RNAO
Registered Nurses' Association of Ontario
L'Association des infirmières et infirmiers autorisés de l'Ontario

Speaking out for health. Speaking out for nursing.

Response to Ministerial Referral on Interprofessional Collaboration among Health Colleges and Professionals

Registered Nurses' Association of Ontario

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Table of Contents

INTRODUCTION

The Registered Nurses' Association of Ontario (RNAO) is the professional organization for registered nurses who practice in all roles and sectors across Ontario. Our mandate is to advocate for healthy public policy and for the role of registered nurses in shaping and delivering health services.

We are pleased to respond to the HPRAC consultation on issues related to the ministerial referral on interprofessional collaboration among health colleges and professionals. This submission by the Board of Directors of the Registered Nurses' Association of Ontario was informed by the perspectives of our members, and it was developed in close consultation with our expert interest groups, especially our Community Health Nurses' Initiatives Group (CHNIG) and the Nurse Practitioners' Association of Ontario (NPAO).

RECOMMENDATIONS

Changes to HPRAC's Definition of Interprofessional Collaboration

- HPRAC proposes that any initiatives should be directed to finding ways to: "assist health regulatory colleges and their members to work collaboratively, rather than competitively, and to learn from and about each other through a process of mutual respect and shared knowledge" (p. 26). RNAO suggests that "rather than competitively" be removed, as it reinforces organized medicine's preoccupation with shared scopes of practice as inherently competitive.

- RNAO suggests that "patient" be replaced by "client" and defined as being "inclusive of individuals, families/significant others, groups, communities, and populations."[1]

- RNAO suggests replacing "improve patient care" to "improve client-centred care".

Changes to the *Regulated Health Professions Act*

- RNAO recommends access to the following additional controlled acts for the profession of nursing:
    - communicating to the individual or his or her personal representative a diagnosis identifying a disease or disorder as the cause of symptoms of the individual in circumstances in which it is reasonably foreseeable that the individual or his or her personal representative will rely on the diagnosis;
    - setting or casting a fracture of a bone or a dislocation of a joint;
    - applying a form of energy prescribed by the regulations under this *Act* (i.e. *RHPA*); and dispensing a drug as defined in subsection 117 (1) of the *Drug and Pharmacies Regulation Act.*

- Supporting interprofessional practice requires the government to act on CNO's recommendation to remove limitations on the following controlled acts currently authorized to RN(EC)s:
    - prescribing;
    - communicating a diagnosis;
    - and administering a substance by injection or inhalation.

As well, it requires providing access to the following additional acts for RN(EC)s:

- setting or casting a fracture of a bone or a dislocation of a joint;
- dispensing, selling or compounding a drug;
- and, applying a form of energy prescribed in regulations under this *Act* (i.e. *RHPA*).

Changes to the *Public Hospitals Act* and its regulations

- Allow RNs to work to their full scope of practice in hospitals settings.
- Allow RN(EC)s to work to their full scope of practice in an inpatient setting.
- Replace the Medical Advisory Committee (MAC) with an Interprofessional Advisory Committee (IPAC).

Changes to the *Healing Arts Radiation and Protection Act*

- To provide RNs with the authority to order X-Rays.

Changes to the *Vital Statistics Act*

- To provide RNs with the authority to sign the Medical Certificate of Death in situations when death is expected.

Liability Protection

- The critical issue that must be addressed is the adequacy of professional liability protection carried by all employers of health-care professionals.
- Those professionals, including the relatively few NPs and RNs who practice as independent contractors or are self-employed, should be fully informed about their professional obligation to clients. Requirements should be in place to ensure that these professionals maintain adequate liability protection reflective of their risk profile.
- The current coverage of $5M that is available through CNPS should be deemed sufficient for NPs practicing as independent contractors. Further, the $1M coverage for RNs is also an acceptable minimum requirement when practicing as an independent contractor.

Education

- It is essential that interprofessional education begins within basic health science education curriculum and that it models interprofessional delivery of educational services.

Funding

- In order to fully realize the objectives of interprofessional care, funding for teams and compensation for all providers must recognize the unique contributions of each profession consistent with this team based approach to care.

BACKGROUND

This referral to HPRAC comes at an opportune time. While interprofessional collaboration is not a new concept, it has only been in this decade that government, policy makers and leaders within the health care system have recognized the contributions of highly functional and effective interprofessional teams. Such teams bring improved access to safe, effective quality care for clients, support retention and recruitment of health care professionals, and enable system efficiencies. The health care system is beginning to reap the benefits of the many national and provincial initiatives to support interprofessional practice including primary health care transition fund projects, new educational programs supporting interprofessional education, legislative changes such as Bill 171, strategies to support chronic disease management, and funding for interprofessional coaching / mentorship projects.

