REVIEW OF BRITISH COLUMBIA HEALTH PROFESSIONS' QUALITY ASSURANCE PROGRAMS

A Report Prepared for the Legislation and Professional Regulation Division, Ministry of Health Planning, Province of British Columbia

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EXECUTIVE SUMMARY

This report was commissioned by the Ministry of Health Planning in order to gain a better understanding of the range and breadth of quality assurance programs in the 23 regulated health professions in British Columbia. The report was to provide (1) an inventory of the existing quality assurance (QA) programs and policies of these professions, (2) a literature review of QA in the context of regulated health professions, and (3) an evaluation framework to review the effectiveness of the QA programs. The report was to exclude entry-to-practice requirements (except relicensure) and complaint and disciplinary processes. The report does not evaluate specific college's QA programs.

The literature on quality uses a variety of terms for a variety of theories and methods; for simplicity, this report uses the term "quality assurance (QA)" as a general term for the range of approaches. The methodology of the report consisted of a literature review, and interviews (or other communications) with representatives of each of the 23 professions' regulatory bodies. Interviews were open-ended and focused on the priority concerns and programs of each college, rather than assessment against a predetermined "checklist".

In BC, government has shown interest in QA in the context of regulated health professions since 1993 amendments to the *Health Professions Act* introduced provisions relating to establishment of quality assurance committees and continuing competency programs. The Health Professions Council's legislative review also commented on QA. The ministry has not to date articulated principles of expectations for QA in this context.

Consistent with earlier literature reviews, the present review found little literature applying QA to the role of health professions' regulators. The report provides a brief overview of industrial quality assurance, and notes the contributions of Donabedian and Berwick in applying this discipline to the health care field. Berwick has noted the divergence between modern QA principles and the traditional focus of health care regulators on identifying "bad apples."

Developments in professional regulation in four jurisdictions are noted. The Pew Commission in the United States has recommended periodic re-examination as a way to address competency concerns. Recent New Zealand legislation provides a legislative model to provide authority and evidentiary protection for QA activities. A series of English reports articulates principles for professional self-regulation, proposals for assuring the quality of medical practice, a "revalidation" model for doctors, and draft guidance on continuing competence. The province of Ontario's Health Professions Regulatory Advisory Council has reported on a series of activities relating to QA, including articulation of principles, a literature review, development and application of an evaluation framework to the Ontario colleges, and recommendations to develop core indicators and evaluation plans.

Based on interviews and communications with British Columbia colleges, a variety of approaches to QA and continuing competency are identified. These do not constitute a model QA program, but present a range of options which may be explored in the context of the particular characteristics of each profession. Colleges have varied in their application of QA theory, and a variety of factors influence the particular choices of QA programs, including the age, size and resources of the college; the environment in which services are provided; the nature of contact with individual patients; the technical or other content of the profession; and the professional culture.

Specific types of QA programs and the viewpoints expressed by the colleges in regard to them are summarized. These include:

- identification of professional competencies or standards of practice,
- continuing education,
- required hours of practice,
- re-examination,
- self-assessments and learning plans,
- peer activities, e.g. mentoring,
- office visits or clinical practice reviews,
- general practice improvement, e.g. newsletters, communications, and
- evaluation of QA programs.

The report presents a synopsis of colleges' comments on these activities. A detailed summary of each particular college's identified QA programs, based on the interviews and on documentation supplied by the colleges, is contained in an Appendix.

The report concludes with a discussion of principles for developing a QA evaluation framework, based on the literature review and the interviews with colleges. Both government and the colleges have specific roles in the development and implementation of such a framework. Government has four approaches available to it. The first is enunciation of principles such as was done in England, in regard to principles of self-regulation, and in Ontario, in regard to QA programs specifically. A second approach is to legislate requirements for QA. To a limited extent, the *Health Professions Act* already recognizes QA and continued competency. The inclusion in the legislation of specific required QA programs is not recommended. Rather, the legislation should provide an adequate framework to permit colleges to implement desired QA programs. Such a framework would enable linking the completion of specific QA programs to renewal of registration (as is already the case). A legislative framework to provide authority and evidentiary protection for QA programs, as in the New Zealand legislation, is already under discussion between the BC colleges and the ministry.[1]

[1] Bill 62, the *Health Professions Amendment Act, 2003*, was passed on October 7, 2003. It requires that a college's QA committee establish a QA program in accordance with the bylaws. Additional bylaw-making powers are granted to colleges. Specific QA programs are not mandated. The bylaw making powers permit linkage of QA participation with registration renewal. The bylaws may provide for assessment of a registrant's professional performance by the QA committee, which may make remedial recommendations where deficiencies are found. Evidentiary protection is provided for information obtained about a registrant in QA activities, except where the registrant knowingly gives false information. The QA committee is also required to notify the Inquiry Committee if there are reasonable

A third government approach is through model bylaws and Cabinet approval of bylaws, and a fourth is through specifying reporting requirements for colleges which would include reporting, not only the activities of their QA programs, but reporting on a timetable for establishing outcome measures and evaluation of the college's QA programs, and reporting on the measures and evaluations once implemented.

With regard to the role of the colleges, their specialized knowledge, expertise and resources are essential to implementation of an evaluation framework, which must recognize the wide variety of starting points, historical experience, and available resources among the colleges. No single optimal model for QA programs emerges from the literature review or college interviews. Colleges are in the best position to identify, not only the professional competencies and practice standards within which QA and continuing competency programs are developed, but also are best able to determine which particular types of QA program will best work within the context of their particular profession. While a "one size fits all" model is not desirable, this does not mean that the choice of QA programs is arbitrary. Colleges should link QA programs to core competencies or standards of practice, and they should be able to demonstrate that the QA programs they have chosen are able to achieve the result of ensuring practitioner competency. On the basis of their specific and detailed knowledge, colleges have an integral role to play with government in identifying appropriate outcome measures and evaluating whether particular QA programs meet their goals. Finally, colleges have a role to promote interdisciplinary QA where appropriate.

Consideration of the roles of government and the colleges leads to specific recommendations for addressing QA in the model bylaws:

- the functions of the Quality Assurance Committee should be articulated, including: overall responsibility for recommending QA policy to the board; approving specific QA or continuing competency programs; identifying outcome measurements for these programs and evaluation methods; and proposing a timetable for implementing these measures and evaluations;
- the college should make renewal of registration contingent on completion of a QA program it chooses; government should not stipulate a particular program, but the bylaws should demonstrate that the college has addressed this linkage;
- subject to adequate legislative authority and to colleges identifying the desirability of such an approach, the bylaws should create and empower assessors in a QA context;
- the annual reports of the college should include information relating to QA, including reporting on the timetable for implementing, measuring and evaluating QA programs.

grounds to believe there has been professional misconduct or incompetence, the registrant's ability to practice is impaired by health or addiction issues, or there is a threat to the public because of failure to comply with remedial recommendations; however, information obtained in the QA process is not to be disclosed. While this does not provide a completely "watertight" separation of the QA and discipline activities, it strikes a balance between fostering registrant participation in QA activities and ensuring there is a remedy available should the QA process bring to light evidence of conduct from which the public must be protected.

TERMS OF REFERENCE

The Ministries of Health Planning and Services have articulated as a primary goal, "Providing high quality, patient-centred care" and have stated that the colleges of the 23 regulated health professions "have a significant role to play in ensuring the provision of high-quality services by health professionals to consumers of health care."

In later February, 2003, the Ministry of Health Planning commissioned this report with the expressed object of "gain[ing] a better understanding of the range and breadth of existing QA programs of the colleges."

The deliverables of this contract are threefold:

1. to inventory the existing quality assurance (QA) programs and policies of the 23 regulated health professions,
2. to conduct a literature review of QA in the context of regulated health professions, and
3. to develop an evaluation framework to review the effectiveness of the QA programs identified.

The analysis specifically excluded an examination of entry-to-practice requirements (except as these may apply to relicensure) and complaint and disciplinary processes.

It should be noted that the evaluation of specific individual colleges' QA bylaws, policies or programs was *not* a deliverable of this contract. In interviews and communications with individual colleges, it was noted that the project was intended to provide an informative inventory of existing programs and policies, and not to audit the QA activities of the colleges against a pre-existing set of standards.

PROJECT METHODOLOGY

A Note on Terminology

The literature on quality provides a potentially bewildering array of names for a variety of theories and methods: quality control, quality assurance (QA), total quality management (TQM), continuous quality improvement (CQI), modern quality management theory, and others. Recognizing that there are important distinctions between these terms and approaches, for the purposes of this paper, the entire field of quality concerns and methods will be referred to as "quality assurance" or QA. This is not intended to restrict the discussion to any specific model. Indeed, within the context of regulated health professions, quality concerns are often addressed under the rubric of "continuing competency" and for the purposes of the present discussion we will take "QA" to be extended to include these matters as well. Where reference is intended to be to a specific model or theory, this will be clear from the context.

Literature Review

The literature review for this project was focused on QA in the specific context of health professions' regulation.

An extensive literature review was commissioned in Ontario in 1997 by the Health Professions Regulatory Advisory Council (HPRAC), and is contained as an appendix in their *Report to the Minister of Health and Long-Term Care: Effectiveness of Colleges' Quality Assurance Programs* (October 2000). This literature review, while it provided an extensive review of quality assurance literature in both the industrial and health care context, found a lack of literature specifically applicable to health regulatory colleges.

With a view to revisiting this conclusion, searches were conducted on the Internet, in the EBSCO host periodical database, and the University of Victoria library catalogue. In addition, colleges were asked about the results of their own literature searches conducted as part of their own planning for QA programs. The results of this review showed little change from the basic finding of the 1997 Ontario review: there appears to be a lack of theoretical quality assurance literature directly relevant to the role of health professions regulatory bodies. Accordingly, the focus of the literature review was shifted somewhat, and selected jurisdictions were reviewed for recent development in health professions regulation. Some of this literature was relevant to quality and continuing competency issues, albeit not necessarily in the context of specific theoretical QA models.

The results of this selected literature review are summarized below.

Inventory of QA Programs

The project called for contact and, if possible, interviews with each of the 23 health professions colleges within a relatively short period of four weeks from the initial email from the Executive Director, Legislation of Professional Regulation, advising colleges that the project was commencing, to the conclusion of the contract on March 31, 2003. Despite this relatively short time frame, 21 of the 23 colleges were able to participate during the term of the contract, the majority by in-person interviews. The willingness of college staff to set aside time on such short notice, and the cooperative attitude to sharing their information, should be noted. There appears to be a genuine interest in communicating "best practices" and learning from the experiences of other colleges, and in general the present project was welcomed as facilitating this type of dialogue.

The majority of colleges participated by way of interviews conducted at the college offices with the Registrar or other persons designated by the college; a total of 16 colleges were interviewed in this way. Two colleges were interviewed by teleconference, and in three cases information was obtained through a combination of preliminary telephone interview followed up by e-mail or website references. In two instances, it was impossible to obtain information during the term of the contract.

A full list of the colleges contacted and the persons interviewed is included in Appendix C.

In part due to the short time frame of this contract, and in part due to the initial and exploratory nature of the review, there was no attempt to develop, at the outset, a specific "matrix" of kinds of QA programs, with a view to "slotting" the colleges' activities under one category or another.

Initially, a preliminary set of questions was provided in advance of the interview, and these questions continued to be provided to colleges requesting them; however, it quickly became obvious that the wide diversity of programs and approaches to QA taken by the 23 colleges did not lend itself well to a preconceived notion of what questions might be appropriate. Accordingly, the interviews tended to a free-form and open-ended exploration of what directions the college was pursuing.

The material in this report in Appendix B summarizing individual colleges' QA programs was prepared from the interviews and from documentation provided by the colleges. While every effort was made to ensure accuracy, the colleges have not reviewed drafts and are not responsible for errors or mischaracterizations that may have arisen. [2]

BACKGROUND

In British Columbia, the concept of QA has been identified a number of times in the past decade: in 1993 legislative amendments, in the legislative review by the Health Professions Council, and in proposed legislation currently under discussion.

There appears to be a longstanding consensus among the ministry and all the health professions that protection of the public is a key objective of self-regulating professions, and that programs which ensure the competence of practitioners and the quality of their services are one of the core responsibilities of the regulatory body, whether or not the term "quality assurance", "continuing competency" or some other term is used.

This principle was specifically articulated in 1993 legislation which introduced the term "quality assurance" and cognate concepts to the statutory framework for health professions' regulation. Both the *Health Professions Amendment Act, 1993*, and the *Health Professions Statutes Amendment Act, 1993*, provide for the inclusion of a specific "duties and objects" provision in the legislation for colleges under the *Health Professions Act* and a number of separate health professions' statutes. Among these objects were, "to establish and maintain a continuing competency program to promote high practice standards among registrants", and to establish "standards of practice" and "standards of professional ethics". In addition, amendments to the *Health Professions Act* specifically identified a "quality assurance committee" as one of the committees to be established under the bylaws of colleges designated under that Act.

[2] Subsequent to completion of this report, the colleges were provided an opportunity to review and comment on their respective sections of Appendix B, which has been revised throughout to incorporate those comments.

Subsequently, the Health Professions Council conducted a legislative review of the governing statutes of the health professions. In regard to quality assurance, the terms of reference for this legislative review stated a "core principle" that there should be "effective mechanisms for monitoring practitioner competency including the ability to set continuing education requirements" and "a committee of the board should be responsible for reviewing standards of practice and codes of ethics".

In its legislative review, the Health Professions Council concluded that "While the [quality assurance] programs vary amongst the professions, all have programs in place to maintain professional competence that indicate substantial compliance with this *core principle*." The Council noted it was "impressed by the commitment of all health professions to the task of quality assurance. All appear dedicated to maintaining high standards of excellence and ensuring public protection in the public interest."

In regard to mandatory continuing education, the Council accepted the comments of the College of Physicians and Surgeons (among others) that there was "considerable evidence that [mandatory continuing education] does not significantly alter the actual performance of physicians" and that other mechanisms should be used to the end of ensuring quality practice. The Council noted that the existence of other quality assurance mechanisms meant that a regulatory body could tailor programs to match its professional needs. The Council concluded that, "In the final analysis, it is up to each profession, in accordance with its public interest mandate, to determine the appropriate means of ensuring quality practice."

During the term of this contract, the ministry circulated a second version of proposed amendments to the *Health Professions Act* first circulated in 2002. While part of these amendments dealt with quality assurance mechanisms, the section underwent considerable revision between first and second drafts and was undergoing further revisions at the time the report was drafted. Accordingly, it would be premature to consider the specifics of this amendment package except as to indicate the continuing interest in the underlying legislative framework for QA.[3]

The British Columbia ministry has not to date, unlike Ontario, articulated a set of principles or expectations for quality assurance programs in the context of health professions' regulation.

[3] See footnote 1 on page 5.

LITERATURE REVIEW

Is There a QA Literature for Regulated Health Professions?

The conclusion of the current literature review is that there remains little or no literature specifically considering the applicability of QA models to the realm of health professions' regulation and the role of the regulatory bodies. There is considerable QA literature addressing professional health care services, but this is often in the context of their functions within various institutions or organizations delivering or administering health care. There appears to be no literature that speaks directly to the role that QA methods might play in regard to the functions carried out by statutorily-mandated regulators and self-regulating health professions' colleges.

This is consistent with the result reached by the 1997 literature review carried out by Harry Cummings and Associates for HPRAC. This report noted the absence of QA literature specific to the issue of regulated health professions: "most of the published literature on QA is focused on hospital or facility-based QA rather than QA for specific health professions." The report speculated that this could be because mandatory QA for professions is a relatively recent development in Canada. It also speculated that the absence could be because much QA literature arises in the United States, which has a more loosely regulated private-market model.

This conclusion does not mean that there is no literature concerning the role of regulators in ensuring professional quality: but that literature is more likely to be discussed in the language of continuing competency and regulatory roles, rather than in the language of the QA literature.

