the regulations that ultimately establish a College should facilitate that.

Regulation also needs flexibility so that it does not impact workforce restructuring or innovative workplace practices, e.g. molecular diagnostics. We can't unnecessarily and unreasonably limit scope of practice. How much can we let them do?

There is an overlap with DAP but this does not negate the need for a College. It serves a different purpose. There is also a need to address the issue of inconsistency in the profession across the country, despite the fact that Health Care is a provincial mandate. Medical Colleges do meet un-officially in the interests of the profession and the public.

All of the bullets listed in the questionnaire about Quality Assurance and Accountability are "bang on" according to Dr. Hoag. There are no clear guidelines to re-entry to profession and there should be. Cost of licensure is certainly an issue to be considered during formation of the College however it is a necessary evil. Professional misconduct must be open to public scrutiny and result of reviews must be published. He is very much in favour of licensure to ensure currency and competency.

It was also felt that Physicians must be involved in defining Scope of Practice as it must be as broad as possible. All information must be available to technologists to assist in the diagnostic process.

All those interviewed at Vancouver Island Health were strongly in favour of the Joint College and wished us luck.

Marc Pelletier, Vice President,
Judy Newman Director, Laboratory Services
Dr. Arun Garg, Dept of Pathology and Lab Medicine
Dr. William Dow, Director of Medical Imaging
Fraser Health Authority

Marc Pelletier expressed some concerns that there might be some overlap with DAP and clear distinction needs to be made between licensure and accreditation. There should not be duplication and un-necessary bureaucracy.

Employers may want to have more input into scope of practice to ensure flexibility.

Public protection is certainly an issue and in some cases public critiques are not tough enough.

We should be sure if we proceed with the College that all models have been looked at.

For example should public complaints be handled by an Ombudsman. There needs to be standardization in the complaints mechanism. Standards and regulations, upon which the College is built, could be distinct from the investigation process. We need to be clear in what we want to achieve. What is it we want that we don't have now?

DAP is an existing mechanism and they have clout. Should they be able to pull a license?

The issue with DAP however is that they only look at operations of a business and not necessarily competence of individuals. Nor should they establish competencies. There is no accountability on MLTs, for example, for Continuing Education. Who makes sure that people are competent, clarifies standards and informs the educators?

Medical Imaging has major challenges with workforce sustainability that do not fall under DAP. They need a mechanism to introduce changes to scope of practice. They need multiple entry levels and entry standards need to be more flexible.

Who judges competency in light of the union position on issues especially when continuing education credits are perceived as being critical. In Lab Science subject MLTs should be reconsidered, as many Techs don't need to be generalists. In this regard CSMLS restricts entry to profession and more flexibility is needed.

How do we keep short-term initiatives going [BCAMRT- emerging out of clinical operations] in the interim while the College is becoming a reality?

It is hoped that the College promotes flexibility to keep up with technological change.

What will be the approach to Quality Assurance as the College evolves? Good QA must be competency based with many streams.

Sustainability of College must be assured, look at cost benefit?

MLTs and MRTs are very professional now, bad ones are a minority: a minority that could create problems however.

In the context of the new structure in BC, Health Authorities have control and authority over human resources and could implement more stringent standards and controls, but

they need guidelines and have nothing to fall back on. How will existing QA in the Authority relate to that of the College?

The College should make the person more responsible.

Don't have false expectation of the College either?

All those interviewed, especially the Laboratory Manager, were generally supportive of a joint college, provided that other innovative models have been considered to be sure it is the best way at the end of the day. Also some of the concerns about entry to profession, internationally trained professionals, and increasing costs for all etc. must be looked at and some innovative solutions found, especially with the control that Health Authorities now have over their own HR.

Ken Winnig
Director of Diagnostic Services,
Northern Health Authority

Mr. Winnig felt that regulatory bodies were meeting the expectation of increased public protection and felt that the current system was working. He felt that recent changes to the Health Professions Act were sufficient to improve professional accountability. Health regulatory bodies should be required to provide evidence of protecting public safety. He did not believe that regulatory bodies restricted the supply or mobility of MLT/MRTs. National standards are set by the CSMLS but national credentialing is desirable also. A college should help with evaluation of foreign-trained technologists as long as they still have to meet a national standard. He did not feel that regulatory bodies impeded workforce restructuring or innovation. Education standards should be set nationally. Continuing education should be mandatory for maintaining competency. Some form of targeted review process that can reasonably be met by any good technologist could accomplish this. In general, the quality assurance program should be developed by the technologists themselves although it would be desirable to get the pathologists' and radiologists' perspectives also. These programs should be designed to both improve the practice of registrants and screen out incompetent individuals. Mr. Winnig felt that the existing complaints and discipline processes were very effective in protecting the public. Having the standardized approach across the different colleges was desirable. He felt that there were many benefits to health stakeholders for public protection. A combined regulatory body would benefit by sharing processes and administrative structure. There is some cost of increased public representation on colleges although much of the work is performed by volunteers. Some of the costs are borne by members and should be reimbursed. A joint regulatory college of MRTs and MLTs is a good idea. Such a college should include CLXTs and other cross-trained individuals. The college should not create a bureaucracy that will become a barrier to hiring new staff.