In 2007, RNAO and NPAO actively participated in HPRAC's consultation in response to Minister Smitherman's referral on the Registered Nurse (Extended Class). Interprofessional teams and collaboration were among the many topics that were discussed at length during public consultations and written submissions throughout that process. In our submissions to HPRAC we provided numerous examples of the barriers to effective interprofessional collaboration especially between NPs and family physicians as a direct result of current legislation, regulation and policy. We also identified challenges resulting from lack of role clarity, structural barriers that do not support true partnerships, and general lack of skills among providers to work as effective integrated teams.

In our view, effective client-centered interprofessional collaboration results from: supportive cultures that enable teams to integrate their knowledge and skills to achieve optimal benefit for individual patients / clients, families and communities; a shared understanding of what interprofessional collaboration is; as well as structures that enable interprofessional collaboration.

A) DEFINING INTERPROFESSIONAL COLLABORATION

i) Achieving a Common Understanding of Interprofessional Collaboration

RNAO supports regulatory colleges and their members working together to implement and strengthen interprofessional, client-centred care across health sectors which is grounded in mutual respect and shared knowledge. This is consistent with the Interprofessional Care Steering Committee's definition of interprofessional care,[2] the 2003 First Ministers' Accord on Health Care Renewal's vision of collaborative patient-centred practice,[3] and the Canadian Nurses' Association's position statement on Interprofessional Collaboration.[4]

This contrasts with the Canadian Medical Association definition of collaborative care, which is as follows:

> Collaborative care entails physicians and other providers using complementary skills, knowledge and competencies and working together to provide care to a common group of patients based on trust, respect and an understanding of each others' skills and knowledge. This involves a mutually agreed upon division of roles and responsibilities that may vary according to the nature of the practice

personalities and skill sets of the individuals. The relationship must be beneficial to the patient, and acceptable to the physician and other providers.[5]

Addressing this cultural barrier to interprofessional collaboration is a critical first step in achieving success, as organized medicine's view of collaborative practice privileges medicine over the needs of clients and authentic interprofessional, comprehensive, integrated health care.

This may be demonstrated by contrasting key principles in the Canadian Medical Association's policy document on *Achieving Patient-Centred Collaborative Care* with an alternative vision that respects the knowledge, skills, and abilities of all members of an interprofessional collaborative team in the following table:

CMA Vision[6]	**CNA[7] [8] and RNAO Vision**
"medical care delivered by physicians and health care delivered by others" (2)	Health and health-care services that address full spectrum of population health, health promotion, disease prevention, curative, rehabilitation, and palliative care.
"models of collaborative care must support the patient-physician relationship" (2)	Models must support the integrity of each patient-professional relationship.
"entry into and exit from a formal collaborative care arrangement must be voluntary for both patient and the physician" (2)	Patients/clients have a human right to health care, and health professionals have a duty to ensure equitable access for all.
"every resident of Canada has the right to access a personal family physician" (2)	Every resident of Canada has the right to access primary health care.
"the physician, by virtue of training, knowledge, background and patient relationship, is best positioned to assume the role of clinical leader in collaborative care teams. There may be some situations in which the physician may delegate clinical leadership to another health care professional. Other health care professionals may be best suited to act as team coordinator." (3)	A physician may be the best choice as a clinical leader in some contexts but not always. Non-physician clinical leaders have already shown their value. Those who have the skills, knowledge, and training to have this role delegated to them by a physician already have the expertise and responsibility to be accountable for their practice as a member of a self-regulating profession.
"Collaborative care must first and foremost serve the needs of patients, with the goal of enhancing patient care; collaborative practice is not contingent upon altering the scope of practice of any provider group and must not be used as a means to expand the scope and/or independence of a health professional group." (4)	Access to and safety of client-centered care is enhanced by fully utilizing the knowledge, experience, and skills of all health-care professionals.
"Where non-physicians have been provided with an opportunity to undertake activities related to patient care typically unique to the practice of medicine (e.g.	Enabling qualified health-care professionals to practice to their full scope as they make independent decisions where appropriate and work collaboratively