The literature on quality may be considered under the headings of "industrial quality management" and "quality management in health care". Industrial quality management literature predates health care quality management; the latter resulted as concepts from the former were imported into and applied to the health care sector (Berwick, 1991).

The QA literature in both the industrial and health care context has been reviewed at length and these reviews will not be recapitulated here. Readers interested in acquiring this background should consult the recent literature reviews in:

- Harry Cummings and Associates. A Framework for Evaluating the Quality Assurance Programs of the Colleges of Health Professions in Ontario (July, 1997), included as Appendix F of HPRAC, *Report to the Minister of Health and Long-Term Care: Effectiveness of Colleges' Quality Assurance Programs* (October 2000)

- Schuster, Mark A. et al. *The Quality of Health Care in the United States: A Review of Articles Since 1987* (January 1999), included in Appendix A of Institute of Medicine Committee on Quality of Health Care in America. *Crossing the Quality Chasm: A New Health System for the 21st Century.* Washington, D.C.: National Academy Press

In order to maximize the utility of the present review, the literature review was specifically focused on identifying QA literature directly relevant to the context of regulated health professions and in particular to the function of the regulatory colleges of these professions. The object was to discover if further literature existed that would supplement the relatively limited profession-specific QA literature noted in the 1997 HCA report.

The conclusion of this review is that there remains, at present, no general literature that attempts to explicate how the principles, models and techniques of QA may be applied to the specific function of health professions' regulators. Put simply, the search for a "QA for Colleges" theoretical literature produced no result. However, it is the case that regulators in a number of jurisdictions are addressing issues of quality, and the experience of particular jurisdictions may be usefully noted.

Accordingly, the remainder of the Literature Review will consist of a brief selected overview of both industrial quality management theory and certain approaches to health care quality management, followed by a description of some specific jurisdictions' approaches to quality improvement in the context of regulated health professions.

History and Overview – Industrial Quality Assurance

Developed initially in the context of industrial production, the principles of QA were subsequently applied to a variety of other contexts, including health care. Concern with quality is seen, by some authors (Berwick, 1991; Dooley) as evolving through three phases.

Society has always been concerned about the quality of goods and services, and over time this concern has developed into a discipline of quality. Dooley asserts that this discipline has evolved through three distinct paradigms: a *caveat emptor* model which existed from ancient times, a *quality control* paradigm that arose with the industrial revolution, and a present *total quality management model* that arose as a result of international competition at the end of the twentieth century. Berwick (1991) similarly characterizes three phases consisting of inspection (which focused on finding and fixing problems in products), quality control (which focused on processes of production), and modern total quality management (a strategic focus on quality integrated horizontally across functions and vertically across hierarchical levels). The following summary is based on the outline provided by these two authors.

The first stage of quality concern was based on the assumption that the quality of goods could be ascertained by immediate inspection. *Caveat emptor* assumes defects will be evident upon inspection by the consumer. This is particularly applicable in the case of perishable goods such as food; but the quality of manufactured goods cannot, however, always be ascertained in this fashion. In such cases, the buyer had to depend on the honesty of the seller and the knowledge involved in the science of manufacture, the so-called "mystery of the trade." The passing down of procedural knowledge through apprenticeship and guilds became an important part of the social contract that provided buyers with assurance of quality for those goods in which immediate inspection would not suffice.

Although neither author makes this connection, relevance of this ancient model can be seen to the system of guilds and the early roots of self-regulating professions. It has been asserted that one of the rationales for self-regulation in the health professions is precisely because the consumer does not posses the specific information and knowledge which would permit him or her to evaluate the quality of the service provided.

The second paradigm of quality, quality control, arose with the industrial revolution. In the factory system, the responsibility for ensuring quality shifted from the consumer to the producer, and became systematized as part of the industrial process. Inspection, originally conducted informally by craftspeople, became standardized in the era of mass production and of management scientist Frederick Taylor. "Quality control departments" centralized a variety of inspection functions by which it was ensured that certain standards were met. There was a shift over time from individual to statistical quality control, but the emphasis remained on ensuring conformance to specifications and standards. By the mid-1920s, it was apparent that inspection of individual products no longer sufficed and in 1931, Walter Shewhart published *The Economic Control of the Quality of Manufactured Product*, which shifted the focus to control of the processes of production.

A number of the early theorists of quality control worked in Western Electric's Bell Telephone Laboratories, which established an Inspection Engineering Department in 1924. This group originated many quality control practices such as acceptance sampling, statistical process control, and management responsibility. The term "quality assurance" was coined by George Edwards, a member of this group.

World War II profoundly impacted the practice of quality in the United States. In the face of greatly increased production volume, the U.S. government was unable to continue its previous system of individual product inspection and tests of conformance to specifications. It was forced to rely on sampling inspection and statistical methods, and to train military suppliers to implement these methods. Approximately 31,000 students were trained in statistical quality control in the U.S. during the war years.

Despite the influx of newly trained quality control practitioners after the war years, statistical quality control declined in the 1950s in the United States. The third paradigm of quality, *total quality management (TQM)* essentially arose with the importing of Japanese models into the United States. These had actually arisen with American theorists whose work found ready acceptance in Japan, where post-war industry had to be rebuilt from the ground up. The theories of Americans such as Edward Deming and Joseph Juran, on loan from Bell Laboratories, were well received by the Japanese.

The Japanese experience led to the development of "QC Circles" around 1962. These were small groups of departmental workers solving departmental quality problems. These were supported by formal training in statistical methods and problem solving. These concepts matured into "Japanese TQC" and ultimately to a variety of quality management approaches including total quality management (TQM), continuous quality improvement (CQI) and others. These approaches flourished as the rise of consumerism and global competition from the 1960s onward

led to the realization that improvement in quality could lead companies to prosper in a competitive environment. This impact was deeply felt in the U.S. auto industry, where the domestic market was seriously eroded by Japanese and German automobiles. The new emphasis was given to strategic quality management, not only in the automobile industry but also, by the 1980s and 1990s, throughout many industries and countries.

Dooley characterizes the TQM paradigm as including the following concepts:

- quality is no longer the responsibility of a quality department but of everyone, and in particular, management;
- product quality is a necessity of competition, not just a product differentiator;
- quality concepts are extended beyond physical products, to services and information, and into new areas such as health care and government;
- human systems (learning, training, education, self-management) come to the forefront;
- benchmarking and "best practices" approaches flourish;
- organizations develop executive line authority for quality;
- continuous improvement of process quality becomes a mainstream organizational activity;
- all activities are focused on the customer's satisfaction, and measures of customer satisfaction and retention become a key management metric.

Within this third phase of industrial quality management theory, there have continued to be refinements and improvements. The interested reader is referred to the HCA literature review for a more complete summary of many of these.

Quality Assurance in the Health Care Context

The QA literature in health care is abundant, but not, as noted earlier, of direct relevance to issues of professional regulation. Accordingly, this report will offer only a "snapshot" of the field, based on the early work of Avedis Donabedian and the more recent work of Donald M. Berwick.

Avedis Donabedian

Donabedian is often credited with pioneering the application of quality assurance methodologies to health care. He has defined the quality in these terms: "... an assessment of quality is a judgment concerning the process of care, based on the extent to which that care contributes to valued outcomes." (Donabedian, 1982)

Donabedian notes that the definitions of quality are many and only partly congruous. However, in his view, this need not pose an insurmountable barrier to the assessment of quality: "Unlike the task of defining the quality of care, the formulation of the criteria and standards to be used for assessing quality is a highly practical business, one that involves a translation of the

conceptual into the operational." The "ideal procedure" for formulating these criteria and standards would involve, first, specifying from among the many concepts of quality one that will be used as a guiding concept, and choosing, from among the many formulations of that particular concept, a smaller subset of options to be used. Among the options to be considered is the choice of approaches to assessment: these criteria will pertain to one, or a mix of criteria regarding:

- structure: "the resources used in the provision of care, and to the more stable arrangements under which care is produced";
- process: "activities that constitute care";
- outcomes: "consequences to health". (Donabedian, 1982)

The three elements of structure, process, outcome, identified by Donabedian, are the foundation for many quality assurance models in the health care field. This triad is adopted, for example, in the Health Canada publication *Quest for Quality in Canadian Health Care: Continuous Quality Improvement (2nd edition)*: "Quality in health care is judged by three key areas, namely structure, process, and outcomes. Structure comprises the necessary resources to conduct the task (e.g. the resources to deliver the care, the physical resources, facilities, organization, standards, policies). Process is the act of doing the task (inputs-tasks-outputs, i.e. the care itself), and outcomes are the result (e.g. effective care, patient satisfaction, efficient use of resources)." This publication notes that most evaluation, in the past, focused on evaluating structure. "The need for improved outcome measurement is presently receiving more attention; however, it is also acknowledged that establishing credible and acceptable outcome evaluation will be a lengthy and resource-consuming task." In view of this, "many within the health care system have turned to the examination of the processes used in health care with the belief that, by improving process, both quality and efficiency can be enhanced."

Donald M. Berwick

Concerns with implementing Donabedian's theoretical approach have led to more recent approaches, as are described in the report on the National Demonstration Project on Quality Improvement in Health Care, in which Donald M. Berwick was principal investigator. Recognizing Donabedian as the founder of the academic discipline of health care quality assurance, Berwick criticized the utility of traditional quality assurance, despite "hundreds of research papers [that] have been written trying to define sound structures, good processes, and suitable outcomes, along with approaches to their measurement. ... though [quality assurance] is a topic with a considerable academic pedigree, [it] never became an applied technology under the old ground rules. The research literature on quality assurance is abundant but generally unsuitable for day-to-day use. It tends towards arcane language, slow methods, and high levels of aggregation: it speaks more to scientists than managers." (Berwick, 1991)

By contrast, Berwick states, "quality assurance" inside health care organizations is "another matter entirely, bearing little connection to the academic field. The Quality Assurance Committee, meeting in a community hospital ... probably pays little attention to the work of Donabedian, or of any of the other deacons of the field from which the committee took its

name." Neither Donabedian nor the Quality Assurance Committee, says Berwick, are adequate to the needs of payers and regulators of health care in the 1990s.

Berwick sees the solution in the application of modern quality management approaches as developed in Japan and subsequently re-introduced to the United States. He alludes to, but does not use the term, theories such as Total Quality Management: "These new experts suggested that the proper quest for quality is not a matter of thresholds, standards, inspection, and certification – not a series of decisions to accept or reject a television set, or an employee, or, for that matter, a doctor – but rather a continuous search for small opportunities to reduce waste, rework, and unnecessary complexity."

Berwick notes that, "It is natural to wonder if the methods of industrial quality management really can help in health care." Among the reservations regarding whether quality management applies to medical care, he cites the following concerns:

- there is no standard, uniform product; each patient is different;
- there is no assembly line; a doctor must make the correct decision;
- the individualistic culture of the United States differs from Japan;
- physicians do not see themselves as team players in organizations;
- quality in health care is too subtle to measure;
- the real problem is not quality, but cost. (Berwick, 1991)

The National Demonstration Project (NDP) on Quality Improvement in Health Care was launched in 1997 to test the applicability of modern quality management to health care. Twenty-one health care organizations were invited to bring an internal quality problem to twenty-one experts in quality management from major companies, universities and consulting firms. In summary, the experiment was regarded as a success. Berwick states that the NDP projects demonstrate success in application to *business* and *service* processes; for this reason alone, the methods are worth adopting. Testing the application of quality management to improve *clinical* processes was limited to only two project teams; nevertheless Berwick feels the applicability in principle to clinical processes was born out by the project.

Berwick identifies the basic principles of modern quality management as follows:

1. Productive work is accomplished through processes.
2. Sound customer-supplier relationships are absolutely necessary for sound quality management.
3. The main source of quality defects is problems in the process.
4. Poor quality is costly.
5. Understanding the variability of processes is a key to improving quality.
6. Quality control should focus on the most vital processes.
7. The modern approach to quality is thoroughly grounded in scientific and statistical thinking.
8. Total employee involvement is critical.
9. New organizational structures can help achieve quality improvement.

10. Quality management employs three basic, closely interrelated activities: Quality Planning, Quality Control, and Quality Improvement. (Berwick, 1991)

Modern Quality Assurance Theory and Its Application to Professional Regulation

As has been noted, QA literature does not focus on the roles of health professions' regulators. Indeed, some of the literature may be seen to be explicitly critical of the regulatory model. An early paper by Berwick (1989) is critical of the "Theory of Bad Apples" which relies on inspection to improve quality: "those who subscribe to it believe that quality is best achieved by discovering bad apples and removing them from the lot. ... Those in health care who espouse the Theory of Bad Apples are looking hard for better tools of inspection. ... [they] publish mortality data, invest heavily in systems of case-mix adjustment, and *fund vigilant regulators* [italics added]."

This approach, says Berwick, leads to the "my-apple-is just-fine-thank-you response" in which various "defence" tactics are employed, which frustrate the intent of measurement tools and ultimately fail in achieving quality. "The signs of this game are everywhere in health care. ... [it] is being played between aggressive Board of Registration in Medicine and other regulators that require hospitals and physicians to produce streams of reports on the contents of their closets. In Massachusetts, for example, merely talking with a physician about his or her involvement in a mishap may commit a hospital administrator by law to report that physician to the Board of Registration in Medicine."

"The Theory of Bad Apples," says Berwick, "let American industry down for decades." In his 1989 article he commends the "Theory of Continuous Improvement" espoused by modern quality management theorists. He addresses the following points specifically to health care regulators:

- they must "become more sensitive to the cost and ineffectiveness of relying on inspection to improve quality"; inspection and discipline must continue but should not dominate, or quality will suffer;
- measuring quality is valuable to improving craft, but it is a "naive and atheoretical belief, rampant today in the orgy of measurement involved in health care regulation, that the assessment and publication of performance data will somehow induce otherwise indolent care givers to improve the level of their care and efficiency";
- regulators "who willingly learn and respect modern principles of quality improvement can have a helpful role ... as the partners of care givers in developing sound measurement tools that represent common values and are for use primarily by the producers themselves; by aggregating data centrally to help care givers learn from each other; by providing technical support and training in methods of quality improvement; and by encouraging and funding studies of the efficacy of technologies and procedures and thus expanding the scientific basis for specifying rational processes of care";

- professionals should specify "preferred methods of care" but must avoid "standards of care, which usually implies minimal thresholds of structure, process, or outcome above which one is safe from being labeled a Bad Apple. ... such floors rapidly become ceilings ...".

Interestingly, some of the tensions which Berwick found between the traditional approach of regulators and the principles of modern quality management were echoed in some of the interviews with B.C. colleges, particularly as these were expressed in concerns to distinguish the college's continuing competency/quality assurance roles from its investigatory/disciplinary ones and provide protection from evidentiary disclosure between the two realms.

Regulating Professional Quality – Jurisdictional Approaches

Although literature searches on "quality assurance" and "professional regulation" yielded little, rather more literature could be found on searches based on keywords of "continuing competency" and "professional regulation". In this regard, it may be helpful to consider some approaches to quality improvement in the context of regulated professions as found in a survey of material from four jurisdictions: the United States, New Zealand, England and Ontario.

United States

United States thinking on QA and professional regulation may be sampled through a series of reports by the Pew Health Professions Commission.

In a chapter in its 1995 report, *Reforming Health Care Workforce Regulation: Policy Considerations for the 21st Century,* the Pew Commission considered regulatory approaches to ensuring practitioner competence. In summary, the report cast doubt on the utility of continuing education, and recommended periodic re-testing, as a means of ensuring continuing competence.

The starting point for the Pew commissioners was the observation that continued public protection could not be assured solely by initial licensure, as this might have little direct relationship to skills used later over a lifetime of practice. Among the continuing competency requirements then in use, the Pew report observed that (at the time of writing):

- most state licensing boards did not impose any requirements on licensed professionals to demonstrate their continuing competence to practice
- about half of medical and nursing boards mandated continuing education as a precondition to maintaining licensure
- where continuing education was mandated, licensees were only required to show that they attended approved courses; there was little review of the relevance of the courses to practice, or whether the licensees understood the course.