**Martin Woods,
Head, Laboratory Redesign
Interior Health Authority**

Mr. Woods felt that regulatory colleges were generally meeting expectations but that their position needed more transparency. A peer-review process between provinces might be beneficial and would meet the need to provide evidence of protecting public safety. There is no evidence that regulatory bodies restrict the supply or mobility of MLTs or MRTs. Credentials could be overseen by a national body that sets standards for competency assessment. Mr. Woods did not feel that regulatory bodies impeded workforce restructuring or innovation. Education standards and entry-to-practice standards should be a collaborative effort between government and regulatory organizations. In regard to quality assurance, the college should be able to sanction an individual if they lack continuing education credits or do not meet the minimum number of hours of professional development. The views of other stakeholders should be represented to the college by the members at large. The college should act to maintain competency among its members but it is also very important that it serve to screen out incompetent individuals. Complaints and discipline processes are reasonably effective measures and seem to work well for other professions, such as lawyers. There is currently no process for MLTs and MRTs and the biggest improvement would be for them have a process at all. Provincial regulators should all use the same approach to handling complaints and discipline. The bottom line on cost effectiveness and sustainability is that the costs of incompetence and the risks to public health far outweigh the costs of maintaining a regulatory body. There may be some economies of scale in combining colleges and some benefits in interprofessional understanding as a result. Regulation may increase membership costs but this has to be balanced against the costs of inadequate regulation. He is in favour of establishing a joint regulatory college of MLTs and MRTs.

Linda Gough, Registrar
College of Medical Radiation Technologists of Ontario

Regulation enhances safety by establishing essential minimum competencies. If there is professional misconduct then there is a complaints process. Registration also sets requirements for registration, such as education and criminal record checks. Many health care facilities will only hire CAMRT-registered technologists. Under the current system in BC, if a patient complains to the facility and the technologist is dismissed, the patient has no further recourse to ensure that the individual does not obtain work elsewhere. In Ontario, CMRTO disciplinary decisions are published on the CMRTA website. While disciplinary hearings protect the public, the challenge is to strike a balance between the public's right to know and the privacy of the member. Colleges generally have a process for demonstrating continued competency. There is no data regarding a relationship between continuing competency programs and patient safety. The number of complaints received is generally a measure as to the overall competency of the professional group as a whole. In developing continuing competency programs, the program should be realistic. The CMRTO focuses on continuous learning as opposed to continuous education.

Since all provinces in Canada are signatories to the internal Trade Agreement for MRTs. The Canadian Medical Association accredits training programs for MRTs in all provinces, which assures that standards are national.

The CAMRT has a national competency profile. The CMRTO recognizes three categories of credentials:

- Graduates of CMA-approved Ontario programs
- Graduates of CMA-approved programs outside of Ontario
- Graduates from outside of Ontario that are not CMA-approved.

The majority of individuals in this last category are foreign trained (80-120 per year) and they are assessed individually. When evaluating training, the College looks at curriculum and credentials and tries to determine if the training is 'substantially similar'. Many applicants are technically competent but struggle with issues such as culture, team environment, and individual accountability. Many have never previously taken multiple-choice examinations and the CAMRT examination can be a barrier. There is no evidence that regulatory bodies have impeded workplace restructuring or innovative workplace practices.

The CMRTO requires an individual to have worked in competent practice for the past 5 years. Individuals self-regulate, that is, they identify whether or not they have the knowledge and skills and judgment to perform a particular task. If not, they work with their employer to ensure that appropriate orientation is provided. This approach accommodates individuals that have specialty expertise in one area but move to another area of practice. If an individual has not practiced in 5 years, they undergo a learning assessment and a plan is developed to refresh their background. Fulfilling this plan usually takes about 6 months. The CMRTO uses continuous learning portfolios. The individual sets learning goals and then completes 25 hours of continuous learning activities. This may take the form of work-related learning activities, such as learning new techniques, rather than formal coursework. The CMRTO has also just begun a

random practice assessment based on feedback from peers, coworkers, patients, self. In regard to whether or not other health stakeholder should be involved in developing and implementing regulated quality assurance programs, Linda felt that this was not realistic because practice is different for different professions. In view of the expense of running QA programs, did not see much benefit to involving other stakeholders in administering QA programs. Complaints are reviewed by a complaints committee. Very few need to progress to a disciplinary hearing. In Ontario, most health regulators use a similar complaints process as they all operate under the Health Protection Act. There are some differences-e.g. nurses use the “Alternate dispute resolution’ process. The CMRTO does not use letters to communicate between the parties, which enable the complainant to respond without having to take time off work.

By making use of the national CMA accreditation process and using the CAMRT national certification as the standard, the costs of maintaining a college are reduced. Most of the cost of the College relate to registration, complaints, quality assurance, and standing committees. Fees are currently \$360.00 per year. The Federation of Colleges in Ontario issues joint publication of hearing dates and provides training programs for committee members, which bring some cost benefits. As to whether or not increased public representation has escalated costs, the CMRTO council is comprised of 8 professional and 7 public members. Public representatives are not provided with any training and government does not allow the Colleges to pay for training. Government currently selects the public members and pays for expenses but is trying to push these costs onto the colleges. The colleges have replied that if they are going to pay for expenses, then they need to have a greater say in who is appointed.

On the subject of a joint college, the greatest foreseeable challenge was coping with so many different disciplines and levels of practice.