CMA Vision[6]	CNA[7] [8] and RNAO Vision
ordering tests) they must not do so independently but undertake these activities within the context of a team and in a manner acceptable to the clinical leader." (4)	within teams has been shown to be safe, effective, client-centred care in multiple settings and jurisdictions.
"As clinical leader, the physician should be responsible for the clinical oversight of an individual patient's care." (5)	The clinical leader should be responsible for the clinical oversight of an individual patient's care.
"Physicians, in their role as clinical leaders of collaborative care teams, must be satisfied with the ongoing existence of appropriate liability protection as a condition of employment of, or affiliation with, other members on collaborative care teams." (5)	Clinical leaders and organizational leadership will ensure appropriate liability protection.
"The effective functioning of a collaborative care team depends on the contribution of a physician" (5)	The effective functioning of a collaborative care team depends on the valued contributions of all team members.
"Governments must enhance access to medical care by increasing the number of physicians and providers, and not by encouraging or empowering physician substitution." (5)	Governments will enhance access to health services by supporting health human resources. Utilizing trained health professionals to their full scope as autonomous practitioners will not replace the need or appreciation for physicians with their knowledge and skill sets.
"Physicians should be appropriately compensated for all aspects of their clinical care and leadership activities in collaborative care teams." (6)	All collaborative care members should be appropriately compensated for their clinical care, leadership, and teamwork.
"Interprofessional educational opportunities must not come at the expense of core medical training. High quality medical education must be available to all medical trainees as a first priority" (6).	Consistent with the needs of the province, both high quality discipline-specific professional education and interprofessional educational opportunities require support.

Inherent within organized medicine's current definition of interprofessional collaboration is a continuation of both medical dominance and the related historical subordination of other health professions. A continuing example of this may be seen in those areas where physician resistance to midwives is still evident in the challenges that midwives face in obtaining privileges in Ontario hospitals. A recent dramatic example involved obstetricians threatening to quit if midwives were allowed to conduct deliveries in Belleville.[9] [10]

Medicine's reluctance to engage in professionally appropriate power-sharing with other disciplines that have overlapping scopes of practice is also exhibited in the profession's support for "physician extender"[11] models that reinforce their hierarchical dominance, such as the role of physician assistant or anaesthesia assistant. These roles have no independent scope of practice. Medicine's insistence on characterizing those who are not under their direct control as

being in competition with them is embedded in language describing nurse practitioners as "physician substitutes" or "mini-docs".[12]

ii) Addressing Power Differentials to Improve Public Safety

"Power is the ability to take one's place in whatever discourse is essential to action and the right to have one's part matter."[13]

Dramatic examples of nurses' concerns being dismissed as trivial even as clients continued to die may be found in Canada, the United States, and the United Kingdom.[14] Judge Murray Sinclair, in reporting on twelve deaths during paediatric cardiac surgery at the Winnipeg Health Sciences Centre, said:

> Historically, the role of nurses has been subordinate to that of doctors in our health-care system. While they are no longer explicitly told to see and be silent, it is clear that legitimate warnings and concerns raised by nurses were not always treated with the same respect or seriousness as those raised by doctors. There are many reasons for this, but the attempted silencing of members of the nursing profession, and the failure to accept the legitimacy of their concerns meant that serious problems in the paediatric cardiac surgery program were not recognized or addressed in a timely manner. As a result, patient care was compromised.[15]

These power differentials are also visible in less dramatic circumstances. An ethnographic study of clinical decision making within an intensive care unit found that "the nursing role, while pivotal to implementing clinical decisions, remained unacknowledged and devalued." [16]

The link between collaborative practice environments and patient safety has been identified. A recent Statistics Canada report suggests that workplace environment, including the quality of working relations between physicians and nurses, was associated with medication errors. The quartile in which working relations were most favourable between physicians and RNs providing direct care within hospitals reported a medication error percentage of 12, in contrast with the 27 per cent reported by those in the worst quartile of nurse-physician working relations.[17]

In addition to client safety being compromised, power differentials also erode workplace safety for staff. The investigation into the death of Lori Dupont, RN, as a result of violence by a physician with a well-known history of abuse,[18] resulted in this important inquest recommendation:

> Ensure that patient and staff safety, as well as patient care, must be the most important factors and not be superceded by a physician's right to practice and that hospitals be able to exercise the appropriate degree of authority over physicians working within their institutions consistent with that of other regulated health professionals.[19]

While respect and collegiality cannot be legislated, it is possible to put into place legislative and regulatory structures that facilitate client and staff safety and increase access to health services through interprofessional client-centered care.

iii) Recommended Changes to HPRAC's Definition of Interprofessional Collaboration

- HPRAC proposes that any initiatives should be directed to finding ways to: "assist health regulatory colleges and their members to work collaboratively, rather than competitively, and to learn from and about each other through a process of mutual respect and shared knowledge" (p. 26). RNAO suggests that "rather than competitively" be removed, as it reinforces organized medicine's preoccupation with shared scopes of practice as inherently competitive.