Aside from the limited actual requirement for continuing education, the Pew report cited literature identifying the deficiencies of continuing education as a means of ensuring competency:

- most inadequate practice does not result from a lack of knowledge, but most continuing education programs do not consider whether the professional knows how to apply their new knowledge
- superior knowledge retention may not be an indicator of competent professional performance
- there is "little evidence of a demonstrated relationship between participation in continuing education programs and job performance or clinical outcomes"
- mandatory remedial education may be ordered as an outcome of disciplinary proceedings, but this provides inadequate public protection as it only identifies poor performance after the fact.

Although the limitations of continuing education are, in the view of the Pew commissioners, understood by many licensing boards, there is great resistance to adopting alternatives such as periodic re-testing or re-certification. These measures are viewed as punitive and are rarely used. Nevertheless, the Pew report notes that periodic re-testing is in fact used in a variety of professions, such as emergency medical technicians (California), airplane pilots (United States Federal Aviation Administration), and for certain specialty areas (American Board of Family Practice certification of family physicians).

The Pew report recommends that regulated health professionals periodically demonstrate competence through appropriate testing mechanisms. These tests could be random or targeted peer reviews; they could also be triggered by a variety of markers, such as length of time in solo practice, number of procedures performed, lack of specialty, number of disciplinary actions, or other indicators established by the regulator.

The report further recommended inter-state cooperation to develop standard continuing competency examinations, and expanded use of modern technological tools to enhance competencies and their assessment.

The responses to the 1995 report were collated in the 1997 report, *Considering the Future of Health Care Workforce Regulation.* This report found that 1995 report's recommendations on "assuring practitioner competence" received the highest score for level of concern and one of the highest scores for level of support (52% support among persons responding).

Respondents raised the following concerns with respect to the Pew recommendation for periodic re-testing:

- it is unnecessary and too costly to require this of all practitioners;
- sufficient resources are lacking;
- cooperation with other states would result in a "lowest common denominator" for minimum competence;

- standardized testing is difficult due to the evolving health care environment and differences in various practices;
- there was lack of agreement as to who was responsible for assuring continued competency: the practitioner as part of professional responsibility, employers, or regulators.

Comments in support of the Pew recommendation noted:

- empirical validation and outcomes studies should be required for current continuing education;
- continuing education programs should be specified, standardized and stricter, with exit testing;
- testing must be based on research-based practice protocols;
- self-assessment and professional portfolio models (as used in Ontario) should be considered;
- testing should involve practical demonstration of competence;
- state-mandated peer assessment programs, inter-professional peer reviews, and proactive fellowship programs should be considered;
- managed care organizations should be legally responsible for proactively ensuring the competency of their staff.

The Pew Commission then revisited its 1995 report and the responses to it in its 1998 report, *Strengthening Consumer Protection: Priorities for Health Care Workforce Regulation*. At this point, the Pew commissioners noted that their recommendations for continuing competence assessments had generated the most action in accordance with the recommendation. They attributed this high level of activity to "tremendous tension between consumer anxiety over quality of care and practitioner anxiety over being asked to demonstrated their competence more than once."

The report reiterates the view that "Continuing education simply is not sufficient to ensure quality throughout a practitioner's career." Moreover, regulatory boards do not require licensees to demonstrate competence at any time after initial licensure, and legislators have not required boards to do so. The Pew report observes that shifts to new reimbursement and delivery structures (managed care) creates a concern that professional competence may suffer from too much attention on reducing costs. Requiring demonstrations of competence periodically throughout professionals' careers could offset this phenomenon.

The Pew report observes that competence and quality have been addressed by a variety of methods:

- "positive" or preventive mechanisms are relied on by consumers and include: accredited education, licensing exams, character checks, and continuing education;
- "negative" or punitive interventions bolster the system by dealing with problems after they have arisen and providing "post-occurrence safety nets". These include: regulatory departments for complaints, enforcement and discipline, and extra-regulatory bodies for peer review, criminal justice, malpractice and tort actions.

The Pew commissioners appear to suggest that current improvements in quality of practice are occurring outside the efforts of the regulatory boards: "Currently, competence is often better determined by private sector assessment and employer evaluations than by self-regulating boards." In this regard, they note:

- the National Committee for Quality Assurance (which is concerned with the private regulation of health plans) is turning its attention to individual practitioners;
- TQM or CQI endeavours that involve not only systems of care but also individual practitioners shift the level of health care upward;
- there is potential for collaboration between public regulator and private sector credentialling bodies, but not all professions support this idea.

The 1998 report concludes by recommending that state legislators and regulators require "that regulated health care practitioners demonstrate their competence in the knowledge, judgment, technical skills and interpersonal skills relevant to their jobs throughout their careers." This would entail developing:

- definitions of competence to include both basic and specialized knowledge, skills and judgment;
- eventual inclusion of other than clinical competencies, e.g. communication skills, ethics, concepts of continuous quality improvement, capacity to admit errors, and ability to empathize;
- criteria by which private sector competence assessments (e.g. voluntary certification by private sector entities) can be deemed to satisfy state requirements;
- research, development, and dissemination of definitions, models and standards for continuing competence assessment (the Pew report recommends a national policy advisory body coordinate state findings of the effectiveness of models they employ);
- relating continuing competence assessments to practice performance and to scope of duties or services provided;
- testing and evaluation (for validity, reliability and fairness) of alternate models for determining practitioner competence (e.g. standardized exams, computer simulations, standardized patients, objective structured clinical exams, office record reviews, practice evaluations, peer review, and patient satisfaction measures).

New Zealand

New Zealand recently tabled legislation concerning the governance of health professions that contains specific provisions concern quality assurance. This legislation does not constitute a complete codification of professional QA, but is interesting insofar as it provides an example of what aspects of a QA regime might have to be entrenched in legislation.

The genesis of the Bill was the "Cull Report", *Review of Processes Concerning Adverse Medical Events* (1991) conducted by Helen Cull, Q.C. The report reviewed processes for reporting and

investigating adverse medical incidents, and was designed to ensure that draft legislation, to improve the framework for occupational regulation of health professionals, adequately protected the public.

The *Health Practitioners Competence Assurance Bill* was introduced to the New Zealand legislature in June, 2002, however it did not proceed as a general election intervened. The Bill is currently on the order paper for the new Parliament.[4]

The Bill would repeal separate regulatory statutes for health professions and bring them under the same regulatory umbrella (similar to the B.C. *Health Professions Act* in this sense). A significant part of the Bill is devoted to practitioner competence, fitness to practise and quality assurance. Much of this is related to improving and providing a consistent complaint process across all the health professions. The Bill eliminates the separate disciplinary tribunals for each profession and creates a single Health Practitioners Disciplinary Tribunal.

On the subject of quality assurance, the legislation's primary concern (in clauses 50 to 60) is to protect confidentiality of information so as to encourage effective QA activities. A "quality assurance activity" is defined as an assessment or evaluation of health practitioners to improve their competence. The legislation does not specify particular types of QA activities, for example, it does not specifically refer to peer review or any particular mechanism of QA.

Confidentiality is extended to information that becomes known, or documents that are produced, as a result of "protected" QA activities. Such information cannot be recorded, disclosed or given in evidence other than for the purposes of the QA activity. There is a "good faith" protection for persons involved in the QA activity. The confidentiality provisions do not apply if no individual is identified or if the individual consents to disclosure. The Minister may also authorize disclosure, if the information relates to conduct that might constitute a "serious offence", for the specific purposes of investigating or prosecuting the offence, or for a Royal Commission or commission of inquiry.

It is clearly important to separate QA activities from disciplinary processes. The legislation adopts an interesting approach to separating these two realms, by excluding from the definition of QA activity the assessment of a "specific significant incident." Such an incident is one that has an adverse effect on one or more individuals, and that is (or can reasonably be expected to be) the subject of inquiry or investigation by certain named statutory agencies. [5]

Protection of a QA activity is not automatic; the Minister of Health must order a QA activity to be protected, on being satisfied that it is in the public interest to do so. Such protection is in force for five years, but can be renewed. Concurrently with declaring a QA activity to be protected, the Minister must appoint a "suitable" person to be responsible for the QA activity. Such a person must be "sufficiently independent of the health practitioners whose services are to be assessed or evaluated." The legislation also requires consideration of the nature of the QA activity, and the employment or services provided by the appointed person.

[4] The Bill was subsequently passed, and it received Royal Assent on September 18, 2003.
[5] This provision was deleted from the final version of the Bill. However, the final version includes provisions that appear to be similar in effect to the new section 26.2 of the *Health Professions Act*, as enacted by Bill 62.

Among the responsibilities of this person are to comply with reporting requirements in the Act. These include reporting on a six-monthly basis to each assessed provider of health services. The report details identified problems, action taken, recommendations made, and how the implementation and outcomes of the recommendations must be monitored. Annually, this information (stripped of individually identifying material) must be reported to the Minister.

The Minister may revoke the protection conferred on the QA activity or revoke the appointment of persons responsible who have neglected or are unable to perform their duties. Grounds for revocation may include, but are not limited to: failure to make required reports, making unsatisfactory reports, or unsatisfactory progress of the QA activity. The Minister must first advise the person responsible of the reasons for the intended revocation, and provide a reasonable opportunity for written submissions. Thereafter, the Minister may publish a Gazetted notice of revocation.

England

England's strategies for quality assurance in the context of professional regulation have taken place in the context of a number of reports and appointments of specific bodies relating to the National Health Services (NHS). Also, note may be taken of a recent consultation report published by the General Medical Council (GMC), the regulatory body for doctors.

The NHS publications include:

- *A First Class Service: Quality in the NHS* (1999) sets out the NHS quality strategy in a framework comprising national standards, a new system of clinical governance at the local level, and strong monitoring mechanisms.
- *Supporting doctors, protecting patients* (November 1999) was a consultation document prepared by the Chief Medical Officer, devoted to problems of poor clinical performance. It specifically addressed the issue of professional self-regulation and how it should support the NHS' own quality assurance activities. It is worthwhile noting that, although the report is directed at the medical profession, the report specifically states that its proposals for good regulation are generic and invites their application to other health professions.
- The "NHS Plan" (July 2000), said to represent the biggest changes to the NHS since it was established in 1948, extended the quality agenda by emphasizing customer service and patient/citizen representation. Implementation is led by the Modernization Board, an advisory body headed by the secretary of health. The Quality Taskforce of the Department of Health is charged with taking forward the NHS quality agenda.
- *Assuring the Quality of Medical Practice* (January 2001) followed from the *Supporting doctors, protecting patients* (1999) document and the responses to it. It makes a number of proposals, a key element being the establishment of the National Clinical Assessment Authority (NCAA), which was set up in April 2001.

Although the NHS recognizes that "achieving consistently high clinical standards requires much more than tackling the small minority of very poor doctors," these recent activities have unavoidably become viewed as responses to "a series of high profile medical scandals." These included the Harold Shipman case, in which a sole-practitioner physician apparently murdered over 400 elderly patients over a period of years. There were, in fact, initial claims by some politicians that the establishment of the NCAA might forestall future "Shipman" cases, however such claims were later modified as it was conceded that the NCAA's role was not, in fact, to "weed out" potential criminals (*The Guardian*, January 8, 2001). The NHS has therefore been at some pains to avoid characterizing its "comprehensive strategy to raise and ensure high clinical standards" as merely a narrow response to such scandals.

It is worthwhile to consider both the *Supporting doctors, protecting patients* proposals and the recommendations of the later *Assuring the Quality of Medical Practice* report which formed the background to the creation of the NCAA.

Supporting doctors, protecting patients

Much of the discussion in *Supporting doctors, protecting patients* ("the 1999 report") concerns the relationship between doctors as self-regulating professionals (primarily considering the role of the General Medical Council), government, and the quality assessment mechanisms carried out by the National Health Service at the local governance level.

The 1999 report takes note of the predecessor Merrison Committee (1975) which inquired into the regulation of the medical profession. The Merrison Committee contended that professional self-regulation was a contract between the profession and the public, with the legislature acting for the public and determining the nature of the contract. It was critical of the fact that, although an increasing range of bodies were becoming self-regulating professions, government had not provided explicit criteria as to the nature of this "contract".

The 1999 report specifically responds to Merrison's challenge for explicit criteria, setting out seventeen "Modern Principles of Professional Self-Regulation in the Health Field." It proposes that, "In order to maintain the privilege of professional self-regulation ... the profession's regulatory activities must be able to fulfill all or some of the following attributes (depending on their area of functioning and limits on their statutory responsibilities)."

Among these "attributes" the following are of particular interest in the present context:

- "Regulatory bodies must set clearly expressed standards of the knowledge, skills, experience, attitudes and values necessary for continuing practice."
- "Regulatory bodies must concern themselves with the competence and conduct of practitioners at all stages in their careers."
- "Regulatory bodies must demonstrate an ability to work across different regulatory boundaries to develop consistent standards."
- "Regulatory bodies must retain high public confidence and have sufficient lay involvement to make an effective contribution in their governance and operation."

- "Regulatory bodies must ensure that those being regulated understand what is expected of them and the role of the regulatory body in relation to their practice and wider health services."
- "Regulatory bodies must review and update standards regularly taking account of feedback from patients, practitioners and other interested parties."

The 1999 report considers the role of the General Medical Council (GMC) in relation to other quality of care mechanisms. In 1997 the GMC introduced professional performance procedures, against which a doctor's performance can be found to be "seriously deficient." The GMC can direct that a panel be setup to assess the practice and make recommendations to address any serious deficiencies. The proposals of the 1999 report are viewed as assisting the NHS to identify emerging poor performance and take action.

The report also notes that the GMC's powers have been extended and that it has, at the time of writing, launched a revalidation initiative under which doctors will be required to demonstrate periodically that they are up to date and fit to practice in their chosen field.[6] This is seen as moving from a reactive model which attempted to ensure the fitness of the majority by dealing with the exceptions.

The report explores how professional self-regulation can support the NHS' own duty of quality. Much of this discussion is specific to the specific governance models of the NHS and need not be summarized here. It is sufficient to note that the 1999 report strongly recommends that mechanisms be established to so that the information as to the results of the quality assessment and improvement mechanisms within the NHS and the institutions delivering its services can be communicated to the professional self-regulating body and vice versa, as appropriate. In particular, the new appraisal system proposed for NHS doctors provides a core of information for GMC revalidation.

Finally, it should be noted that the 1999 report proposed to replace the disciplinary procedures used by NHS employers with a new integrated process involving NHS and professional bodies. This would be aimed at providing an "early diagnosis" in a neutral environment. This report recommended the creation of Assessment and Support Centres which would provide impartial support to the local employer and provide a supportive environment for the doctor undergoing assessment. The Centres would have a medical director and board chaired by a layperson, and would maintain close liaison with the GMC. The intent would be to provide rapid referral, impartial assessment, advice on handling, and a unified approach. A number of possible outcomes of referral (which could include self-referral) are identified in the 1999 report. However, the proposal to create these Centres, which were seen as stigmatizing, was not followed up in the 2001 recommendations.

[6] As of November, 2003, the GMC website indicates the GMC informed the profession in April, 2003 that doctors will be invited for initial revalidation commencing in April, 2005, and that subsequent revalidation will be required every five years.

Assuring the Quality of Medical Practice (January 2001)

The 1999 proposals, with modifications, were translated into recommendations in this report. Of relevance here are the report's recommendations to assure the quality of individual practitioners, to establish the National Clinical Assessment Authority (NCAA), and to involve the self-regulating professional bodies.