Catherine Syms
Director of Risk Management
BC Cancer Agency and BC Centre for Disease Control

Ms. Syms is a lawyer and has worked with the College of Physicians and Surgeons and the College of Nurses in BC. On the subject of public safety, Ms. Syms said that while there needs to be independent people on the college hearing committees, it is also important to have content experts. The College of Physicians and surgeons does not investigate all complaints. The College of Nurses investigates all complaints and this has led to investigating complaints that have little merit. There needs to be a balance so that the public feels that their complaints have been addressed while not committing to investigating all complaints. She suggests including patients in discussions of how a college can improve public safety. Also, involving patient advocates before a complaint is made to the college can sometimes resolve issues. The public needs to be educated as to what their role is, such as questions to ask their doctor, what drugs they are taking. The Safer Health Care in Canada initiative is attempting to reduce medical errors. They have implemented 6 interventions, such as rapid response teams and medication reconciliation. A problem with the existing legislation is that under Section 51 (HPA?) which specifies a confidential internal review process, only certain professions are listed and she has experienced problems including individuals in the review process who are not listed by the legislation. She believes that health regulatory bodies should be required to provide specific evidence of how they protect public safety. In this regard, the College of Nurses have done a good job. They have standards around disclosure and disclosure is also built into their standards of practice. By comparison, the College of Physicians and Surgeons is poor at disclosure. The Law Society of BC includes disclosure in their code of ethics. In regard to labour supply, mobility, and credentials, she felt that national standards are essential. She felt that existing means of assessing people's skills, such as examinations, were not sufficient and that it was necessary to assess people on multiple levels. It is not appropriate to oblige foreign-trained individuals to retrain. Regulatory bodies have sometimes impeded innovation, for example, physicians blocking the introduction of nurse practitioners. Often insurers stipulate what a college member may or may not do in a given situation. This can be difficult for the college because if they act against the advice of the insurer, the insurer will no longer provide coverage. When individuals are multiskilling, the public needs to be educated about the roles and scopes of practice of those multiskilled practitioners. Entry-to-practice requirements should be set by experts and front-line workers. In regard to quality assurance, there needs to be a national approach. We have to ensure that people maintain their skills. This could be accomplished by issuing temporary licenses or offering different levels of membership in order to accommodate changes in scopes of practice. We should include stakeholders such as professional associations and regulatory colleges in designing quality assurance standards and there needs to be consistency across the provinces. For this to work, we need to ensure access to education for all members. In regard to complaints, public discipline hearings can be a way of showing that an organization cares about the public. Hospitals these days seem to be moving away from placing blame on individuals and are taking a systems approach. Patients may still want to see an individual made accountable. Patients often feel that they are being shuffled around from person to person and communication is by letter only whereas patients may appreciate an opportunity to meet

with the physician in person. Most times, the patient feels isolated in this process. Some organizations have patient advocates to facilitate communications between patients and the college. The College of Nurses meets with the patient and communication is more open. It is preferable if complaints can be resolved at the organization level and never reach the college. The complaints and discipline process can be improved by subscribing to a philosophy such as “Safer Health Care Now” and adopt similar standards around disclosure, education, and training. The benefits of regulation are that patients are reassured that they are being cared for by a member of a recognized profession. At a professional level, it brings cohesiveness to the group, credibility for the profession, and provides assurance that members are meeting required practices through continuing education and common standards. She felt that in general, there should be benefits to a combined college. Although increased public representation may escalate costs, the benefits far outweigh this. The health professionals have some responsibility to fund these costs but given that the HPA is a government initiative, then government also has some financial responsibilities. On the subject of a joint college, Ms. Syms suggested that standards of practice and responsibilities should be clearly defined, particularly where there is cross-over between the disciplines such as CLXTs. If not clearly defined, this could be confusing to the public as well creating concerns about liability.

Dr. Catherine Halstead

**Division Head of General Laboratory Services, Department of Pathology,
Children's and Women's Hospital (Provincial Health Services Authority)**

1. Public Safety

- a) Are BC health regulatory bodies generally meeting this expectation? If not, why not? What more can be done to ensure they do?

They are, but interviewee says she hasn't examined the question in detail. What she has seen in her experience of working with registered nurses, physicians, and midwives is that when the scope of practice and similar standards are set by professionals such as physicians and the standards and requirements are open, the process can be a vehicle for accountability to the public.

- b) Are there better ways to improve public safety than through professional self-regulation? Are there examples?

There might be better ways, and it might be preferable to have more than one approach. For example, in the hospital setting there is not only the oversight of professional self-regulators, but also internal processes such as incident reports and ongoing education which also ensure public safety.

However, these internal processes don't deal well with individuals who have a "sub-optimal" background. Self-regulation establishes a baseline for professionals. Other oversight activities are additional.

There may also be systemic problems that negatively impact public safety but which professional regulation alone can't address. In a complex organization, there need to be other ways to address problems and correct them.

- c) Are recent changes to the Health Professions Act sufficient to improve professional accountability? If not, what more needs to be done?

Interviewee says she doesn't know.

- d) Should health regulatory bodies be required to provide specific evidence of protecting the public safety? If so, are there examples of good practice or ideas?

Generally, the complaints process of the College of Physicians and Surgeons is a good model. There is a public record of complaints, and the follow-up, as well as public representation on the board. This is an adequate approach.

Public accountability is essential, and this sort of demonstration of evidence should be required.

2. Labour Supply, Mobility & Credentials

- a) Is there any evidence that regulatory bodies restrict the supply or mobility of medical laboratory or radiation professionals?

Interviewee says she doesn't know. This issue is a concern, however. General comments the interviewee has heard suggest that there may be a problem that a college could restrict availability of labour supply, but she doesn't have specific evidence.

b) Is there a better way of ensuring national standards for credentials?

There are problems with differing standards in different provinces. People can get certified in a province where standards are lower, get some experience, and then move on. National standards would eliminate problems like this.

In regard to certification of foreign-trained technologists, there should definitely be a unitary national standard.

In regard to differing labour needs in different provinces, there may be ways to establish different competencies and certify on that basis, as is done in nursing. However, generally speaking, there should be considerable cooperation among provincial bodies and national standards.

c) Are there other barriers that should be considered? For instance, access to education programs? Improved foreign credential recognition?

Both of these are big issues. The lack of educational programs is serious. If educational institutions favour locals over outsiders, this can cause problems for provinces that don't have their own programs.