- RNAO suggests that "patient" be replaced by "client" and defined as being "inclusive of individuals, families/significant others, groups, communities, and populations."[20] "Patient" suggests someone along the illness, rather than health, continuum. This more inclusive framing reflects interprofessional collaboration that must take place across practice sectors, including community health settings such as public health, home health, and primary care. Agencies and organizations choose the meaning of client that is most suitable for its population, and so may refer to their clients as persons, residents, communities, etc.

- RNAO suggests replacing "improve patient care" to "improve client-centred care". "Client-centred" may be defined as "an approach in which clients are viewed as whole persons; it is not merely about delivering services where the client is located. Client-centred care involves advocacy, empowerment, and respecting the client's autonomy, voice, self-determination, and participation in decision-making".[21] Within discussions of interprofessional collaboration, it is essential to situate clients as the experts in their own lives and as active participants in defining the goals that coordinate the practices of the health-care team.[22]

B) LEGISLATIVE AND REGULATORY BARRIERS TO INTERPROFESSIONAL COLLABORATION

i) RN Scope Issues: Increased Access to Controlled Acts

The practice and role of RNs continuously evolves with changes in work environments, technology, and educational and policy parameters. As a result, regulatory regimes will not necessarily reflect current practices. They must be updated to provide RNs with independent access to controlled acts that have become an integral part of their practice. Without this independent access, the profession is not truly self-regulating. Most importantly, an expanded scope of practice for RNs will bring the following benefits: greater retention and recruitment of nurses; decreased administrative complexity and costs associated with delegation of acts that should be within the scope of nursing; and increased access to quality and timely care.

RNAO recommends access to the following additional controlled acts for the profession of nursing:

- communicating to the individual or his or her personal representative a diagnosis identifying a disease or disorder as the cause of symptoms of the individual in circumstances in which it is reasonably foreseeable that the individual or his or her personal representative will rely on the diagnosis;

- setting or casting a fracture of a bone or a dislocation of a joint;

- applying a form of energy prescribed by the regulations under this Act (i.e. RHPA); and

- dispensing a drug as defined in subsection 117 (1) of *the Drug and Pharmacies Regulation Act.*

RNs have knowledge, skill, and experience to support having the authority to perform these acts within their scope of practice. This will ensure timely access to care, reduce the need for delegation, and support progression of care management in a timely way.

Communicating a diagnosis is often required to obtain consent for intervention and treatment. In a number of practice settings, RNs cannot practice honestly and transparently with their clients without communicating a diagnosis. Therefore, they must either go through a time-consuming and expensive process of delegation or conduct their practice in a manner that does not technically violate the Act, but does in fact create moral distress through a violation of ethical principles and values. Examples of the situations in which RNs need to communicate a diagnosis include:

- RNs in acute care settings who are caring for clients with secondary conditions, such as urinary tract infections, cannot communicate why they are administering drugs or other treatment. This hinders initiatives directed at clients to be attentive to medications and other treatments that they are receiving in order to protect themselves against iatrogenic mishaps. Waiting for a physician to disclose a urinary tract infection could delay treatment, while an evasive answer about this new medication could undermine trust and rapport between the nurse and client.

- In an emergency department, RNs cannot communicate the results of a pregnancy test. This results in clients waiting for long periods while physicians deal with more acute cases.

- Public health nurses work under medical directives to communicate the results of pregnancy tests and refer clients who test positive for counselling. Similarly, in sexual health clinics, public health nurses must operate under medical directives to communicate diagnoses about sexually transmitted diseases.

- For marginalized clients, direct interaction between the community health nurse and the client may occur only once at a single point in time. One of the critical methods of reducing marginalization involves open, honest, transparent disclosure as a means of establishing trust with individuals and groups with good reason not trust.

The regulation which governs the application of energy needs to be updated. It has not kept pace with technological changes. While some acts are outside nursing scope (like defibrillation), similar acts (defibrillation) are in the public domain (for example in arenas and shopping malls).

In a variety of contexts, RNs dispense medication as a routine part of implementing medical directives, generally for clients who meet specific criteria or as a delegated act to respond to a particular client's situation. This is common in remote communities but also pertinent in the following examples:

- In an out-patient clinic, an RN may dispense an insulin pen to a client with diabetes to take home.

- In an emergency room, an RN may dispense the first dose of an antibiotic for a child with an ear infection when the pharmacy will not be open until the next morning.

- Birth control pills are dispensed by public health nurses in a sexual health clinic.