The 2001 report states that "The starting point for promoting high standards of practice is helping doctors to keep their skills up to date so that problems are prevented." It sees this as supported by:

- Continuing Professional Development programs: the report recognizes their value, but notes that the coverage of some groups (such as locums) is "patchy" and also identifies a weakness in "the tendency for learning to follow a doctor's interests rather than seeking out improvement where he or she is weakest or in other areas where they need to develop expertise";
- Appraisal and clinical audit: pursuant to the NHS plan, all doctors employed in or under contract to the NHS will be required to participate in annual appraisal and clinical audit from 2001 on, and changes to the GMC's authorizing legislation will enable this information to be part of the revalidation process as early as 2003.[7] Agreements have been reached to include professional development plans in the job plans of consultants to the NHS.

The report also recommends the establishment of the National Clinical Assessment Authority (NCAA). Concerns about clinical performance that are not resolved locally will be referred to the NCAA, which will give advice or initiate an assessment of the doctor's clinical practice, and provide a report with recommendations. The NCAA will use trained and lay assessors who will conduct local visits, gather information, and interview staff in the context of a supportive environment and non-stigmatizing process. Self-referral is also contemplated. The NCAA remains an advisory body, however, and the employer or health authority remains responsible for dealing with the problem at all stages. Nor does the NCAA process displace other processes such as referral to the GMC and disciplinary actions, and the various opportunities for representation and appeal in such processes. Recognizing that "lack of insight" might cause some poorly performing doctors to refuse to cooperate with an NCAA assessment, the report notes that such refusal would constitute grounds for disciplinary action by the employer for refusal to comply with the employer's reasonable request.

Further information on the NCAA can be found at its website, www.ncaa.nhs.uk.

On the specific issue of self-regulation's role in maintaining and raising standards, the 2001 report endorses the principles of self-regulation stated in the 1999 report, and notes a number of initiatives broadening the GMC's role. It acknowledges the need for partnership with professional bodies in modernizing the NHS.

[7] See footnote 6 on page 25.

The General Medical Council (GMC)

Amendments to the GMC's governing legislation were made in late 2002 which permit it to implement a number of proposals to make it more effective, inclusive and accountable. In particular, this legislation permits the introduction of "revalidation, the regular demonstration by doctors that they meet the standards we require for continued registration." (GMC website, 2003).

In its 2002 Annual Report, the GMC specifically notes that the traditional voluntary actions of doctors to keep themselves up-to-date was no longer appropriate: "in a changing world, society demands a more robust and effective system to ensure that a doctor is fit to practice. While the current medical register entry indicates a doctors' competence when they are first registered, it may no longer adequately reflect their continuing fitness to practice. Patients need to be able to trust their doctors and revalidation – through the regular testing of a doctor's continuing ability – will be an integral part of the process of earning this trust."

The GMC 2002 Annual Report provides the following information about revalidation:

- it will benefit and assist doctors and reassure patients;
- the link between appraisal and revalidation will be communicated to doctors; the GMC will establish "a single authoritative source of information and guidance to support doctors in collecting, storing and submitting information for appraisal and revalidation";
- the first doctors to be revalidated will submit their information folders to the local revalidation group about two years after the legislation is passed;
- piloting has shown that doctors can collect information about their practice in a reasonable time, and that decisions can be based on this information;
- the GMC is testing various parts of the revalidation process;
- peer and patient questionnaires are being developed to provide information on fitness to practice in terms of working relationships with colleagues and patients;
- in time, revalidation will become a condition of continued practice in those areas which require licensing (e.g. prescribing).

In addition to revalidation, the GMC has published a draft consultation document on Continuing Professional Development (*Keeping up to date, GMC guidance on Continuing Professional Development*, available at the GMC website, www.gmc-uk.org). The GMC recommends that doctors take regular part in educational activities which maintain and further develop competence and performance.

The draft guidance document (open for comment until May 31, 2003) recommends that doctors use CPD to keep themselves up to date in the seven areas the GMC has previous articulated as *Good Medical Practice*: good professional practice, maintaining good medical practice, relationships with patients, working with colleagues, teaching and training, probity, and health.[8]

[8] As of November, 2003, the GMC website indicates that although the formal consultation period is closed, the GMC is still accepting comments on this document.

It provides examples of knowledge, skills, attitudes and behaviour that are included in these seven areas and which could be kept up-to-date with CPD.

The draft guidance document states that CPD should:

- be informed by reflection on the doctor's work and identification of areas where further development is needed;
- relate to the professional development of the doctor in the context of the organization where the doctor works;
- cover all areas of practice, including non-clinical areas such as management, research and teaching;
- take into consideration the environment in which the doctor works;
- recognize the benefits of learning across professional boundaries.

The document encourages a diversity of CPD activities depending on specialty, opportunity, priorities and personal learning styles, but recognizes the following principles:

- CPD's overall objective is improving health care for patients;
- CPD helps doctors improve career opportunities and work satisfaction;
- CPD should cover all aspects of *Good Medical Practice;*
- CPD should be targeted at meeting specific needs and outcomes, identified by the doctor on the advice of professional organizations and taking into account the needs of the organization where the doctor practices;
- CPD should incorporate public and patient involvement in development, standard setting and quality assurance;
- all doctors should support medical and other colleagues taking CPD;
- doctors should discuss and review CPD with others as appropriate, including through the vehicle of appraisal systems;
- CPD should incorporate valid and reliable measures of assessment may be helpful in assisting individual doctors to judge their progress, and in the context of revalidation.

Ontario

The Canadian precedent for quality assurance in professional health care regulation is set by the province of Ontario, and is outlined in the Health Professions Regulatory Advisory Council (HPRAC) report of October, 2000.

The genesis of this activity commenced with the *Regulated Health Professions Act, 1991*, which was proclaimed in force in December, 1993. The Act required college councils to make regulations, prescribing a Quality Assurance Program, by 3 years after the proclamation of the RHPA (i.e. December 31, 1996). The RHPA also mandated HPRAC to evaluate and report on effectiveness of the QAPs to the Minister of Health by December 31, 1998.

In February, 1996 the Ministry of Health communicated "Principles for Quality Assurance Programs and Regulations Under the Regulated Health Professions Act, 1991 (RHPA)" to the colleges. In this document the ministry envisaged that QAPs for all colleges would include three components:

- to identify and address the issue of members who are incompetent or unfit to practice, or whose deficient skills can be improved through remedial activities;
- to maintain and improve individual members' competence;
- to raise "the collective bottom-line performance of the profession, by focusing on patient outcomes and 'what works best'."

At the same time, in February, 1996 HPRAC requested colleges to submit written reports outlining their QAPs, by the end of December. At this date, which was originally specified by the Act as the date for colleges to have QAP regulations in place, the majority of regulations had not been approved; many were not approved until 1998/99.

In March, 1997, HPRAC retained Harry Cummings & Associates (HCA) to review the material submitted by the colleges, conduct a literature review of quality assurance (QA) and continuous quality improvement (CQI) in health care, and propose an evaluation framework for the 1998 evaluation report required from HPRAC to the Minister of Health. In July, 1997, HCA presented its report: *A Framework for Evaluating the Quality Assurance Programs of the Colleges of Health Professions in Ontario*. This report identified seven main QAP components:

- peer review;
- continuing competence;
- measures to address behaviour or remarks of a sexual nature;
- general review and enhancement of the profession;
- standards of practice;
- entrance to practice requirements;
- practice enhancement and remediation.

In January, 1999, HPRAC retained HCA to conduct an evaluation of the 21 health professions Quality Assurance Programs (as per the RHPA statutory requirement). The evaluation was based on the 1997 evaluation framework and a model QA program (including six of the seven main QAP components identified in the 1997 report). This provided the basis for a comparative assessment. Both the evaluation framework and the model were accepted beforehand by all colleges.

In July, 2000, HCA submitted its *Final Report on the Evaluation of the Quality Assurance Programs of the Ontario Colleges of Health* to HPRAC. In October, 2000, HPRAC concluded its *Report to the Minister of Health and Long-Term Care: Effectiveness of Colleges' Quality Assurance Programs*. Among the recommendations of this report were:

- colleges be required to fully implement all components of the model QA program by December 2001;

- colleges develop and implement overall evaluation plans for their QA programs by December 2002;
- colleges, ministry and HPRAC collaborate to develop consistent core indicators to facilitate evaluation of QA programs;
- HPRAC be given statutory authority for ongoing monitoring of colleges' QA programs and evaluating their effectiveness.

As of March, 2003, HPRAC's website indicates that this report remains under consideration by the ministry.[9]

Some observations that may be made concerning the Ontario experience that the time lines for developing and implementing the quality assurance programs were long, and initial target dates were not met. Such lengthy development times are consistent with the experience of individual B.C. colleges in development of their own QA programs.

In addition, Ontario facilitated the process by communicating to the colleges the principles which it sought to see implemented in the QA programs. This is somewhat consistent with the approach recommended in England in the Chief Medical Officer's 1999 report, articulating "Modern Principles of Professional Self-Regulation in the Health Field" some of which pertained to QA program development.

Finally, although Ontario colleges' programs were evaluated against a "model QA program" derived from the components identified in the earlier HCA review, it is notable that colleges were involved in discussion of this framework and were required to agree to the evaluation framework and the model QA programs, prior to the evaluation being conducted. Moreover, there was found to be a wide diversity of approaches to QA among the colleges, and not all elements of the model QA program were implemented by each college.

[9] As of November, 2003, the HPRAC website indicates the report remains under consideration by the ministry.

INVENTORY OF QA PROGRAMS IN BC COLLEGES

This part of the report summarizes information obtained in interviews with the health professions colleges or other regulatory bodies as listed in Appendix B. In addition, reference was made to college websites and to other published material provided by or referred to by the colleges in discussion with them.

As in Ontario, the striking characteristic of QA programs in British Columbia health professions' colleges is their diversity, both of definitions of QA and of approaches to it. The premise of this section of the report, which grew throughout the process of college interviews, is to conceive of QA programs as comprising a "tool kit" from which individual colleges selected the tools which best met their current needs, resources, and stage of regulatory development. The B.C. Health Professions Council highlighted the same concept in referring to a variety of "mechanisms" from which colleges could tailor QA programs meeting their needs

The aim of discussion with the colleges was to identify, without evaluation, the tools to QA which each was currently using or were considering, and what they saw as the advantages or barriers to implementation of the various types of QA programs. The aim is to identify a spectrum of possible approaches which may form the basis for future development of appropriate QA mechanisms according to parameters which are suggested in the Evaluation Framework proposed in the final section of this report.

As noted in the "methodology" section of this report, earlier, interviews were entered into without a preconceived model, framework, or "checklist", although such a checklist tended to evolve over the course of the interviews. Nevertheless, the guiding principle of college interviews in this initial review was to discuss the QA programs which were actually being implemented or of interest to the particular college, rather than to adduce their reasons for declining to implement other, theoretically possible approaches.

As some colleges expressed concern as to the use to which this information would be put, it was stated that the present inquiry did not constitute an evaluation of colleges against the components of a "model QA program" as in Ontario. Such an evaluation is outside the scope of this project. Moreover, it is recommended that, as in Ontario, the prior participation by the colleges in identifying and agreeing to the elements of such an evaluative model should be sought, and an opportunity given for colleges to verify and if necessary correct any findings of fact.

Because of the informal nature of these initial interviews, and in order to ensure colleges were able to feel candid in expressing their views as to the advantages or disadvantages of certain QA programs, the choice has been made not to attribute particular comments, which might be seen as evaluative of certain types of QA programs, to specific college interviews.

The specific information obtained from individual colleges about their own programs is separately summarized at greater length in Appendix B. This section will present an overall view of the types of programs which may be encountered, and the advantages and disadvantages perceived for each. Examples may be given from specific colleges: these are illustrative only and

are not intended to imply endorsement of that particular college's approach nor, conversely, to imply that other colleges do not use similar approaches or are deficient in failing to do so.

Among the types of QA programs or policies that may be encountered are:

- standards of practice/professional competencies;
- continuing education;
- required hours of practice;
- re-examination;
- self-assessments and learning plans;
- peer activities;
- office visits or clinical practice reviews;
- general practice improvement;
- evaluation of QA programs.

Before considering these specific programs, a discussion of the overall framework in which colleges conceptualize their QA programs is in order.

Application of QA as Modern Quality Management Theory

When the legislature introduced the term "quality assurance" in the *Health Professions Act* in 1993, this was in reference to one of the committees of the college, and the legislation did not define "quality assurance". Moreover, apart from committee structure, the Act did not use the term "quality assurance." In setting out the duties and objects of colleges the Act referred to "continuing competency".

From the point of view of health professions' regulators the question is whether government intended, by its reference to "quality assurance," to commend to regulators the theory and methods of QA management in any or all of its forms, and to require them to apply these to the regulation of health professions. Or was government's intention more modest, intended only to set in place a committee structure under which "continuing competency" programs could be administered?

In interviewing individual colleges, it will be seen that colleges have come down on both sides of this issue. Some colleges have, indeed, approached their mandate of ensuring practitioner competency within a broad quality management framework. (It should be noted that QA theory can be applied to all the deliverables of a college, not just its practitioner competency role. It makes sense, for example, to consider establishing measures and benchmarks for, e.g. registering applicants, handling complaints, or responding to public inquiries. Some colleges do appear to be embarking upon this "broad" TQM approach, in which case practitioner competency programs fall out as a subset of the broader venture.)

Other colleges have taken an incremental approach, building upon existing programs designed to ensure continuing competency. Still others have implemented specific programs modeled on

those first developed by other colleges, without necessarily placing these within any broader context of quality theory.

The advantages of setting the practitioner competency issue within the framework of a broad QA/TQM model is that there is considerable literature and sophisticated tools have been developed. The disadvantage is that very little of this literature is directed at health professions' regulation. It does not appear that the theoretical framework has been developed which would apply this broader literature specifically to this context, nor is it clear that the analysis has been done which would indicate the utility of all the TQM tools to professional regulation.

In addition, in discussions with some colleges, concern was expressed that the norms of quality assurance differed from those of professional regulation. This echoes, to some extent, the concerns expressed by Berwick (1989). Even in those colleges where concerns were not articulated as to a conflict in roles, many colleges stressed the importance of isolating their investigatory and disciplinary functions from their quality assurance or continuing competency functions. It was noted by several colleges that legislated protections were required to ensure that information gathered in the quality assurance context did not become evidence in disciplinary procedures. It must further be noted that, although the majority of colleges who expressed views in this area saw a potential for conflict or need for protection, a minority of colleges did not see a conflict between the roles but were prepared to regard them as falling along a continuum which they felt was manageable.

Types Of Quality Assurance Programs in BC Health Professions Colleges

Turning to specific types of QA programs implemented or considered by the colleges, by way of preamble it should be noted that many of the colleges, particularly the smaller ones, expressed concern that government would demand QA programs whose development and implementation would be beyond the financial and other resources available to the college. No college utilized all of the following QA programs, and many utilized only one or two.

Particular QA programs appear to have relevance to particular colleges, depending on a variety of factors, including:

- age of the college: newer colleges may still be occupied with establishing their registration and disciplinary processes and may have yet had little opportunity to turn their attention to continuing competency matters;
- size of the college: while larger colleges may have advantages in terms of resourcing their programs, their size may also present challenges in implementing certain types of QA programs over a large membership;
- financial and other resources: several colleges cited members' "ability to pay" as a consideration in implementing what they perceived as potentially costly QA programs, particularly in light of other costs such as professional association fees and insurance; some colleges felt the ministry should provide funding;

- the environments or organizations within which the regulated professionals perform their services: some professionals practice within institutions which already have their own QA programs, or whose quality of service is supervised by their employers; conversely, others are employed by private businesses which may have their own concerns or resistance to certain types of QA programs which may be regarded as intrusive;
- the extent of ongoing contact with patients or clients: some professions have only limited or infrequent contact with individual patients or clients (e.g. their primary role is providing products or services to other health providers), and this may affect the type of QA programs best suited. Some professions, such as emergency medical attendants, do not enter into an ongoing relationship with their clients; others have ongoing relationships which may extend over periods of years;
- the varying "content" of the profession: several colleges characterized their professions along what might be considered a "technical" vs. "people" continuum of services, and saw the QA needs differing along this spectrum;
- finally, what may be called the "culture" of the profession – the receptivity of its members to certain types of tools or methods over others. It appears, for example, that some professions or professionals are particularly receptive to the use of formal self-reflection tools leading to individualized learning plans, others stated that they do not think such approaches would be well received by their registrants, who would be most receptive to a more traditional "continuing education" course approach.