In regard to recognition of foreign credentials, this is a significant issue in the face of upcoming labour shortages. It might be possible to offer restricted or trial practice, with evaluation after a specific time period. Differences among countries should also be recognized, since some have training which is so well-defined that we can have confidence in it. It's not productive to force everyone with foreign training to go through a complete Canadian training program when we are facing a labour shortage. Foreign credentials should be more thoroughly evaluated.

d) Do regulatory bodies negatively impact workforce restructuring or innovative workplace practices?

Some of the impact of regulatory bodies in this area could be beneficial, in ensuring that standards of practice are related to the specific workplace situation, ongoing evaluation of programs and services, and the emerging needs of new services.

The essential question is competency. Training programs, for example, have been modified to reflect new methods and programs, and skill sets have changed and become more differentiated in recent years.

Regulatory bodies need to be in tune with these changes and consider new kinds of training and certification opportunities.

In the hospital setting, there is constant budget pressure that will drive institutions to use personnel who get paid less, and this entails a definite risk of compromising quality to meet budget targets. Regulatory bodies are useful in setting standards, even though this might increase costs.

When restructuring is imposed from outside, quality of staffing can be compromised. Interviewee says it is her job to ensure that personnel are adequately trained, and a

regulatory body can be useful in speaking out against negative changes in this regard when consultants or outside agencies demand restructuring.

At the same time, a regulatory body could have a negative impact on potentially beneficial restructuring and innovation. A new regulatory college should be open and flexible in the definition of competencies and job descriptions.

Generally, regulatory colleges are beneficial in this area.

- e) Increasing entry-to-practice education requirements are sometimes cited as professional protectionism. Who should set education standards?

This is connected to the previous question. A bad “mind set” in the college could lead to professional protectionism. Educational requirements should be set by the college in collaboration with national bodies.

Other organizations, such as educational institutions and other professional bodies should have a consultative role.

3. **Quality Assurance & Accountability**

- a) To what extent should health regulatory bodies be required to use a particular approach?

From the perspective of a regulatory college, complaints are the most serious issues. Proven complaints should result in compulsory action.

Complaints should be formally investigated, and the degree of seriousness of the investigation should depend on the gravity of the complaint.

The college should decide on the appropriate response, but it won't be perceived as doing its job if the response is too indirect or “non-committal.” For this reason, sanctions are appropriate in serious complaints.

The minimum standard is to screen out incompetence, and this may be the primary focus in the early stages of the college. The credentialing process will be important for identifying incompetent individuals early on.

As the college evolves, continuing education should take a more important role. Voluntary compliance isn't sufficient. People will take continuing education more seriously if it's compulsory.

Documentation of required hours of practice is also important.

Re-examination, however, is not effective. It only reveals whether or not a person knows what is on the test, and doesn't say much about performance and competency.

Publication of standards and guideline is useful, especially if the college wants to evaluate how well members know the standards.

A reliance on specialist or advanced certification doesn't play a big role in quality assurance, since it doesn't address the basic questions of competency.

- b) Should other health stakeholders be involved in the development and implementation of regulators' QA programs?

On a consultative basis, yes, but the members of the college will be the most knowledgeable about how to monitor their own profession.

Such a consultation process would start by looking at what other colleges have for their QA programs, and perhaps invite collaboration of key personnel from other colleges that interact with this college. People from colleges with similar missions, and groups like DAP, might also be part of these discussions.

- c) To what extent should the primary focus of programs be improving the practice of individual registrants or screening out incompetent registrants?

Practice improvement should be part of the evolution of the college. Identification of competency problems will help identify key areas of weakness in primary training and ongoing practice requirements. Sharing this information will be helpful in improving standards.

- d) How effective are such [complaints] processes in protecting the public?

They are most effective in ensuring accountability of members. They may serve some role in protecting the public but the important effect is deterrence. However, the complaints process only reveals the “tip of the iceberg,” and while deterrence is valuable, the process doesn’t fix inherent problems.

Publicizing the complaints process allows the opportunity for feedback to the profession as a whole.

A better model is that used by Canadian Medical Protective Insurance. This leads to education and thus to better overall outcomes. It doesn’t necessarily identify culpable individuals, but points out actionable issues that can lead to learning as a whole.

- e) How can complaints and disciplinary processes be improved?

See comments above. An important component should be letting members know what remedial programs are available. Thus, members could take advantage of, say, remedial or mentoring programs.

- f) Should all provincial health regulators use the same or a similar approach?

Within a given province, the approach depends on the type of practice. Regulators should share information about what works and what doesn’t. But the process should depend on the profession and the competencies involved. For example, many complaints about MLTs are from patients. It may be easier for a patient to complain about an MLT than a doctor because the patient has less contact with the MLT.

4. Cost Effectiveness & Sustainability

- a) Are there other costs/benefits for health stakeholders that should be taken into account?

Interviewee says she doesn’t understand the context of this question.

- b) Are there potential benefits of combined regulatory bodies?

Yes, less administrative overhead.

- c) Has increased public representation escalated costs? Who should bear their costs?

Yes, this approach increases costs, but it's worth it, because public representation increases credibility and accountability. The overall cost is ultimately borne by the taxpayer in any event.

This also includes the cost of membership and certification, which should be included in collective agreements.

The trade-off is that the government is effectively subsidizing the cost of the regulatory college, but the quality of healthcare improves correspondingly.

5. Summary Questions:

Is there any other issue that you would like to raise?

Colleges should remain attentive to evolving needs of workplace, and avoid professional protectionism. They also need to be able to respond to changes in the workplace.

Generally speaking, are you in favour of creating a new, joint regulatory college for MLTs and MRTs?