- Public health nurses dispense medication such as Ritalin, insulin, or allergy shots in a school setting.

- In psychiatric units, RNs dispense drugs to clients who are leaving the unit for the weekend.

Community health nurses working in remote settings have often been responsible for setting or casting a bone fracture or joint dislocation. RNs with the required knowledge, skills, and experience should be authorized to set and cast.

The experience of our members is that delegation and medical directives for these four acts consume large amounts of time and resources, resources that would be better directed to providing client care.

ii) RN(EC) Scope: Implementing the College of Nurses' Recommendations

In the past decade, much has been accomplished to support the implementation of the RN(EC) role. Examples include changes to regulations under the *Public Hospitals Act* (1990) and various long-term care legislations to enable the role in hospital outpatient and emergency departments and in long-term care homes, respectively. These changes enabled more than 60 positions for NPs to be established. These NPs now contribute to improved access and effective interprofessional teams in hospitals, community care access centres (CCACs), and long-term care homes. Changes to the *Nursing Act* in August 2007 enabled new specialty roles (NP Adult, NP Paediatrics and NP Anaesthesia) that further support government priorities on improved access, recruitment / retention of health professionals, and chronic disease management.

However, to enable these roles and to support the full integration of primary health care nurse practitioners, numerous changes to legislation and regulation are required. Submissions from the College of Nurses of Ontario (CNO), the Registered Nurses' Association of Ontario, and the Nurse Practitioners' Association of Ontario (NPAO) on the RN(EC) referral identified numerous legislative, regulatory, and policy barriers that restrict NP practice and negatively impact the effectiveness of interprofessional teams and patient access to safe, evidence-based, and timely care.

Many restrictions remain in the Nursing Act and Regulation 275 including drug / lab / diagnostic test lists, limitations related to diagnoses, and limited access to controlled acts. In regard to other legislation under the mandate of the Minister of Health and Long-Term Care, the following represent significant barriers to NP practice and interprofessional collaboration:

- Public Hospitals Act (PHA) Regulation 965

- Health Insurance Act (HIA) Regulation 552

- RHPA Regulation 107 (Forms of Energy)
- Regulation 682 Regulated Health Professions Act
- Health Arts Radiation Protection Act (HARP)
- Drug and Pharmacies Regulation Act

Supporting interprofessional practice requires the government to act on CNO's recommendation to remove limitations on the following controlled acts currently authorized to RN(EC)s: prescribing; communicating a diagnosis; and administering a substance by injection or inhalation. As well, it requires providing access to the following additional acts for RN(EC)s: setting or casting a fracture of a bone or a dislocation of a joint; dispensing, selling or compounding a drug; and applying a form of energy prescribed in regulations under this Act (i.e. RHPA).

The proposed changes will: reflect current education, competencies, and practice of RN(EC)s; increase client access to timely health-care services; increase efficiencies within the system and enhance cost-effectiveness by decreasing duplication; and clarify and enhance RN(EC) accountability. These changes will also result in improved retention and recruitment of RN(EC)s working in Ontario by enabling them to be utilized to their full capacity, and will thus aid in ameliorating many of the current health system challenges.

Changes proposed by CNO and supported by RNAO, NPAO and other stakeholders would have multiple positive impacts for patients, interprofessional teams and the heath care system. To cite but a few examples outlined in submissions on the RN(EC) referral:

- Removing restrictions to the drug/lab/diagnostic tests list would eliminate frequent interruptions by NPs with collaborating physicians, eliminate the need for repeat patient visits to another professional and improve timely access to evidence-based care for patients.
- Expanding access to controlled acts and authorities will also have a positive effect on in-patient hospital services and improve efficiencies within the system.

NP practice demonstrates that medical directives and delegation are a barrier to interprofessional practice. Medical directives and delegation are mechanisms utilized by many professions to address legislative and regulatory limitations. During the public consultations on the RN(EC) referral, NPs cited hundreds of examples of the need for medical directives to enable their practice despite the competencies, knowledge, and skill inherent in NP practice. The barriers resulting from the need for these mechanisms include:

- Additional and excessive administrative workload for NPs related to the complex process required to develop and approve directives.
- Challenges to maintain directives consistent with best evidence and emerging technologies.
- Use of directives establishes an environment of mistrust in relation to scope of practice.

The use of medical directives has allowed the value of the NP role to be demonstrated in hospital and other settings. However, the cumbersome nature of developing and maintaining

medical directives prevents this from being a reasonable solution for a prolonged period of time. If we accept that health care is evolving to better meet the needs of clients and families, then we need to accept that health-care provider roles and the legislation that governs their practice must also evolve to meet those needs.

iii) Other Legislation Beyond RHPA

Other legislation and associated regulations that restrict or limit RNs from practicing to their full competencies within their current scope of practice also are barriers to interprofessional collaboration.