As stated above, possible program approaches to QA may include: standards of practice/professional competencies; continuing education; required hours of practice; re-examination; self-assessments and learning plans; peer activities; office visits or clinical practice reviews; general practice improvement; and evaluation of QA programs. We will consider each of these in turn.

Standards of practice/professional competencies

The identification of professional competencies, or more specifically, of standards of practice which may be related to these competencies, has been undertaken by a number of colleges. Where present, these are often used to shape QA activities, both in terms of planning for QA activities generally, or for the design of specific instruments such as self-evaluation tests. An example of the latter would include the self-evaluation instrument used by the Registered Nurses' Association of British Columbia.

The recent discussions of labour mobility and the need to enter into inter-provincial agreements on matters of entry to practice have meant that some colleges have access to documentation of professional competencies developed for this purpose. Where these exist, such documents may be of use in providing a basis for QA planning.

Continuing education (CE)

To some extent, continuing education may be seen to be the "default" program of almost all (but not all) colleges. Mandatory completion of specified hours of CE, or CE credits, is commonly a prerequisite to renewal of registration.

Colleges that do not mandate continuing education as part of their QA programs (and some that do), criticize the relevance of CE to demonstrated performance improvement. This can be both from a pragmatic point of view: the mere fact of attendance at a CE course does not mean that knowledge was acquired, nor does it provide a measure of the extent of participation. From a more theoretical perspective, some interviewees cited the literature that critiques CE, and the relevance of knowledge acquisition to performance in practice. Several interviewees and literature sources also acknowledged the problem that practitioners may tend to identify and participate in those courses which are of interest to them, not necessarily areas in which they have identified practice deficiencies.

On the plus side, proponents of CE noted that it is familiar to registrants, broadly accepted by practitioners and gets compliance. There is no "learning curve" associated with implementing a CE program as there would be with introducing other new types of programs, which may require considerable education and communication with registrants as they are introduced. Others expressed the view that CE was particularly well suited to conveying technical information and was therefore particularly important and a priority for professions where obtaining current, rapidly changing "state of the art" technical knowledge was a major component of practice.

Both the quantity of CE programs required, and the type of CE activity credited, are normally articulated in college policies or bylaws. Within a mandatory CE program, there are a number of choices which colleges must make along a variety of parameters. First, there is the choice of what kinds of activities earn CE credits. Primarily, these consist of courses or seminars, often in lecture or discussion panel format, but which may include "hands on" technique. Other modalities such as video, self-study, and literature review may be accepted. Several colleges permit credit for study groups consisting of several registrants; these often require pre-approval by the college QA committee according to published guidelines. Many colleges also provide credit for involvement in teaching or research. Some, but not all, will give CE credit for board or committee membership, and for annual general meeting attendance. Some interviewees disputed giving credit for what they regarded as administrative duties which were of benefit to the college but not necessarily to the members' professional development; others saw such activities as conveying information of direct relevance to the participating professional and felt credit was appropriate.

A second parameter is the extent of involvement of the college in approving specific courses or activities for credit. There is a range of approaches. At least one college, while requiring mandatory completion of CE credit, takes no position on the choice of courses: it is left for the registrant to determine what courses are relevant, and to assign an appropriate credit (within limits) to participation in each course. The majority of colleges, however, provide some stipulation as to which courses may be credited. Often this is by reference to recognizing courses provided by recognized academic institutions or organizations, or which have been approved by

external accrediting organizations. Colleges (often through their QA committee or registrar) may also be willing to approve other courses delivered outside these pre-authorized providers. A minority of colleges maintains a listing of specific approved courses; registrants who do not find their intended course on the list must submit it for pre-approval and addition to the master list before it may be credited.

In addition to approving courses or activities for CE credit, colleges may specifically require the completion of certain CE activities. These may be generic, for example the completion of training in CPR or infection control; or there may be CE requirements in specific treatment modalities, perhaps applicable only to a subset of registrants practicing those modalities.

One of the factors affecting the use of CE as a QA instrument is the extent and nature of providers of CE courses or activities. Some professions are well served by an array of courses delivered by various providers including academic institutions, hospitals or health authorities, or their professional membership associations. Others may participate in CE designed for other professions than their own, but which provides information relevant to their own practice. Courses in communications, office management, conflict resolution and other generic skills may be available to and utilized by a variety of professions. Commercial suppliers to the profession may also provide seminars or other information that may be recognized in a CE program.

Some colleges take an active part in identifying, promoting or advocating the development of CE courses. This may be particularly necessary in smaller professions where the motivation of providers to supply CE may be limited: an instance was cited where the college actively lobbied the local community college to provide relevant CE programs. A minority of health professions' colleges actually delivers some CE programs themselves, although this may be limited to participation in annual conferences and the like. Others felt that actual CE course delivery was not an appropriate college role, either because resources were limited or they felt this was part of the mandate of the professional association.

Although most colleges established policies which limited the amount of credit which could be obtained for certain kinds of CE (clinical education vs. general management practice courses; course attendance vs. private literature review; ceilings on credits for certain activities, e.g. teaching), in general mandatory CE participation was not tied to identified competencies or standards of practice. The choice of relevant CE courses was, in general, left to the professional judgment of the individual practitioner.

Finally, the reporting and follow-up from mandatory CE is very limited. Several colleges require only a reporting that minimum hours have been completed as per the policy. Many require the reporting of the names of actual courses or activities, and some require proof of participation be obtained and submitted, or alternatively, retained by the practitioner for possible future demand by the college. Only a few colleges appear to audit reported participation.

Colleges do not report collecting information as to outcomes of the course, although some acknowledge receiving informal reports of the perceived success or utility of particular courses by way of discussion with participants or course deliverers. The collection of evaluation sheets,

common after many courses, appears to be limited in use to the deliverers of the course and is not shared with the college in anything other than informal ways.

There does not appear to be any general practice of directing specific practitioners to specific CE activities, although some colleges noted this could be a consequence of an undertaking or order given in the context of disciplinary action.

Required hours of practice

Many colleges stipulate the completion of minimum hours of practice as a precondition to renewal or continuation of registration. This can be regarded as a QA program to the extent that many interviewees stated that "hands on" practice was the best assurance of competency.

In setting such standards, some colleges distinguish between clinical practice and other aspects of practice; one college stated that they had been unable to obtain government approval for draft bylaws which made this distinction. This discrepancy was not further explored.

Some colleges address this requirement in terms of minimum number of practices or procedures rather than hours of practice; still others do not stipulate a quantitative measure but require "active" practice.

One college, taking the position that active practice is particularly important for new registrants, requires differential practice requirements, the requirement being higher in the initial years of practice than subsequently.

Re-examination

The literature on professional regulation, in particular the Pew Commission report in the United States, took the position that periodic re-examination should be a requirement for relicensure, and drew a parallel to the practice in aviation. (The recommendation, it should be noted, has been controversial.) England, as noted earlier, appears to be taking a similar approach to physicians.

There is little evidence of use of or interest in re-examination as a QA tool in its own right, in B.C. health professions. The Licensing Board for Emergency Medical Assistants reports having used re-examination until recently, but having moved from this model. A number of professions permit registrants who have not completed another requirement, such as mandatory continuing education, to re-write registration exams as an alternative.

Self-assessments and learning plans

A number of professions, in particular the nursing professions, have developed various tools for self-assessment. Typically, these instruments take the form of questionnaires or checklists which permit the registrant to evaluate their practice against certain competencies or standards of practice, and to identify successes and deficiencies in each. These instruments may be in booklet form, and provide an opportunity to document educational activities, awards, commendations and other material which the registrant feels is relevant to the self-assessment. The registrant is encouraged to use the self-reflection tool to identify learning needs and develop a learning plan; to carry out that plan; and to record an evaluation of the outcome of the plan.

While several colleges have invested considerable time and resource in developing these tools, in general they are *not* mandatory, but are recommended for use. In particular, the self-assessments and learning plans are not submitted to the college, and considerable pains are taken to assure the member that they are confidential and will not be requested by the college. Some colleges require the declaration, at renewal of registration, that a self-assessment and learning plan has been done, but no additional details are required. At least one college requires the member to review the learning plan with a colleague or peer, and to obtain that person's signoff on the plan.

In discussions with colleges using these instruments, particular emphasis was given to the confidentiality of the self-assessment. In part, this was seen as necessary to ensure the instrument would be properly and candidly used, and was consistent with what was seen as a non-judgmental, non-disciplinary "quality assurance" approach. Others made the point that disclosure of the self-assessment to the college would, in the absence of legislated protections, obligate the college to commence investigation or discipline if circumstances warranting this were disclosed, and this would basically negate the use of the self-assessment tool.

Peer activities

This heading embraces a variety of QA approaches which are distinguished by some sort of formalized process involving peers or colleagues (as contrasted to activities involving the registrant alone, or activities involving college staff such as investigators or assessors).

It is widely recognized that peer involvement and informal consultation is a feature of professional life, although this may be limited somewhat by availability of peers (e.g. in remote locations) or conditions of practice (e.g. where professional colleagues are employees of competing commercial enterprises). The definition of "peer" may include not only colleagues in the same profession, but also potentially persons in cognate professions or related areas of service delivery.

There appears to be relatively little formal QA activities specifically centred on peers. One college, as has been noted, requires peer review and signoff of learning plans. Others encourage coaching or mentoring situations, although there do not seem to be specific examples of formalized programs in this regard. One profession noted the use of "study clubs" which

involved two or more registrants engaging in a morning study session, followed by an afternoon clinical practice session in which one registrant actual "scrubs in" with another's' practice, to apply the techniques.

Peer review activities are referenced in the literature but appear to have very limited use at present. The major barrier cited by many colleges is lack of evidentiary protection along the lines which the *Evidence Act* provides to hospital quality assurance committees. Peer review of practice is impossible, it is contended, if there is no protection from disclosure of information to subsequent disciplinary, civil or criminal actions, and no protection for the peers involved in the review. Several colleges indicated they had communicated these concerns to the ministry in the context of ongoing proposed amendments to the *Health Professions Act*.

Office visits or clinical practice reviews

Some colleges do have or have had office visits for the purposes of review. These are usually conducted by staff of the college or other persons trained and designated by the college for that function. As a quality assurance function, the purpose of such visits is for education and practice improvement, not to discipline.

The review will usually be limited to a visual inspection of office layout (e.g. identifying security concerns) and equipment, office procedures, and patient files. There does not appear to any general practice of observation of clinical service delivery to patients, in part because of privacy issues.

Developmental issues for colleges implementing these programs include the need to train assessors and to set specific standards for evaluation. As in the case of peer review activities, evidentiary concerns and protection of assessors from liability were issues. The ministry's proposed amendments to the *Health Professions Act* are specifically addressing these issues, although at the time of the interviews, the issues had not been resolved to the satisfaction of many colleges. The analogy of "watertight compartments" was often used to describe the relationship which was desired between quality assurance activities and the colleges' disciplinary role.[10]

General practice improvement

This heading was one identified in the Ontario model bylaws and comprises a wide range of approaches to the general education and improvement of practice in the profession overall. It may comprise a variety of approaches by which colleges communicate with their members and the general public. These include newsletters, publication of summary decisions of discipline or ethics committees, practice bulletins, and college web pages. Some colleges are also able to resource and provide to members the services of a professional library.

[10] See footnote 1 on page 5

These measures are used to some extent by all colleges. In particular, the availability and relatively low cost of publication on the internet has meant that almost all colleges have a web site which very many are using to publish bylaws, standards of practice, practice guidelines and standards, newsletters and other information for members. Many colleges have specific sections devoted to their Quality Assurance Committee or activities and a number of others identified their intention to provide this in the near future.

Evaluation of QA programs

Although many colleges recognize the desirability of measuring and evaluating the outcomes of their QA program, few have done so in a comprehensive way. For many, this is a consequence of the relative "newness" of the college or of a newly implemented QA program: with a current focus on planning, development or initial implementation of the QA program, development of outcome measures, monitoring and evaluation is still seen to be some years in the future.

That said, it is recognized that some colleges have spent considerable time, often over a period of years, designing, testing and validating specific QA tools. Others, to date, have undertaken little or no activity towards gathering outcome data.

The relevance of the question "how would we know if this program worked?" is supported both in the theoretical literature and practical experience. Likewise, it is recognized that outcome measurement and evaluation is often the last and hardest aspect of QA to implement. (See for example, the remarks in Health Canada, 2000.)

Among the barriers to more active college participation in evaluation of QA programs are a number of observations, many of which are barriers to the implementation of QA generally. These include:

- the ministry has not provided principles or guidance in this regard (it should, however, be noted that not all colleges may be viewed as desiring such guidance);
- some colleges feel that the ministry should provide financial support if it desires colleges to increase their QA activity;
- some colleges expressed the view that the ministry can best promote QA principles by applying QA principles to its own processes and relationships to the colleges, in particular a greater degree of consultation and transparency;
- colleges have not gathered outcome data in the past, and there is considerable work and resources required to begin to identify and collect relevant data, let alone analyze it;
- the process of implementing QA programs through to outcome evaluation is a lengthy one, demanding continued commitment often over several years; there was concern that the ministry might attempt to impose an unrealistic and rushed timetable on colleges;
- the varying sizes of colleges mean that they have widely varying resources to apply to the task; to some extent, colleges which have made the most progress in this area are ones which either have been able to allocate sufficient financial and staffing resources, or who

have been fortunate in having board or staff members with QA expertise acquired in other contexts that has been applied to the colleges' own concerns;
- it is possible that some evaluation measures might require legislative support, either to ensure compliance or to provide protection for participants;
- the tool of patient satisfaction surveys, noted in the literature, appears to have received little attention to date.

TOWARDS AN EVALUATION FRAMEWORK

The final component of this project was to propose an evaluation framework for future ministry use. In particular, the ministry expressed an interest in how an evaluation framework might be implemented in the context of model bylaws for health professions.

Unfortunately, the compressed time frame for this report did not allow for the full development of a proposed evaluation framework as originally contemplated. However, this section of the report will consider the respective roles of government and the colleges in establishing and implementing such a framework. In light of these roles, specific recommendations will be made for government action, in particular provisions to be included in the model bylaws developed by the ministry.

The following principles are derived from the literature review and from observations made in interviews with the colleges and the literature they provided.

Again, it is worth reiterating that the interviews conducted with the colleges were not intended to be evaluation of the colleges' QA programs. Rather, information obtained as to the range of college QA activities, and from the literature review, has been used to shape the general proposals in this section. As in Ontario, the ministry may wish to discuss these proposals with colleges and obtain their consensus to their use (or use of some modifications of these) in any future evaluative activity.

While every effort was made to ensure that significant aspects of each college's QA program were not omitted, the time frame of the present project did not permit the opportunity to check back with colleges and verify all information provided. It would be desirable to provide an opportunity for colleges to comment on or correct any of the observations attributed to them.[11]

The Role of Government

The development of an evaluation framework must take account of the respective roles of government, through the ministry, and of the colleges of the health professions. Government can articulate and administer an evaluation framework through four approaches:

[11] This was subsequently done. See footnote 2 on page 9.