Yes. Interviewee says she can't really speak to the benefits of amalgamation for these professions. The groups might be too disparate.

Nancy Kotani

**Corporate Division, Clinical, Innovative and Development/Chief
Children's and Women's Hospital (Provincial Health Services Authority)**

1. Public Safety

- a) Are BC health regulatory bodies generally meeting this expectation? If not, why not? What more can be done to ensure they do?

They are meeting the expectations.

- b) Are there better ways to improve public safety than through professional self-regulation? Are there examples?

Not that I can think of.

- c) Are recent changes to the Health Professions Act sufficient to improve professional accountability? If not, what more needs to be done?

Interviewee says she isn't familiar enough with these changes to comment.

- d) Should health regulatory bodies be required to provide specific evidence of protecting the public safety? If so, are there examples of good practice or ideas?

No comment.

2. Labour Supply, Mobility & Credentials

- a) Is there any evidence that regulatory bodies restrict the supply or mobility of medical or radiation professionals?

No specific comment.

- b) Is there a better way of ensuring national standards for credentials?

No specific comment.

- c) Are there other barriers that should be considered? For instance, access to education programs? Improved foreign credential recognition?

No specific comment.

- d) Do regulatory bodies negatively impact workforce restructuring or innovative workplace practices?

If they become dogmatic, they can. They need to be flexible. One example is if very specific standards for training are set but they are impossible to satisfy in some specific instance.

- e) Increasing entry-to-practice education requirements is sometimes cited as professional protectionism. Who should set education standards?

There should be a collaborative process, involving the regulatory body, the community of practice, and educational institutions.

3. Quality Assurance & Accountability

- a) To what extent should health regulatory bodies be required to use a particular approach?

They should use all of them, but especially required hours of practice. But most of them do so anyway.

- b) Should other health stakeholders be involved in the development and implementation of regulators' QA programs?

Laboratory physicians and radiologists.

- c) To what extent should the primary focus of programs be improving the practice of individual registrants or screening out incompetent registrants?

Improving practice should be the priority. Participation should be compulsory. There will always be opportunities for voluntary participation.

- e) How effective are such [complaints] processes in protecting the public?

They play a role, but not a definitive one. They give the public the assurance of a published disciplinary process and published findings as well. But they are limited because they only capture major cases, and cases of gross negligence. They don't cover minor cases and issues, so they are not wholly satisfactory or appropriate.

- f) How can complaints and disciplinary processes be improved?

They are fine the way they are for what they do.

- g) Should all provincial health regulators use the same or a similar approach?

No. Each body needs to be looked at on the basis of appropriate training and economy. The most stringent process should apply to the most autonomous professions.

In the case of the technical professions, which have little autonomy on the job, the process needn't be a stringent. Technical professionals are usually directed by somebody else, and disciplinary and performance issues are usually addressed by the employer, while competency questions are handled by whoever directs the work. Patient contact is also minimal, in comparison, say, to nursing.

4. **Cost Effectiveness & Sustainability**

- a) Are there other costs/benefits for health stakeholders that should be taken into account?

No.

- b) Are there potential benefits of combined regulatory bodies?

There is efficiency to be gained. The requirements for training, scope of work, and so on are similar enough.

- c) Has increased public representation escalated costs? Who should bear their costs?

Disciplines should bear those costs. They should come out of their fees. The employer shouldn't bear those costs.

5. **Summary Questions:**

Given that many health professions are currently self-regulated and given that changes have been made to the HPA and the regulations of some colleges are being brought into

line with these changes, what would be your concerns, if any, about creating a new, joint health regulatory body for MLTs and MRTs.

Interviewee says she's not sure it's necessary to consider these positions as requiring the same level of regulation as physicians and nurses or pharmacists.

The downside is excessive bureaucracy, and decreased flexibility in terms of workforce planning and resourcing. There will be less flexibility for employers to plan their workforce.

Is there any other issue that you would like to raise?

No.

Generally speaking, are you in favour of creating a new, joint regulatory college for MLTs and MRTs?

No. The biggest concern is increased requirements for training. If required training becomes more than a 2-year diploma program then it takes costs way beyond what a publicly funded hospital can handle. For example, physiotherapists now need a master's degree for the same scope of work. These requirements change compensation expectations. Public sector hospital budgets can't cope, and hospitals will hire less doctors and clinical professionals.

This problem is inevitable, because people take pride in their professions. Service then becomes extremely costly. As an example, consider the fees charged by lawyers, whose costs are borne by clients. With medical professionals, however, hospitals, the public, and the government purse must bear the cost. Regulation like that which is proposed doesn't add measurable improvements to quality of care, in relationship to cost.

Professions increase their educational requirements partially because their jobs become more complicated and there is more to learn. But a major factor is that they are viewing the world "through their own regulatory window," and have an advocacy role for their discipline. The current shortfall of nurses, caused in large part by the increase in academic training required, is an example of this process.

Sharmen Lee
Executive Director
Diagnostic Accreditation Program

1. **Public Safety**

- a) Are BC health regulatory bodies generally meeting this expectation? If not, why not? What more can be done to ensure they do?

Interviewee doesn't know if she's in a position to comment on the effectiveness of other regulatory bodies. However, a regulatory framework does provide assurance in the crucial area of ensuring ongoing competency.

Some people may question the effectiveness of such regulatory bodies, because while they may set high standards for entrance into a profession, they may not have measures to ensure competency later on, say 20 years after an individual's initial certification.

For example, requirements for CME need to be specific to the individual practitioner and practice. The process needs to require the demonstration of competency.

Generally, the self-regulation process is effective, partially because it has been in place long enough for the public to be familiar with it. For example, the licensing of pharmacists and physicians is acknowledged and recognized.