Regulations under the *Nursing Act* give nurses who meet certain conditions the authority to initiate specific controlled acts. These nurses may decide based on their knowledge and expertise that a specified procedure is required and initiate that procedure without a direct order or medical directive from a physician. While RNs have the authority to initiate, it is limited in practice by the *Public Hospitals Act, Regulation 965*. This regulation requires a medical order for the initiation of treatment and diagnostic procedures.

Changes to regulations under the *Public Hospitals Act* (1990) enabled nurse practitioners' roles (NPs) in hospital outpatient and emergency departments. These NPs now contribute to improved patient access and effective interprofessional teams in hospitals.

Regulation 965, however, continues to limit nurse practitioners (NPs) from working to their full scope in a hospital inpatient setting. They cannot diagnose, prescribe for, or treat inpatients without the use of medical directives. In contrast, NPs who work in outpatient settings – such as an emergency department or ambulatory clinic – can diagnose, prescribe for and treat hospital outpatients under their own legislative authority. This is also the case for NPs in the community. This limitation on RN(EC)s in inpatient settings is inconsistent, uses resources inefficiently, and is inconsistent with self-regulation.

The provision for a Committee (MAC) in the *Public Hospitals Act* is another barrier to collaborative practice. It reinforces the inequitable power relations between physicians and other providers, and provides inequitable access to senior decision-makers (e.g. the Board) that is not available to other health professionals and staff within the organization.

- To reflect commitment to truly interprofessional practice, the act should be amended to replace the MAC with a Interprofessional Advisory Committee (IPAC) composed of members that represent all regulated health professionals involved in interprofessional practice. This is already the case with the Local Health Integration Networks (LHINs), and we recommend that it be the same for hospitals.

Other legislation that impedes nurses' current authority to perform controlled acts is the *Healing Arts Radiation and Protection Act*. Under the *Act*, the authority to ordering x-rays is granted to physicians and granted only narrowly to NPs, who may order x-rays of the "chest, the ribs, the arm, the leg, the ankle or the foot". These limited allowances for NPs, and the failure to recognize the ordering of basic X-rays by nurses working in areas such as emergency departments or fracture clinics, lead to inefficiencies within the system, unnecessary delays in treatment, and inconvenience for clients.

Amendments to *HARP* and Regulation 107 under the *RHPA* would facilitate wellness and preventative care by NPs, which is an important aspect of nurse practitioner scope of practice. This has the potential to significantly contribute to achieving government goals for improving the health of Ontarians.

Presently, in cases of expected death, only physicians and registered nurses (RNs) in the Extended Class (RN[EC]s) can sign a Medical Certificate of Death (MCOD).

Registered nurses are presently given the authority to pronounce death when the death is expected; however, they are not permitted to sign the MCOD. Changes are needed to the *Vital Statistics Act* so that RNs will have the authority to sign the Medical Certificate of Death in situations when death is expected.

A registered nurse who has been caring for a client with terminal cancer of the pancreas cares for the client and provides support for the family until the client expires. Under existing legislation, the RN must then call the family physician or RN(EC) if available to come to the residence to complete the MCOD so that the body can be removed by the Funeral Director.

There is often a considerable delay before either the physician or RN(EC) is available to come to the home and sign the MCOD. Since the body cannot be removed from the home until the MCOD is completed, there is undue stress placed on the family at an already emotionally difficult time.

Under circumstances when death is expected and has been planned for in the plan of care, and the decision to 'do not resuscitate' has been discussed with the client and family and agreed upon, the RN who has been caring for the client has the knowledge, skill, and ability to sign the MCOD. RNs having this authority would lead to improved client-centered care and more appropriate use of resources.

In 2006 the Ontario Palliative Care Association (OPCA) formed a Certification of Expected Death Task Force to address the current system issues that often make it difficult for people living with progressive life-limiting diseases and their caregivers to know with certainty that transfer of the body post-death will be simple and expeditious. Following many months of consultation with a number of associations and agencies, the task force developed a 'motions for approval' document to be submitted to the Office of the Registrar. The essence of the document describes circumstances when RNs should have the authority to sign the MCOD.

There are also examples of restrictions to NP practice arising from legislation under the control of other Ministries. An example is the *Highway Traffic Act* that does not authorize NPs to complete and submit Fitness to Drive reports. Although the Ministry of Transportation of Ontario is aware of the restriction and has proposed legislative changes in the past, the proposed changes have failed to make the legislative agenda.