- enunciation of principles
- legislated requirements
- approval of bylaws
- reporting requirements

The first approach, *enunciation of principles*, was followed both in England and Ontario. In England, the 1999 report *Supporting doctors, protecting patients* responded to the recommendation of the Merrison Committee (1975) that government provide explicit criteria applicable to professional self-regulation, viewed as a contract between the profession and the public, proposing seventeen "Modern Principles of Professional Self-Regulation in the Health Field." Some of these are relevant to the QA function, and the ministry may wish to consider articulating similar principles for consideration by the B.C. professional colleges. These might include, from among the 1999 report's principles, the principles that regulatory bodies are responsible to:

- set standards of the knowledge, skills, experience, attitudes and values necessary for continuing practice;
- ensure competence and conduct at all stages in practitioners' careers;
- develop consistent standards across different regulatory boundaries;
- retain public confidence and have effective lay involvement;
- ensure that those being regulated understand what is expected of them and the role of the regulatory body in relation to their practice and wider health services;
- review and update standards regularly.

Consideration may also be given to Ontario's "Principles for Quality Assurance Programs and Regulations Under the Regulated Health Professions Act, 1991 (RHPA)" which identified three components of the regulatory role:

- identify and address incompetence or unfitness to practice, and improve deficient skills through remedial activities;
- maintain and improve individual members' competence;
- raise "the collective bottom-line performance of the profession, by focusing on patient outcomes and 'what works best'."

The second approach, *legislated requirements*, have already been included in the *Health Professions Act* in terms of the specific reference to a "quality assurance committee" and the mention of a "continued competency program" in the legislated duties and objects of the college. Conceivably, legislation could also mandate particular types of QA programs or activity. However, this does not provide sufficient flexibility to allow for the wide variations among the several colleges. Rather, a better option is to ensure that there is an adequate legislative framework to permit colleges to implement desired QA programs. The legislative framework for many such programs exists, insofar as there is authority for colleges to impose requirements for renewal of registration; it is usually at the re-registration stage that colleges will impose their requirements for mandatory continuing education, or completion of self-assessments, or whatever other requirements are put into place.

Besides ensuring legislative authority to link QA programs to renewal of registration, another area requiring legislative authority is to provide the authority for, and set evidentiary limits on, various types of QA-focused assessment. This was noted in interviews with many colleges, and is exemplified in the New Zealand legislation. It is understood that, at the time of writing of this report, there has been considerable discussion between various colleges and the ministry in regard to the circulated draft amendments to the *Health Professions Act*, and that the ministry feels this legislative area will be addressed.[12]

The third mechanism which government may employ to pursue its QA objectives is the Cabinet approval of the bylaws of the profession. The ministry has, for some years, circulated model bylaws for the use of professions under the *Health Professions Act*. It may include what it considers to be appropriate QA provisions in the model bylaws and encourage their adoption by the colleges. In addition, the ministry may recommend to Cabinet the approval or otherwise of bylaws proposed by the colleges, and thus is in a position to influence the colleges in this regard. The content of model bylaws is likely the area which permits the greatest flexibility and most creative approaches, and will be treated at greater length, below. As discussed below, it is recommended that government not require the inclusion of particular kinds of QA or continuing competency programs in the bylaws, but should leave this to the judgment of the colleges, subject to a reasonable requirement that colleges be able to justify their particular choice of programs on the basis of the public interest considerations articulated for self-regulating professions by the government.

Finally, a fourth mechanism by which government may encourage QA activity is to require specific reporting from the colleges as to their QA programs, as part of their annual reports. The annual report can provide a mechanism for colleges to report on their measurement and evaluation of their QA programs. This provides assurance that the choices the colleges make in establishing certain types of QA or continuing competency programs, actually achieve the intended result. It is recognized that not all colleges will be in a position to establish outcome measures or conduct evaluations immediately, and, recognizing the divergence in "starting points" among the colleges, it is not recommended that government establish an arbitrary target date by which evaluations must be conducted and reported. Rather, the annual report can be used by the college to explicate its progress to that desired goal along some timeline which is reasonable for the profession, while still being acceptable to the government.

The Role of the Colleges

Government may establish the principles and general requirements for QA through use of the above four mechanisms, but their implementation in the context of a specific health profession depends on the specialized knowledge, expertise, and resources of the college. From this perspective, any evaluation framework must first take into account the great diversity of QA approaches and programs between colleges. Throughout this report is has been noted that

[12] See footnote 1 on page 5.

colleges have arrived at their present QA activities from a wide variety of starting points, historical experience, and available resources. Moreover, the working environments, technical skills, and professional cultures vary widely among professions and will have a great impact on what sort of QA programs will be most effective.

The colleges are responsible to define specific professional competencies and practice standards, which in turn form a framework within which continuing competency is addressed, and within which colleges may identify QA programs of particular relevance.

No single optimal model for QA programs emerges from the literature or from interviews with the colleges. Given the general accountability expectations articulated for the professions by the government as representative of the public in the "self-regulation contract", it is then a matter for each college to determine what programs will best ensure QA and continuing competency in the specific context of their profession. While it is possible, on the basis of the information gathered in this report, to compile a "checklist" of possible approaches, it would be unfortunate to regard such a checklist as having any evaluative role. While inventorying colleges against such a checklist may have, as in Ontario, some utility in terms of describing the range of approaches taken, such a list should not be regarded as constituting an "ideal" or "model" QA program which would be "complete" only if each and every approach were implemented by each and every college.

This report does not recommend identifying a single "model" QA program nor does it recommend including such a model in the model bylaws. There is nothing in the literature, nor arising from interviews with colleges, which gives reason to suppose that a specific program (e.g. mandatory continuing education) which works within the context, culture and resources of a particular profession will necessarily work equally well within the context, culture and resources of another. The colleges are sensitive to these issues and how these affect their choice of QA programs.

Moreover, to impose a uniform requirement to implement certain types of QA programs (e.g. by specifying a set of programs in the model bylaws) would ignore the efforts already made to date by colleges in implementing QA or continuing competency programs, and could undermine them. The introduction of such programs can be a lengthy process which may involve an extensive period of consultation and "buy in" by the members of the profession. To set these efforts aside in pursuit of an arbitrary "ideal model" could be counter-productive.

If it is true that there is no basis for imposing a "one size fits all" model on all the professions, this does not mean that the choice of QA programs must be arbitrary. Many colleges have identified core competencies or established standards of practice which provide a basis for their specific QA programs. Those who have not yet created such a linkage should be encouraged to explore this. In addition, as part of their QA mandate, colleges should be able to demonstrate that the programs which they implement do achieve the desired result of ensuring practitioner competency. Indeed, it is submitted that, because of their specific and detailed knowledge of the profession, the colleges are in an ideal position to partner with government in establishing what outcome measures should be used to determine the degree to which a particular QA program achieves its goals.

A final role for colleges is promoting QA, not only within their particular profession, but encouraging participation of their members in interdisciplinary QA, where appropriate. This could involve identifying and removing any regulatory barriers which might exist.

Provisions Which Might Be Included In Model Bylaws

In light of the above discussion, it is recommended that the ministry consider including in model bylaws provisions addressing the following topics. These are intended to strike a balance between government's role in articulating general principles and the self-governing professions' role in applying these principles in the context of their particular disciplines.

- Quality Assurance Committee: the bylaws should state, not only the composition of the committee, but should articulate its functions, including: recommending overall QA policy to the board and identifying and approving specific QA or continuing competency programs. It should be the responsibility of the Committee, in articulating specific programs, to identify outcome measurements and evaluation methods and propose a timetable for implementing these, if they are not concurrently implemented.

- Renewal of registration: while government should not insist that any particular program be made a precondition of renewal of registration, government should expect to see that the college has identified the completion of some form of continuing competency program and linked it to re-registration as set out in the bylaws for that particular college.

- Assessors: subject to adequate legislative authority being in place, and to colleges identifying this as a desirable QA approach for their profession, the college may adopt bylaws to create and empower QA assessors.

- Reporting: the annual reports of the college should include information relating to their QA mandate, including: actions of the QA committee; the timetable for implementing, measuring and evaluating QA programs; the actual measures for the relevant period; and the results of any evaluations conducted.

Next Steps

This report comprises a first survey of the range of QA and continuing competency programs carried out by the health professions' colleges in British Columbia. While there has been no intent to evaluate any particular college's programs (indeed, it is suggested that it is the proper responsibility of the college itself to identify and carry out any evaluation), it is nevertheless desirable that the factual information contained in this report is as accurate as possible. The ministry may wish to provide the colleges with an opportunity to comment on or revise the material attributed to them.[13]

[13] This was subsequently done. See footnote 2 on page 9.

Although colleges were most cooperative in this project, there was inevitably some apprehension as to the action which government might wish to take as a result of its consideration of this area. Therefore, if the ministry accepts the premise of this paper that government ought to articulate general principles and develop jointly with the colleges indicators or measures for evaluation of outcomes, but not require specific programs or evaluations, then communication from the ministry articulating these principles may go some way in alleviating any anxiety which may be felt by some colleges.

Finally, as part of its ongoing development of model bylaws for the professions, the ministry may wish to consider including provisions relating to QA as identified above, and discuss these with the colleges as appropriate.

APPENDIX A: TERMS OF REFERENCE

Background

"Providing high, quality patient-centred care" is a primary goal of the Ministries of Health Planning and Services. The regulated health professions, or "colleges" have a significant role to play in ensuring the provision of high-quality services by health professionals to consumers of health care. The Ministry of Health Planning is proposing amendments to the *Health Professions Act*, which are intended to enhance the role of the colleges in developing and implementing "Quality Assurance" (QA) programs. In the future, colleges will be required to specify QA programs in their bylaws although colleges will have considerable latitude in the design of QA programs. Bylaws of the colleges will require approval by Cabinet. The Ministry will be developing model bylaws to guide the colleges in designing acceptable QA programs.

Before developing model bylaws for QA programs, the Ministry would like to gain a better understanding of the range and breadth of existing QA programs of the colleges.

Services

Under the direction of the Director, Professional Regulation, the contractor will:

- conduct an inventory of existing programs and policies of the 23 regulated health professions which are aimed at improving the quality of services provided by registrants.
- conduct a literature review of Quality Assurance initiatives in the context of the regulation of health professionals, nationally and internationally to explore models, methods and evaluation specific to improving the quality of care provided to patients.
- develop an evaluation framework to review the effectiveness of the QA programs identified.

Scope

Each of the 23 regulated health professions shall be included in analysis.

The analysis shall include an inventory of programs of the colleges which have as an objective in whole or part the maintenance or improvement of quality services provided by registrants, including but not limited to such matters as:

- continuing education and continuing competence requirements;
- programs for self-assessment and peer review;
- programs for practice assessment;
- remediation programs (non-complaint driven) to identify and address practice issues of registrants who are incompetent or unfit to practice; and,
- other programs of colleges which are intended to raise the collective performance of the professions to improve "patient outcomes".

The analysis does not include an analysis of entry-to-practice requirements, except as they may relate to criteria for re-licensure, or of the complaint and disciplinary processes of the colleges. The contractor will interview representatives of each of the 23 regulated health professions and with academic experts and professionals working the area of quality assurance in health care.

APPENDIX B: INDIVIDUAL COLLEGES

Chiropractic

The profession has been regulated since 1934, when the *Chiropractic Act* was enacted. It is presently regulated by the British Columbia College of Chiropractors, established pursuant to the *Chiropractors Act*. The College has approximately 820 registrants.

It is expected that the profession will be brought under the *Health Professions Act* and that QA directions and mechanisms will continue to be a responsibility of the College Board.

At present, the Rules pursuant to the *Chiropractors Act* require mandatory Continuing Education (CE) as a condition of renewal of registration. Registrants must complete 24 hours CE in two years; of this, 6 hours must be in radiography. Activities may include courses or "hands on" activities. The College occasionally specifies and produces mandatory CE on specific topics.

The view was expressed that for this profession, in addition to the maintenance of current knowledge relevant to clinical judgment and decision-making, the core practice also involves the maintenance of manual skills. Accordingly, the best assurance of continuing competence includes the performance of these skills on a regular basis. The College does not specify minimum hours of practice, but does register "regular" members on the basis of "full time" practice (which is not defined), as distinct from a "seniors" registrant who practices less than 15 hours per week.

The College does not suggest or require formal self-assessment tools or the development of learning plans. It is possible that some CE programs might provide information in these areas to interested practitioners.

The College has a Standards of Practice Committee which is responsible for coordinating peer review functions. The Standards of Practice Committee has trained chiropractors to function as inspectors for the purpose of performing office inspections of every member. The goal is to have every member inspected at least once every five years. These inspections would not include observation of patient care but would include review of record-keeping. The Standards of Practice Committee also acts on referrals from the Board, the Registrar and the Ethics & Discipline Committee to review whatever practice issues might be identified in any particular case. The deinsuring of chiropractic services by the Medical Services Plan (MSP) means that the College no longer has MSP billing information to inform its reviews.

Specific clinical practice guidelines are produced by the College and by the Canadian Chiropractic Association and international bodies. These are promulgated through the College website and mailings to members. Digests of disciplinary decisions and ethics committee findings are also published.

The College has approved funding to encourage members to publish clinical case studies which could be used as part of general professional education.

The College noted it has consistently demonstrated its awareness and understanding of the core competencies in both public and private forums. Privately, the College continuing education and peer review functions focus on both the maintenance and development of knowledge and skills in the practice of chiropractic. The College took the view that, publicly, it has repeatedly sought to inform the former Health Professions Council (HPC) and the government of its core competency, particularly in the context of the HPC's Scope of Practice Review where, in the College's opinion, extensive submissions were made relating to core competence in relation to the high velocity, low amplitude movement of the joints of the spine, which the College believes should be exclusive to chiropractic.

Dental Hygiene

The profession has been regulated since 1995 by the College of Dental Hygienists of British Columbia, pursuant to the Dental Hygienists Regulation under the *Health Professions Act*. There are approximately 2000 dental hygienists in the province.

The College's Quality Assurance Committee has established continuing education requirements for registration and re-registration of dental hygienists.

The basic requirement is completion of 75 credit hours over a 3 year cycle, commencing January 1 of the year following initial registration. Of these, 50 credits must be in dental hygiene practice. As an alternative to completing these credit hours, registrants may sit an exam approved by the Board or complete a dental hygiene refresher course approved by the Registration Committee. Non-practising registrants need not maintain CE credits, but must complete them, sit the exam, or attend a refresher course prior to re-entering practice.

The College's Guidelines indicate which CE activities may be included as credit hours. These include programs or courses offered by approved sponsors (e.g. the College, accredited dental hygiene or dental schools, regulatory bodies, hospitals, etc.); participation in study clubs registered with the College; conference attendance; presenters; faculty or instructors; various programs of advanced or specific studies; and publications.

The Quality Assurance Committee may approve or disapprove credits based on their relevance to the practice of dental hygiene.

The College compiles information as to number of credit hours completed, but does not otherwise compile or analyze information as to registrants' CE activity. Registrants are requested to maintain a file including details of courses attended, and may be asked to provide these records to the College.

Around 1997 the College engaged a consultant to review literature and consult with registrants about continuing competence. The current CE program was supported, and registrants indicated a strong desire to continue with it as the existing program. It should be noted that mandatory CE is familiar to a number of registrants, dating back to the period prior to the establishment of the present College, when the profession was regulated under the *Dentists Act*. In addition, the CE program has resulted in a sizable infrastructure in BC of courses, seminars, study clubs and conferences.

The College has articulated Standards of Practice, a Code of Ethics, and publishes practice guidelines (called "Interpretation Guidelines") based on inquiries received from registrants. These are provided for general registrant information, and are not linked to particular CE courses.

There is no formalized self-assessment program. Peer mentoring exists on an informal basis, but there is no formal program of peer review.

The College provides information about regulatory matters through its website and newsletter, including records of decisions in complaint cases.

Dental Technology

Dental technology has been regulated since 1995 by the College of Dental Technicians of British Columbia, pursuant to the Dental Technicians Regulation under the *Health Professions Act*. Prior to designation under the *Health Professions Act*, the profession was regulated under the *Dental Technicians and Denturists Act*. The College registers both dental technicians and assistants, for a total of approximately 1100 registrants.

The profession is characterized by limited contact with the public. Only two aspects of practice involve the public (shade taking, repairs); the remaining technical services are provided to dentists.