However, the public would be more alarmed if they knew the degree to which other self-regulating bodies do not ensure ongoing competency. The challenge is the perception of self-interest in the process of self-regulation. Generally, the process is too "reactive." Individuals pass the initial hurdle of certification, then have very little interaction with the regulating body except when there is a complaint.

Regulatory bodies should improve the quality of practice, rather than simply ensuring compliance with minimum requirements. She's not sure that the existing bodies are effective in this mission.

- b) Are there better ways to improve public safety than through professional self-regulation? Are there examples?

Interviewee isn't familiar with other examples sufficiently to be able to comment, but refers to her remarks in the first question.

- c) Are recent changes to the Health Professions Act sufficient to improve professional accountability? If not, what more needs to be done?

Interviewee isn't familiar enough with these changes to be able to comment specifically.

- d) Should health regulatory bodies be required to provide specific evidence of protecting the public safety? If so, are there examples of good practice or ideas?

The interest of the public is in knowing that only qualified people are practicing, and it is the regulatory body's responsibility to provide evidence that this is so. There should be ongoing requirements for maintaining licensure.

The complaints process also needs to be open and transparent. For example, the website of the College of Physicians and Surgeons prominently shows disciplinary actions taken.

Overall, a regulatory body must demonstrate to the public how it is ensuring public safety. This should include “balanced” evidence, that is, measures taken proactively to sustain licensure, as well as the complaints process.

In summary, this is the preferred model for regulation.

2. **Labour Supply, Mobility & Credentials**

- a) Is there any evidence that regulatory bodies restrict the supply or mobility of medical or radiation professionals?

The only way this could happen is if there are not common requirements for entry to practice. For example, one province might set a higher standard for certification than another. However, where the requirements are the same, regulatory bodies definitely will not pose this restriction.

- b) Is there a better way of ensuring national standards for credentials?

National standards aren't necessarily the best approach. This is because the scope of practice may differ depending on available labour resources. For example, nurses in some other provinces are given a wider scope of responsibility.

There should be common basic core standards, but there's also the need to be able to respond to specific provincial requirements.

Another factor which needs to be considered is difference in provincial educational standards and resources. Regulation must recognize the need to “fine tune” standards to meet specific provincial needs. An example of this in practice is the way in which specialist physicians are certified by a national body, but must also be licensed provincially. Bodies in the provinces must have the ability to decide what's appropriate in their setting.

- c) Are there other barriers that should be considered? For instance, access to education programs? Improved foreign credential recognition?

Regulatory bodies can help eliminate some of these barriers, because they set responsibility for establishing equivalencies. The problem now with foreign-trained professionals is that their qualifications may be unfairly questioned. Insofar as a regulatory body can help standardize, it might be easier for foreign-trained professionals to be qualified.

The problem is most evident in the private industry, where “qualified but not registered” professionals are in employment. Requirements aren't standardized, and it's unknown what an individual's qualifications are because they aren't standardized. Overall, regulation is helpful in eliminating barriers rather than creating them.

- d) Do regulatory bodies negatively impact workforce restructuring or innovative workplace practices?

Regulatory bodies can have this effect. The problem is in defining scope of practice. Innovative and patient-focused delivery systems may mean using skill sets required of other professions. The professions have to work together, and not be so protective of scope. The focus needs to be on the patients.

- e) Increasing entry-to-practice education requirements is sometimes cited as professional protectionism. Who should set education standards?

This is the wrong question. Instead, the regulatory body should determine the absolute basic scope of knowledge and how it can be demonstrated. There will always be educational institutions with different mandates and responsibilities, and there is a danger in this situation of overtraining. Therefore, scope-of-practice considerations should also address questions of educational curriculum.

Specifically, at the entry level, regulatory bodies should recognize that requirements and standards change over time. Standards should not be set arbitrarily. For example, the requirement by some bodies that individuals have a master's degree may be unreasonable.

Although regulatory bodies should have the authority to set these standards, it should be done in partnership. Generally, the process of setting these requirements should include people with knowledge and expertise in the field, including educators, institutions, and some professionals not directly involved in the field. National and provincial associations can play a big role.

A specific problem that needs to be addressed is that regulatory bodies and the individuals involved in them can get out of touch with evolving standards and requirements.

3. Quality Assurance & Accountability

- a) To what extent should health regulatory bodies be required to use a particular approach?

Regulatory bodies need to be given the discretion to use appropriate mechanisms. For example, using only a single method is usually an error. For example, it isn't in the public interest if mandatory continuing education is the only method chosen.

There must be some form of assessment of basic level of competency. The objectives should include finding out who is inadequate to practice, to promote competency generally, and to remediate individuals with weaknesses. The specific approach will depend on the specific situation.

Regulatory bodies should be given general direction about how to accomplish these goals, but should also have the latitude to develop "creative" approaches. Consumers want to know that licensure means professionals have maintained their competency, and the public has a right to know that there is scrutiny, and that regulatory bodies are effective. From this perspective, it is a bad attitude if regulatory bodies and their members don't want anyone "looking over my shoulder."

An example of how this should not be done is the way in which physicians are granted hospital privileges. In theory, this authorization is reviewed each year, but in practice the renewal is automatic.

- b) Should other health stakeholders be involved in the development and implementation of regulators' QA programs?

Yes. There should be a structured approach, uses a range of strategies. Doing so helps counter the perception that regulation is a closed process. Including others also shows that regulation is not just for the benefit of the profession's members.

Even "lay" people can make a contribution, and it's important to have other expert stakeholders representing a range of expertise. Such an approach also improves accountability in the interest of promoting public safety.

A possible problem in implementing such an inclusive approach is "turf" disputes.