C) LIABILITY PROTECTION AS A PERCEIVED BARRIER TO INTERPROFESSIONAL COLLABORATION

i) Experience of Inadequate Liability Protection as a Barrier to Practice

The argument of "inadequate liability protection" has been a significant barrier for nurse practitioners (NPs), not only in regard to interprofessional practice but to successful integration of the role throughout the health-care system.

When the regulated NP was established in 1998, concerns about access to and adequacy of professional liability protection were raised by the physicians, employers, and NPs. The concerns, especially on the part of organized medicine, resulted in delays in the development and implementation of policy necessary for the funding of NP positions and in some instances in the successful integration of NPs into practices.

The 2004 report, *The Integration of Primary Health Care Nurse Practitioners in the Province of Ontario*[23] documented concerns raised about liability protection in NP-family physician collaborative practices. The report noted that fewer physicians were concerned about liability when the NP role was well-defined and when the NP had longer experience as an RN. The report also indicated that more physicians had concerns about liability when the NP was dissatisfied with communications or collaboration and if the NP was also concerned about liability.

As a result of discussions involving RNAO, NPAO, the Nursing Secretariat and the Canadian Nurses Protective Society (CNPS), changes were made to CNPS coverage for NPs across Canada in 2004 (for details on the coverage available to RNs and NPs as a benefit of their membership in RNAO, visit www.cnps.ca and click on the brochure). The following year, CNPS and the Canadian Medical Protective Association (CMPA) issued a joint statement on liability protection for NPs and family physicians in collaborative practices (available at www.cnps.ca – click on the joint statement).

ii) Requirement for Regulated Health Professionals for Mandatory Liability Protection

It is essential that questions on professional liability protection are framed within the context of a comprehensive understanding of law and risk as it applies to the Canadian experience. This response is framed within the learning gained primarily through the experience of nurse practitioners.

In Ontario, virtually all registered nurses (RNs) and nurse practitioners (NPs) are employees. Consequently, vicarious liability applies – it is the responsibility of the employer, not the professional who is an employee, to ensure that the organization has adequate liability protection. When an employment relationship exists, regardless of the scope of practice of the employee, the employer is responsible to ensure oversight of the employee and is responsible for the actions of every employee. The employer bears responsibility for the cost of the liability, and it is the employer who is financially responsible for any awards made by a court for the actions of an employee.

Over the past 2-3 years, concerns have been expressed at many different venues (e.g. Quality Management Collaborative Conference, FHT Action Group, meetings of Association of Family Health Teams of Ontario) in presentations by CMPA, CNPS, and independent legal counsel about the lack of awareness of the need for professional liability insurance on the part of employers. These same groups have also commented that it is highly likely that some of the newer models of care, especially within primary health care, may have some coverage but may not be adequately covered.

It is our assessment that the critical issue that must be addressed is the adequacy of professional liability protection carried by all employers of health-care professionals. Any recommendation that suggests that all RNs and NPs or other health professionals with employee/employer relationships must be self-insured is not based on fact or evidence. It only contributes to misinformation about risk and misunderstandings about employer responsibilities under Canadian law.

We acknowledge that those professionals, including the relatively few NPs and RNs who practice as independent contractors or are self-employed, should be fully informed about their professional obligation to clients. Requirements should be in place to ensure that these professionals maintain adequate liability protection reflective of their risk profile.

iii) Minimum Levels and Types of Professional Liability Coverage

It is not reasonable to compare the liability experience of one professional group with another. Although scope of practice may overlap, practices vary widely and are very different within a practice setting and from one setting to the next.

In addition, not all practitioners within a profession experience the same risk profile. For example, a family physician that does obstetrics has a much higher risk profile than a family physician that does not do obstetrics. This is an important consideration should recommendations be made about minimum levels of coverage for professionals.

It is well established that RNs and NPs have relatively low risk. Given the data available from the US experience, the current coverage of $5M that is available through CNPS should be deemed sufficient for NPs practicing as independent contractors. Further, the $1M coverage for RNs is also an acceptable minimum requirement when practicing as an independent contractor.

We would further recommend that the type of coverage required must be “occurrence based”. This type of coverage ensures that regardless of when a suit is brought forward or if the professional leaves the team, adequate protection to pay out any successful claims will be available. There is no need for “tail coverage” as required when coverage is “claims made.”