The College registers dental technicians, and has also been registering assistants for about 12 years. Policies on supervision limit delegation by a dental technician to a maximum of three assistants and a student, unless the College specifically grants an exemption.

The College mandates Continuing Education for dental technicians only (in the future it may consider requiring CE for dental assistants). The current requirement is completion of 30 hours CE in 3 years. The College approves each specific course and maintains a list of approved courses on its website. Course approval is delegated to College staff under supervision of the Quality Assurance Committee which meets 3 times per year.

Registrants who wish to receive credit for a course not on the list must submit course details and request it be added to the list. Since the College approves each individual course, it does not conduct spot audits. Every registrant must prove that each course is relevant.

The view was expressed that Continuing Education is one appropriate method for addressing quality assurance in a profession where cutting edge technology is very important. The College does not require registrants to take any specific courses, but does require that they take a specific number of technical courses; a certain number of courses on infection control; and limits the number of non-technical courses that can be accumulated in each continuing education cycle.

College staff noted that the "culture" of the profession is technically oriented, and perhaps not as conducive to self-reflection tools.

Inspections are carried out by College staff on visits to each laboratory once every 3 years, a practice that predates the college's establishment under the *Health Professions Act*. The focus of inspection is on compliance with the legislation and an inspector would review for e.g. a registrants' compliance with infection control, record keeping, registration and supervision standards. This is an inspection process currently carried out for the Inquiry Committee rather than the QA Committee.

Other QA tools, such as competency review or peer assessment have not been considered, and are viewed as being potentially too costly.

Dentistry

Dentistry has been regulated under provincial enactment since 1886. It is presently regulated by the College of Dental Surgeons of British Columbia, under the authority of the *Dentists Act*. There are approximately 2750 dentists licensed to practice, and 4788 certified dental assistants licensed to practice.

In addition to recommending policy statements on standards for oral health care, the Quality Assurance Committee monitors a mandatory Continuing Education program setting out requirements for relicensure. For dentists, this consists of 90 credit hours in a three year cycle. For certified dental assistants, 36 credit hours are required in a three year cycle. The courses or equivalents must have significant intellectual or practical content, directly related to the practice of dentistry or certified dental assisting, or to the professional responsibility or ethical obligations of the participant. Specialists must complete 50% of their credits in their specialty area.

CE credits may be obtained in courses from dental schools or associations, health departments, CCHA accredited hospitals, or commercial organizations; for attendance at scientific meetings; for work as faculty or lecturing; for publications; and for post-professional exams or advanced study. Subject to certain limits, credit may be given in areas of dental practice management, personal enhancement, and self-study programs.

Credit may also be obtained for "study clubs". These are groups of dentists and/or certified dental assistants who meet with a mentor, normally on a monthly basis, to pursue further study in

a particular aspect of dentistry. This may involve didactic study and/or clinical treatment of patients.

The College is interested in exploring mechanisms to ensure continuing competency in group settings, being cognizant of evidence that "hands on" learning may best be related to maintenance of competence.

The College contributes $5.00 per dentist per year to the Canadian Collaboration on Clinical dental practice guidelines (CCCD), an evidence-based research arm of the Canadian Dental Association (CDA).

The College contributes $50.00 per dentist annually to the Pacific Dental Conference to cover the registration cost for all licensed dentists in BC.

Denturism

Denturism has, since 1995, been regulated by the College of Denturists of British Columbia, pursuant to the Denturists Regulation under the *Health Professions Act*. Prior to designation under the *Health Professions Act*, the profession was regulated under the *Dental Technicians and Denturists Act*.

The College identifies QA as comprising entry level, continuing competence, and inquiry and disciplinary processes. Within the continuing competence area, the College sees this as supported by standards of practice, inquiry and discipline, mandatory continuing education, reminders, and mentoring.

A mandatory continuing education program requires the completion of 30 hours approved continuing education instruction within a three year period, of which a minimum of 5 hours must be acquired in each year. Of these, 20 hours must directly relate to patient care (examples listed in the College's policy include anatomy and physiology, oral health, infection control, radiology, etc.) and 10 hours may be indirectly related to the practice of denturism (e.g. practice management, ethical and legal obligations, communications skills). Approved activities can include participation in:

- relevant courses or programs
- group study (study clubs) relating to denturism
- developing or teaching a course, or leading a group study activity
- mentoring another registrant
- conducting research in denturism.

In addition to reporting hours taken, registrants must submit verification of attendance. As an alternative to obtain 30 credit hours, a registrant may write the current licensing exams.

The Quality Assurance Committee must approve the course or activity in advance of its being taken, and the College has articulated its criteria for approval in a policy approved in 1997.

Dietetics

The profession has only recently become self-regulating under the College of Dietitians of British Columbia, pursuant to the approval in 2002 of the Dietitians Regulation under the *Health Professions Act*. Prior to the recent establishment of the College, the British Columbia Dietitians' and Nutritionists' Association (BCDNA) coordinated continuing competency activities. The College has not yet approved its own programs in these areas. There are 988 dietitians subject to regulation.

This is a very new College, in the process of becoming established. As much of the profession's quality assurance activities had been conducted by the British Columbia Dietitians' and Nutritionists' Association (BCDNA), representatives of the BCDNA as well as the College were interviewed.

The College has not yet approved Standards of Practice or developed a QA program. At present, dietitians continue to participate in the BCDNA's Professional Action Credit (PAC) program. The PAC program required accruing 45 points over a 3 year period. The last 3 year cycle finished March 31, 2003. Pending the College establishing its own QA requirements, the PAC has been extended on an interim basis (15 points for one year ending March 31, 2004).

Accumulation of the required points is a precondition for renewal of BCDNA membership. It should be noted that the PAC requirement is for points, not hours. Members may self assess their participation in various activities on a scale from 1 to 5, depending on their view of how much has been added to their knowledge or competency by participation in the particular course or activity. The BCDNA does not require or approve specific courses or learning activities; rather, it is entirely up to the registrant to determine which will be relevant. It is felt this takes into account the role of the registrant as a professional, and also the diversity of environments in which dietitians function makes it difficult to stipulate courses which must be taken by all members.

The Association does not gather information on the PAC outcomes, and does not audit. There has been some discussion as to whether the College should review or assess the PAC information, or do audits. This is very preliminary, as the College has not yet developed its QA program.

In addition to the PAC program, the BCDNA two years ago introduced a requirement for members to complete a Self-Assessment and Learning Plan. These Plans are reviewed by a peer reviewer (who need not be a dietitian) at the outset, and once again after the learning activities are completed.

The BCDNA feels that the PAC is well accepted and supported by dietitians, and costs little to administer. Concerns were expressed that more elaborate QA programs could be beyond the financial ability of the College and its registrants.

Emergency Medical Assisting

Emergency medical assistants are regulated by the Emergency Medical Assistants Licensing Board of British Columbia, under the *Health Emergency Act.* It is expected that the profession will become self-regulating under the *Health Professions Act* sometime in 2003. It is expected that most of the 3200 paramedics presently licensed and many of the 7,200 First Responders will become registrants of the College.

Since the College is not yet operational, programs presently administered by the Licensing Board may or may not be adopted by the new College. The Licensing Board formerly addressed issues of competency by requiring emergency medical assistants to be re-examined. First Responders are examined every three years and EMA FA and EMA 1 are reviewed once every two years by completing an examination by either the Worker's Compensation Board or the EMA Licensing Board. EMA 2 and ALS Attendants were re-examined once every five years. The process for these two levels consisted of seven days of review followed by two days of examination.

In 2002, the Board introduced a mandatory continuing education program put on by the Paramedic Academy for Paramedic 1, EMA 2 and ALS levels. This requirement replaced the previous two week review/examination process that was in place. The continuing education program consisted of reflective call review and theory based presentation. The services provided by emergency medical assistants are defined by protocols developed and approved by the medical community, and the focus of continuing competency is primarily to ensure that these protocols are understood and correctly applied. In discussion, it was noted that the "protocol-based" nature of this profession may be seen to differ from "client-based" professions – i.e. those in which the practitioner is involved in an ongoing relationship with the client over a period of time – and that the QA or continuing competency requirements of this profession may differ accordingly.

Further consideration of QA in the context of this profession must await the establishment of the College under the *Health Professions Act*.

Hearing Aid Dispensing

The Board of Hearing Aid Dealers and Consultants regulates the practice of hearing aid dispensing in British Columbia. The Board is established pursuant to the *Hearing Aid Act*.

It was not possible to obtain input from this Board prior to the expiry of the term of this project.

Licensed Practical Nursing

The profession has been regulated since 1995 by the College of Licensed Practical Nurses of British Columbia, pursuant to the Licensed Practical Nurses Regulation under the *Health*

Professions Act. Prior to this, the profession was regulated under the *Nurses (Licensed Practical) Act*. The College regulates 5500 nurses in the province.

The College has taken a broad approach to adopting the principles and techniques of quality management, having established in 2002 a Quality Accountability Council as leadership group responsible, among other things, to establish a Quality Accountability Framework linked to the College's Strategic Directions. The Framework has a much broader role than simply ensuring the continuing competency of practitioners; it covers all aspects of College operations. The terms of reference of the Quality Accountability Council state that the Framework is to be developed and implemented "consistent with the guiding principles of a client-centred, evidence-based and outcomes-focused approach to processes and systems across all aspects of the College Governance, Management, Committees and Operations." The College has engaged in a process of identifying performance indicators across the full range of its activities, for reporting to the Board on a regular basis.

The College has articulated six Standards of Practice and identified a number of indicators for each of Knowledge, Competent Application of Knowledge, Provision of a Service to the Public, Code of Ethics, Regulation of Own Practice, and Responsibility and Accountability.

The College addresses the issue of practitioner competence through a mandatory Continuing Competence Program introduced in 1999. Over a five year cycle, a random annual selection of nurses is required to complete the GROWTH (Growth, Reflection, Opportunities, Worth, Thoughtfulness and Healing) program. This process consists of a professional portfolio and a competency review.

The professional portfolio is a self-reflection tool which provides a framework to identify professional strengths and learning needs. It is envisioned as a life-long learning tool to be kept up to date throughout the nurse's career. The tool provides a format for self-assessment against the Standards of Practice indicators, and for identification of a learning plan. The portfolio may include various supporting documents such as educational transcripts, performance appraisals, letters of reference, awards, and other material the user finds relevant. Personal or confidential information about clients or colleagues is not to be included without consent, and the documentation notes that the portfolio need not be shared with employers or co-workers. Nor is the portfolio submitted to the College.

The competency review is a questionnaire which is submitted to the College.

As with some other Colleges, the view was expressed that peer review processes were limited by the lack of evidentiary protection for this activity.

Massage Therapy

Massage therapy has been regulated since 1946, originally under the *Physiotherapists and Massage Practitioners Act*, and since 1995 by the College of Massage Therapists of British

Columbia, pursuant to the Massage Therapists Regulation under the *Health Professions Act*. The College regulates about 1700 practitioners.

The College publishes its Continuing Education Policies and Procedures on its web site. The policy requires mandatory continuing education as a condition of continued registration. Active registrants must complete 24 credits of continuing education over a two year cycle (each cycle begins on November 1 of an even-numbered year). There are provisions to prorate this requirement for new registrants, and for setting credit requirements for inactive registrants returning to practice.

The Quality Management Committee (QMC) of the College evaluates and accredits courses and activities that contribute to the professional standards for massage therapy. The complete listing of accredited courses and activities is published on the college's web site. The listing indicates the provider or instructor offering each activity, the number of credits for the activity, and the coding category under which it is to be reported to the College.

The required 24 credits must consist of a minimum 14 "practical education" credits (up to a maximum of 24 credits) and may include up to 10 credits for "professional development." Registrants must report to the College, not only the credits completed, but also the type of practical education or professional development, using codings set by the College for these activities.

Practical education may include on-site activity, distance education, attendance at a lecture or conference, or other activity approved by the QMC. Up to 8 credits may be approved for participation in educational or examining activities (as an instructor, assistant, exam author, examiner or model). The QMC also accredits audio or video tapes, books and other materials, and registrants who use these and pass the open-book exams can obtain credit, up to maximums in each cycle, as described in the published policy.

Practical education credits may be given for participation in a study group whose frequency and content must be approved. The College publishes criteria for the accreditation of study groups, requiring description of the content, format and duration of study. The provision of an anonymous, relevant case history of clinical record is required, as well as written verification that the activity has occurred. Sessions may be evaluated by the QMC on a random basis.

Professional development credits are awarded for activities concerning the business practice of the professions, such as professional ethics, communication skills, and record-keeping. They may be given for accredited on-site or distance education activity, and may also be given for publication in a QMC-recognized professional journal or periodical.

The College requires registrants to report and code their credits by October 31 of the last year of the cycle, and to provide written certification or verification of completion of each activity.

Medicine

Medicine has been regulated under provincial enactment since 1867. The College of Physicians and Surgeons of British Columbia currently regulates the profession pursuant to the *Medical Practitioners Act*. There are in the order of 8500 physicians active and practicing in the province, plus approximately 500 out of province registrants who hold BC licensure but are not active.

In addition to being interviewed, the College provided the following written statement outlining its QA activities:

"With respect to continuing medical education (CME), the College relies on the requirements of the accreditation bodies i.e. the Royal College of Physicians and Surgeons and the College of Family Physicians of Canada, which are the accreditation bodies for specialists and family practitioners respectively. Both these organizations have extensive monitoring programs for continuing medical education, and accreditation status with those bodies is dependent on fulfilling their requirements. In general, these requirements include 50 hours of CME in various forms per year. It should be noted that while CME is easy to measure and monitor, it is a poor indicator of physicians' skill and competence. Most medical licensing bodies in Canada, in accordance with detailed evaluations through the Federation of Medical Licensing Authorities of Canada, have opted for the "performance model" as being more indicative of the quality of care that physicians provide their patients. In other words, while CME addresses what the physician knows or should know, performance defines how that knowledge is applied to patient care. The measurement of performance is, of course, more complex then a rather simplistic compliance with continuing educational requirements. It is also a well known fact that physicians are likely to take part in CME activities in areas which they have interest in, while other areas where they have no interest and where performance might be lacking are not likely to be the subject of continuing medical education or academic pursuit. Nevertheless, at a very recent meeting of our Council, it was decided that confirmation of continuing medical education standards either through the Royal College or the College of Family Physicians or through other means may be desirable.

The College administers a program called the Committee on Office Medical Practice Assessment (COMPA) which reviews physicians' office practices. Between 150-200 offices are audited each year involving both specialists and general practitioners. The program involves trained physicians spending a 1/2 day in an office discussing office management and patient management with the physician, reviewing medical records, looking at office equipment, telephones, staffing, accessibility and many other aspects of medical practice. Physicians are either selected at random or are targeted on the basis of certain well-established criteria. There is no disciplinary aspect to these reviews and they are fully remedial. Where significant deficiencies are identified, follow-up assessments are conducted. Also, the assessed physicians receive a detailed summary of the practice review.

The COMPA program has also been expanded to include self-assessment. About 800 physicians each year receive the protocols, which are used by the COMPA assessors, with the invitation to apply the various criteria to their own practice. This program is designed to remind physicians

of the various factors which should be reviewed and the standards which are current for office practice.

The College funds the Clinical Competence Program ... which operates through the Division of CME at UBC. This program involves a two day assessment of the skills and knowledge of a general practitioner. The program provides a measure of the strengths and weaknesses of the physicians and, as well, an educational prescription to address identified deficiencies. Some physicians self refer to this program, others are requested to undertake the program by the College, having been identified as being of concern through other College processes.

The College administers a program called the Diagnostic Accreditation Program (DAP) which accredits, subsequent to review and inspection, all diagnostic facilities in the province. Therefore, laboratories, x-ray facilities, hospital pathology departments, EEG facilities, EMG facilities, respiratory function facilities, nuclear medicine departments, and so on must be accredited and must meet the well established criteria for the operation of such facilities, before physicians are allowed to refer to them. This applies to both public hospitals and private diagnostic facilities.