- c) To what extent should the primary focus of programs be improving the practice of individual registrants or screening out incompetent registrants?

The work of regulatory bodies is often viewed as negative, and this doesn't have to be so. A comprehensive approach is needed. Regulation should also help professionals identify how their skills can be improved.

There must be a mechanism to identify those who are not competent and deal with the problem appropriately. Regulation creates an increased need for and expectation of programs to sustain and improve competency.

At the same time, there must be a means to sanction those who fail to meet competency standards. However, the best way to ensure a stable labour force is to avoid sanctions.

- d) How effective are such [complaints] processes in protecting the public?

Generally, the process is effective and appropriate. The openness and transparency of the process serves the public, and also helps ensure fairness for the respondent, with the potential of exoneration in the public eye. That there is a complaints process also emphasizes the need for responsibility on the part of professionals, and the knowledge that there are specific consequences for failing to meet competency standards.

- e) How can complaints and disciplinary processes be improved?

Interviewee says she can't comment on the work other regulatory bodies.

- f) Should all provincial health regulators use the same or a similar approach?

Yes. Approaches should be the same or similar, depending on differences from profession to profession. All processes should meet the requirements of natural justice, and allow for communication and the sharing of information.

4. **Cost Effectiveness & Sustainability**

- a) Are there other costs/benefits for health stakeholders that should be taken into account?

No comment to this question.

- b) Are there potential benefits of combined regulatory bodies?

There can be some benefits. Core processes that each body needs to undertake can be shared. Many of the best practices are shared. A joint body means that there will be uniformity in process. There is still some value to maintaining some autonomy, however, with coordination and sharing.

- c) Has increased public representation escalated costs? Who should bear their costs?

An example is the College of Physicians and Surgeons, which has some lay members on its board. Interviewee isn't sure how much that adds to cost, and thinks it would depend on how the panel is structured.

However, based on what she knows of compensation levels for this type of activity cost is not an important factor.

5. **Summary Questions:**

Given that many health professions are currently self-regulated and given that changes have been made to the HPA and the regulations of some colleges are being brought into line with these changes, what would be your concerns, if any, about creating a new, joint health regulatory body for MLTs and MRTs.

Interviewee has no concerns.

Is there any other issue that you would like to raise?

Interviewee says her agency is an accrediting/regulatory body, and as such one challenge has been that there is no college for technologists that her agency accredits. For this reason, it's difficult or effectively impossible to then mandate standards for technologist practice. This means that the agency has no way to ensure standards.

Generally speaking, are you in favour of creating a new, joint regulatory college for MLTs and MRTs?

Absolutely.

Marcy Cohen
Research and Policy Director
Health Employees Union

July 4, 2007-07-11

In response to the Public Safety question, the HEU believes that public safety issues are systematic issues more so than individual employee issues. In other words, Colleges have traditionally focused on individual licensing, continuing education, and discipline rather than on system improvements, best practice promotion etc. as a priority.

Quality improvement processes are separate from the College and there is a disconnect here. There needs to be a better prioritization of the College role and focus. The example she referenced was physician 'medical errors' and the system level quality improvement processes put in place to reduce these errors.

There is also an issue around training standards. Who trains, for how long, with what content and to what competencies? The College can determine the competencies but not necessarily the delivery of training. Again, this creates a disconnect.

HEU also has a concern about private training colleges doing the training for MLAs. They don't undergo the same rigor that public institutions do around qualifications of instructors, training standards etc.

In response to the question, "Who should set the competencies and training standards?" HEU feels it should be a collaborative process involving employers, employees, government, unions, and the professional association. It should be a real partnership.

MLAs can now do more things, with technological advances, that can help relieve skill shortage problems. However, HEU has a concern that the MLAs collective voice will not necessarily be heard in the joint college's structure linked with MLTs, CLXTs, and MRTs. HEU feels that MLAs can do more, only if they have the appropriate training or in-service, and they should be allowed to contribute. Unions can be a part of the solution vis-à-vis the skill shortage.

The HEU also wants to lessen the "turf wars" that exist between unions over roles and responsibilities and who represent who. There is a potential problem with a joint college that represents members from several different unions [HEU, HSABC, BCGEU] and this needs to be well thought out as we go through the process. For example, there has been a suggestion of a Lab "Technician" function to meet the needs of some employers. This would be somewhere between an MLA and an MLT. If this ever came about who would represent them? Career laddering is a distinct possibility that might make some sense but it would also require more cooperation, collaboration and communication [change management] over all.

The HEU could not effectively respond to the QA and accountability questions without further consultation with its members.

HEU wants to see good training standards, good entry-to-practice requirements and more focus on improving practice. Employees must be involved in the process.

The Complaints and Discipline process raises questions when dealing with employees who are supervised by others. Whose responsibility it is when acts are delegated? HEU is

not opposed to discipline, but it should be as a last resort, when other means have been exhausted.

Cost and sustainability is certainly an issue for HEU. They represent MLAs who are lower paid than MLTs or MRTs and how will balance and affordability be considered. Value for money is also important.

HEU has taken a strong position in support of Internationally Trained Professionals as one of the many solutions to the current labour shortage. They are less supportive of subject-specific certification/training as they favour a more “generalist” approach to retention and recruitment. [People doing the same thing over and over is boring, variety is challenging] HEU also favours more effective bridging and ESL programs to make it easier for internationally trained professionals to pass exams and enter the workforce.

In summary, HEU cannot take an “official” position at this time on whether they favour a joint BCSLS/BCAMRT regulatory college or not. They require much more consultation with their membership, i.e. they cannot say yes and they cannot say no.