D) FACILITATING AUTHENTIC INTERPROFESSIONAL COLLABORATION ACROSS SETTINGS

Research has identified a lack of a clear understanding of interprofessional collaboration among health professionals, particularly around the roles and scopes of practice of other professionals.[24] [25] To increase the potential for successful interprofessional collaboration, it is

essential that interprofessional education begins within basic health science education curriculum and that it models interprofessional delivery of educational services. This will serve to foster insight, knowledge, appreciation, and collaboration among the disciplines from the earliest stage of development. This groundwork of greater understanding of the roles of other professional colleagues will foster other determinants of collaboration such as mutual respect, sharing, and enhanced trust.[26] Values promoted within formal education must be reflected in clinical practice settings, as all too often a marked divergence between formal and informal curricula leads to cynicism.[27]

Authentic interprofessional collaboration in primary health care must be operationalized in how health-care services are structured and funded. Rostering to a specific physician, rather than to a community health centre or family health team, reinforces medical dominance by privileging the client's relationship with the physician over all others. Rather than a "my patient" mentality, structures must reflect shared responsibility to meet the goals of the clients. A common documentation standard, for example, is a means to ensure a common understanding and uniform accountability for clear communication.

Tracking the professional practice of multidisciplinary teams by physicians' billing numbers effectively makes invisible the competencies and contributions of other health-care professionals. It makes little financial or clinical sense to have an incentive system that reimburses physicians for health promotion and disease prevention work that is actually best provided by other members of the health-care team.

In multiple health care settings where NPs work, electronic health records have been introduced to support interprofessional practice. NPs have noted that the framework for these systems is grounded in traditional medical practice (ie. fee for service codes) and are not tailored to the language, definitions or culture of NP practice. We also find that often the communications used to introduce and support implementation of these systems focus on medicine or reduce the other members of interprofessional teams to "allies" or "others". Electronic health information systems must be structured in a manner that is mindful of the needs of all members of interprofessional teams. Electronic information sharing strategies are critical to the success of interprofessional collaborative teams.

Embedded in the RN(EC) standards of practice is the requirement for a consultative relationship with a physician. One of the ongoing challenges has been the development of appropriate and fair compensation models to support these relationships. Physician compensation is a bi-partisan negotiation between the Ministry of Health and Long Term Care and the Ontario Medical Association. Despite the fact that the compensation is directly related to the relationship between the NP and the physician, NPs are not represented as part of those negotiations. Previous agreements have resulted in unreasonable additional workload requirements for the NPs (i.e. data collection) in order to complete the process for physician compensation. The most significant barrier has been the introduction of numerous financial incentives/bonus/premium payments to physicians based on the work done by NPs (i.e., immunizations, mammograms, smoking cessation, etc).

In order to fully realize the objectives of interprofessional care, funding for teams and compensation for all providers must recognize the unique contributions of each profession consistent with this team based approach to care. Continued utilization of incentive payments directed to only one member of the team undermines interprofessional care. The result of this unjust enrichment is to make the work of nurse practitioners invisible and has the potential to

limit NP scope of practice. This model of compensation reflects an outdated and hierarchical model of care that is not sustainable within a transformed patient centred health care system.

Authentic interprofessional collaboration requires each profession's scope of practice to be commensurate with their knowledge, skills, and ability. This can only be achieved through changes to legislation that enable professionals to practice to full and often expanded scopes. Limited scopes of practice create a requirement for delegation for controlled acts; acts which will only be performed by professionals if they have the required knowledge, skill, and ability. Delegation is a complex and documentation heavy process, which is often inefficient. Delegation of controlled acts to nursing by medicine, one profession controlling the practice of another, impacts on professional autonomy, the provision of safe patient care, and timely access to care. In Ontario, the controlled acts model is designed to enable the delivery of health services of regulated professions, not to restrict access to the same controlled acts by other health professionals.[28]

Although many physicians support interprofessional collaboration in theory, in reality many also see themselves as the 'leaders' or 'final decision-makers' of the 'team'[29]. This attitude undermines the very essence of interprofessional collaboration.

Leadership is a dynamic process that should be directed by the individual client and situation. It should not be taken for granted that only 'one' profession has the knowledge, skill and ability to assume this role. The success of inter-professional collaborative care requires: the right care, at the right time, in the right place, by the right care provider[30], making it essential that one profession does not hold dominion over another.

CONCLUSION

Our thanks to HPRAC for your continued efforts to enable broad and comprehensive consultation on the referral on interprofessional collaboration. We are hopeful that the perspective we have provided is helpful to HPRAC's deliberations and we are confident that this important work will have a positive impact on patient care and advance the implementation and integration of interprofessional collaborative teams throughout Ontario's health-care system.

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