HEU is willing to be part of a dialogue and a process on this initiative. They need to consult with members, look at the research and ensure that alternatives have been considered. They are willing to partner and collaborate.

Barbara Wong, Director, Human Resources
David Chow, Manager, Microbiology
BC Biomedical Laboratories Ltd.

1. Public Safety

- a) Are BC health regulatory bodies generally meeting this expectation: If not, why not? What more can be done to ensure they do?

Generally speaking, the DAP is meeting this expectation. We recommend strengthening the medical supervision requirements of CAP. We also recommend that BCSLS advocate on behalf of members not working under proper medical supervision.

- b) Are there better ways to improve public safety than through professional self-regulation? Are there examples?

Yes, public safety can be improved through the implementation of a total quality management system with appropriate accreditation. One example that BC Bio participates in is the College of American Pathologists (CAP) accreditation program. The CAP Laboratory Accreditation Program is an internationally-recognized program and designed to go well beyond regulatory compliance, the program helps laboratories achieve the highest standards of excellence to positively impact patient care.

- c) Are recent changes to the Health Professions Act sufficient to improve professional accountability? If not, what more needs to be done?
- d) Should health regulatory bodies be required to provide specific evidence of protecting the public safety? If so, are there examples of good practice or ideas?

DAP publishes the names of accredited organizations. In order to receive this accreditation, specific public safety requirement must be met.

2. Labour Supply, Mobility and Credentials

- a) Is there any evidence that regulatory bodies restrict the supply or mobility of medical or radiation professionals?

Yes. Provinces with colleges have provincial entry requirements with associated fees. Anecdotally, MLTs perceive the application as an inconvenient bureaucratic process.

- b) Is there a better way of ensuring national standards for credentials?

CSMLS is already the national certifying body for medical laboratory technologists and medical laboratory assistants, and the national professional society for Canada's medical laboratory professionals

- c) Are there other barriers that should be considered? For instance, access to education programs? Improved foreign credential recognition?

Yes, the Joint Medical Laboratory Advisory Committee (formerly a committee of the PLCO) was formed to create recommendations from industry stakeholders and educational institutions to improve education programs and workforce planning. The CSMLS already has a prior learning assessment process for foreign credential recognition.

- d) Do regulatory bodies negatively impact workforce restructuring or innovative workplace practices”

An additional body adds unnecessary limitation that may get in the way of improving workplace practices.

- e) Increasing entry-to-practice education requirements is sometimes cited as professional protectionism. Who should set education standards?

Education standards and competency requirements should be set under medical direction. The industry and educational institutions should work collaboratively to implement the standards.

3. Quality Control and Accountability

- a) To what extent should health regulatory bodies be required to use a particular approach?

To ensure the highest standards of ongoing competency are consistently met, a combination of approaches should be applied. These approaches may differ depending upon the position and the setting.

- b) Should other health stakeholders be involved in the development and implementation of regulator’s QA programs?

Yes, multiple stakeholders need to work together to set minimum standards. For instance the BCSLS can advocate for more specific DAP standards with respect to competency assessments, much like the CAP program currently requires.

- c) To what extent should the primary focus of programs be improving the practice of individual registrants or screening out incompetent registrants:

The primary focus of the programs should be the continuous improvement and should include appropriate retraining, retesting and where required screening out incompetent registrants.

Complaints and disciplinary processes:

- a) How effective are such processes in protecting the public?

We perceive that such processes are generally not effective in protecting the public.

- b) How can complaints and disciplinary processes be improved?

Rather than focusing on a c complaint and associated disciplinary processes, BC Biomedical believes that a total quality system needs to be implemented across other organizations. It is vital that appropriate metrics are monitored regularly and root causes are identified and holistic solutions designed and implemented. A total quality system does deal with complaints efficiently and effectively in a systematic way but is not the only means of identifying issues. The focus of a total quality system is not on blame, but on continuous improvement.

- c) Should all provincial health regulators use the same or a similar approach?

No comment as we are not expert on provincial health regulatory bodies’ processes.

4. Cost Effectiveness and sustainability

- a) Are there other costs/benefits for health stakeholders that should be taken into account?

A regulatory body may require non-value added work such as assessing credentials that have already been recognized by CSMLS or the employer. A regulatory body may also cause delays to accrediting individuals for practice, to resolve complaints or problems taking disciplinary action, etc. The costs of the membership, the time required for registering and re-certifying and other associated costs would all have to be taken into account.

- b) Are there potential benefits of combined regulatory bodies?

They can share costs and expertise over a wider membership, however, they may have conflicting interests.

- c) Has increased public representation escalated costs? (please clarify). Who should bear their costs?

Ultimately, all costs would be borne by the taxpayer in BC.

5. Summary Questions:

Is there any other issue that you would like to raise?

If the reserved act is venipuncture, BC Biomedical Laboratories Ltd., would have even more issues as our MLTs do not perform venipuncture.

We are very concerned about the issue of delegated supervision for venipuncture. Currently, venipunctures are performed by our MLAs who operate under the medical direction of our Medical Director through a defined delegation process.

Has support from all of the medical technologists been determined? Our practice is to involve medical technologists in decisions that affect them.

Given the existence of CAP, DAP and our Total Quality program which includes annual performance review, competency assessment, continuing education, training, orientation, training and education funding, in-service continuing laboratory education programs, we are not convinced of the value of a college for MLTs.

Generally speaking, are you in favour of creating a new, joint regulatory college for MLTs and MRTs?

Although we agree with the principles of public safety, accountability, quality assurance, and sustainability, we do not see the value of creating a new joint regulatory college for MLTs and MRTs. We feel strongly that the medical laboratory technologists and the public are best served by working under integrated and clear Medical Direction.