The College administers a program called the Non-Hospital Medical/Surgical Facility Program through which it inspects and accredits more than 50 private surgical facilities in the province. These facilities vary significantly in complexity and size. They include multi-disciplinary facilities such as Cambie Surgery Centre and False Creek Surgical Centre which provided a facility for a variety of operative procedures, and opthalmological facilities, cosmetic surgery facilities, and so on. These facilities provide uninsured surgical services to patients but also provide many procedures which are paid for outside of the Medical Services Plan by organizations such as the Workers' Compensation Board and ICBC. Again, physicians can only practice in accredited facilities. Depending on the size of the facility, many physicians, especially surgical specialists, may have privileges and procedural privileges in such clinics.

The College has always felt that it is essential for physicians to have access to up to date, comprehensive medical information. Since practising physicians do not have access to University Medical Libraries unless they are on University staff, the College has, for years, maintained its own College Medical Library. This Library has a staff of 10 and is designed to provide physicians with up to date information upon request. The annual budget of the Library is over 1 million dollars and statistics show that approximately 1/2 the College membership accesses the Library at least once per year. Physicians, may of course, have access to University Libraries if they are on the University staff or may personally subscribe to journals and other publications based on their specialty and special interest.

The College publishes a quarterly newsletter which outlines current matters which physicians should be aware of, and also highlights issues which have led to complications or complaints which the College has had to adjudicate.

The College administers a number and variety of drug prescribing programs. The most visible one is called the Triplicate Prescription Program which monitors the use of narcotics and deals with situations where narcotics may be over prescribed, used inappropriately or where patients

may be multi doctoring in order to obtain narcotics and mood altering drugs. This program has also been extended to drugs such as benzodiazepines and other drugs which are subject to abuse. The program is remedial and educational and through various mechanisms identifies situations where physician prescribing may not be fully appropriate, allowing for such a concern to be pointed out to the physician involved. It is of course impossible for the College to monitor all prescriptions of mood altering drugs, but through fairly sophisticated computer programs, multi doctoring by the same patient or high level prescribing or use of certain drugs can be identified. Unusual situations result in correspondence with the physician where he or she is provided with the opportunity to provide reasons for the identified concern or to change the pattern of prescribing.

The College administers the Provincial Methadone Program. Physicians who are authorized to prescribe methadone must meet certain criteria before such authorization is extended. These include educational endeavours and other requirements and compliance with protocols. Physicians prescribing methadone are audited by individuals experienced in that area. Approximately 100 physicians receive such an audit each year.

The College was involved in the development of clinical practice guidelines. However, by agreement this responsibility has been transferred to the Medical Services Commission who, along with the B.C. Medical Association, has established a clinical practice guideline and protocol program.

The College developed an advisory panel on physicians' credentials. This program provides advice to smaller hospitals with respect to physicians' credentials and procedural privileges. The program is currently inactive because of the enormous changes that are occurring in health regions and the planned regionalization of the credentialling function.

The College expends much time and energy in dealing with approximately 1200 complaints each year. While a very small number of complaints ultimately result in disciplinary action, the vast majority are handled through remedial and corrective processes. Therefore, physicians who are subject to a complaint with respect to conduct, competence or quality of medical care provided, where the concern is found to be valid, receive advice from the College as to how such situations should be avoided in the future. In other words, we consider complaint management to be remedial and educational with the understanding that there are situations where disciplinary action may need to be instituted.

In some situations, the College, in accordance with Section 53(6) of the Medical Practitioners Act, will resolve to review a physician's practice in detail. This may result from a complaint or complaints, a review of prescribing profiles, concerns expressed by a colleague or other indications. Such reviews provide a detailed analysis of the physician's practice which is provided to the physician with specific instructions as to what changes are required. Such reviews may, of course, lead to further disciplinary action.

Physicians who are members of hospital staff have their practices in hospitals scrutinized through medical staff mechanisms including credentials committees, departmental reviews, and

hospital based quality assurance mechanisms. While such reviews are largely independent of the College, if concerns are identified the College becomes involved in addressing these matters.

While the College is not an educational institution, it is involved in courses and conferences which provide specific education and direction to physicians. The College operates workshops for methadone prescribers 3 or 4 times per year. About 50 physicians attend each of these workshops. The College co-sponsors, along with the Oregon Foundation for Medical Excellence, 2 annual courses on the treatment on chronic pain and the management of patient addiction. Between 125-200 physicians attend each of these courses. The College sponsors an annual Ethics Conference, which provides instruction and discussion of medical/ethical matters. The College is involved in co-sponsoring and making presentations in the Annual Conference of Physician Leaders attended by medical administrators, chiefs of staffs, and heads of departments. The College also has significant involvement with the University Department of Continuing Medical Education in the area of telemedicine, ethics and professionalism. Members of the College staff also make periodic presentations on a variety of subjects to medical students, medical residents, and local medical associations and organizations."

Midwifery

Midwifery became a self-regulating profession in 1995 under the College of Midwives of British Columbia, pursuant to the Midwives Regulation under the *Health Professions Act*. A total of 83 midwives are registrants.

The College's current QA program falls under two categories: Continuing Competency, and Requirements for Active Practice.

The College has articulated three policies on continuing competency, in the following areas:

- neonatal resuscitation: annual certification is required, by completing a course meeting or exceeding the *National Guidelines for Neonatal Resuscitation* of the Interdisciplinary Committee, Canadian Institute of Child Health, as these apply to the scope of practice of midwifery. A midwife who is a certified NPR instructor may meet the requirement by providing evidence of a current NPR instructor's certificate and having taught at least one NPR course in the previous twelve months.
- cardiopulmonary resuscitation: certification every 2 years is required, to a minimum standard of Basic Rescuer (Level C) of the Canadian Heart Foundation.
- emergency skills in obstetrics: registrants must successfully complete a course of assessment of emergency skills in obstetrics, every three years. The required standard is completion of a full-day course of assessment that covers six specific areas defined by the College. The College's policy sets out five acceptable programs/assessments, and the Quality Assurance Committee may accept other courses as equivalent. Certified instructors who provide evidence of having instructed or examined in such a course in the previous 36 months may be considered to have met this requirement.

In addition to its policies of mandatory continuing education, the College has established requirements for active practice as a condition of renewal of registration. Reflecting the view that it is important to ensure new registrants have adequate exposure to practice, the required number of births per year attended as a midwife is greater for registrants in the first two years of practice, than thereafter. Registrants in the first two years must attend 40 births as principal or second midwife, over a two year period; thereafter, attendance at 60 births over a five year period is required. The policy also stipulates that minimum numbers of births be attended in an out-of-hospital and hospital setting. Somewhat different standards are set for registrants engaged in research or teaching, and for registrants serving special needs populations.

The College has had a draft "Peer Case Review Policy" since 1997, but has not made this mandatory, due to concerns that there was not legislative protection for the confidentiality of the process, as is provided for hospital QA by the terms of the *Evidence Act*. The College feels that similar evidentiary protection must be afforded for processes that take place outside of hospital settings, in order to implement this policy.

The College is cognizant of the seven components of QA programs which have been defined by the College of Midwives of Ontario in regulations under that province's *Midwifery Act* (provision of clinical information; continuing education and professional development; peer case review; quality of care evaluation; self-assessment; practice audits; remediation of behaviour and remarks of a sexual nature). These seven components are being considered by the British Columbia College in its development of its own QA programs.

The College is waiting for upcoming amendments to the *Health Professions Act*, which are expected to further define the required framework for College Quality Assurance Programs, to be finalized before proceeding with further development of its QA program.

Naturopathy

Naturopathic physicians have been subject to provincial legislation since 1886 and became self-regulating under the *Naturopathic Physicians Act* in 1936. In 1999, the *Naturopaths Act* was repealed and the regulation of the profession is now under the College of Naturopathic Physicians of British Columbia, pursuant to the Naturopathic Physicians Regulation under the *Health Professions Act*. There are approximately 180 naturopathic physicians in British Columbia.

The College noted its entry requirements include at least 3 years undergraduate study at a College-approved post-secondary institution, graduation from a College-approved school of naturopathic medicine program that requires at least 4500 school hours over four years, successful completion of College-approved North American Board of Naturopathic Examiners (NABNE) exams in a wide range of subjects, and successful completion of the College's oral and jurisprudence exams.

The College has articulated a Continuing Education Policy which requires the completion of a minimum of 40 hours over a two year period (from February 1, 2002 to January 31, 2004). Registrants may meet the Continuing Education requirement by completion of up to 40 hours Category "A" credits or a combination of Category "A" and Category "B" credits, provided that a minimum of 10 hours in Category "A" is met.

Category "A" hour credits are granted for participation in annual general meetings or committees of the College, annual general meetings or conclaves of other naturopathic physicians' associations as specified in the policy, or other professional health associations' committees or meetings. (Maximum hours are stipulated for each of these.) The College policy expressly states that "a Naturopathic physician cannot consider themselves competent in the field of Naturopathic medicine if they do not attend Naturopathic centered meetings, e.g., CNPBC, BCNA, ONA, NWNC, or CNA meetings. It is essential to each physician that they be aware of changes to legislation, professional responsibilities, etc. This information is often only attained by attendance at the aforementioned meetings."

Category "A" hours can also be granted for participation as a committee chair or member, board member, or officer, up to maximums for each type of participation as set out in the policy, and an overall 10 hour maximum.

Category "B" provides credit (up to 30 hours) for participation in educational courses and seminars that are accepted by recognized health care professions and professional bodies (examples are provided in the policy), and providing the College with the seminar schedule and allocated hours. In questionable cases, registrants must obtain prior approval in order to ensure credit will be granted.

Naturopathic physicians are also required to maintain continuing education hours for College approved specialty therapies including chelation therapy, ozone therapy, hyperbaric therapy and acupuncture. Verification of completion of four hours per four years must be provided to the College to maintain certification in the specialty.

Credit may also be given for:

- business or practice management courses, up to a maximum of 5 hours per two year period
- subject to pre-approval, up to 5 hours may be credited for use of video or audio tapes of courses and meetings
- preceptor-ships
- teaching or giving seminars
- courses concerning procedures or techniques not part of the naturopathic legislation, so that members may express to patients the advantages or disadvantages of these procedures.

The College engages in general professional improvement through presentations at Annual General Meetings, including description and review of the outcome of complaints processes, and other communications with its members.

Under the supervision of the Standards of Practice Committee, a program of office visits was formerly provided under which members were given assistance in improving their practice. Due to the substantial increase in the number of registrants, the office visit program has not been active, and the College has instead tried to convey similar information in workshops.

The College also notes that the outcome of disciplinary processes may involve remedial activities which have a quality improvement component.

Occupational Therapy

The College of Occupational Therapists of British Columbia was established under the Health Professions Act in December 1998 to regulate the profession pursuant to the Occupational Therapists Regulation. There are approximately 1200 occupational therapists in B.C.

As a relatively new College, the Quality Assurance Program is in a formative stage. The Board of the College adopted a Quality Assurance Program in January, 2003 which articulates the Philosophy, Goals and Guiding Principles to ground the program as it is developed.

The QA Committee of the College is, pursuant to College bylaw, responsible to make recommendations to the Board on continuing competency requirements, re-entry to the profession, essential competencies of practice (formerly "standards of practice"), professional ethics, and professional practice guidelines.

A key focus of the College's planning for its QA programs is the *Essential Competencies of Practice for Occupational Therapists in Canada* (ACOTRO, 2000). This document was developed jointly by the regulatory bodies for occupational therapy in all provinces in Canada. The essential competencies were developed in the context of labour mobility issues and the definition of entry-to-practice requirements across the various jurisdictions. The College adopted this document in January, 2001, as its Standards of Practice, and the competencies therein defined are being used as basis for QA/Continuing Competency program development. The published Principles of the QA Program state that it is to be "based on a competency-based framework."

The Board has articulated a QA philosophy "founded on the assumption that each registrant is a competent practitioner and motivated to maintain, develop and improve their level of competence based on accepted essential competencies." In the College's view, professional accountability entails that the "fundamental responsibility for ensuring quality practice rests with each individual registrant."

The College has articulated eight QA Program goals. These include ensuring registrants are aware of the Essential Competencies, the Code of Ethics, and Professional Practice Guidelines, and that they are engaged in the Continuing Competency Program. Registrants who do not meet the essential competencies are to be "engaged in a competency improvement process until competency is attained."

Among the Guiding Principles articulated by the College, it may be noted that there is an explicit requirement for evaluation of the QA Program. The QA Program will "self-evaluate using objective indicators and adopt best practices."

Opticianry

Opticianry has been self-regulating since 1994, by the College of Opticians of British Columbia, pursuant to the Opticians Regulation under the *Health Professions Act*. The College has approximately 1200 registrants.

The College introduced a self-assessment questionnaire in 2002. This questionnaire is only completed by registrants who are contact lens fitters on a 3 – 4 year rotational schedule. The "Continuing Competency Assessment" form includes sections on equipment and supplies; client files; interpretation of prescriptions; prefitting evaluation; contact lens selection, ordering, and delivery; follow-up procedures; physiological responses; fitting; and lens modifications. Where areas are assessed as deficient, the respondent must identify an action plan and completion date.

In addition, to maintain the annual license for contact lens fitting, minimum requirements for the number of certain specified fitting requirements have been established.

The view was expressed that health professions carried out in commercial environments (and where the registrant may not themselves own the practice), such as characterize opticianry, may present both opportunities and challenges for regulators seeking to implement various types of QA programs. On the one hand, it was felt that opticians would be highly motivated to identify and obtain state-of-the-art training in the techniques and technologies that are both relevant to their professional practice and which may also be a commercial benefit. On the other hand, programs involving peer review could be difficult to implement in an environment where one's peers may well be one's business competitors. Concern was also expressed that peer review could not be implemented in the absence of evidentiary protections as provided by the *Evidence Act* for hospital based QA programs.

Optometry

The Board of Examiners in Optometry of British Columbia regulates the practice of optometry. The Board is established pursuant to the *Optometrists Act*. There are approximately 400 registered optometrists.

It was not possible to obtain input from this Board prior to the expiry of the term of this project.

Pharmacy

The College of Pharmacists of British Columbia regulates the practice of pharmacy, pursuant to the *Pharmacists, Pharmacy Operations and Drug Scheduling Act*. Approximately 3400 pharmacists are registered with the College.

The College's QA program is structured around the Framework of Professional Practice (FPP) adopted by the College in June, 1997, revised in April 2003 and validated by practicing pharmacists. The Framework presents a good practice model and is considered an intrinsic part of the College's QA program. The Framework defines why the profession of pharmacy exists and the five primary roles that pharmacists perform, whose components are further sub-detailed:

- provide pharmaceutical care;
- produce and distribute drug preparations and products;
- contribute to the effective operation of the pharmacy;
- maintain professional development and contribute to the professional development of others; and
- contribute to the effectiveness of the health care system.

The Framework is published on the College's website.

Until recently, the College's quality assurance program was the RxCARE program (Pharmacist Continuing Assessment, Reflection and Enhancement). Effective 2003, the College has introduced a new Professional Development and Assessment Program (PDAP), the first cycle of which commences in September, 2003. Information on the PDAP program has been sent to pharmacists and is available on the College's website.

Under PDAP, all pharmacists are encouraged to complete the Self-Assessment Form based on the FPP, annually. Only pharmacists selected for the particular cycle are required to submit the completed Self-Assessment Form to the College. Once every three years the College will randomly select approximately 1500 pharmacists to take part in the program. Every pharmacist will be required to participate once every six years. Pharmacists who have not been selected for a particular cycle may elect to register in the program should they choose to do so. Pharmacists who successfully completed the RxCARE program are exempt from PDAP until 2005. Exemptions are also granted to those pharmacists who are licensed with the College and within the past five years have completed the national Pharmacy Examining Board of Canada (PEBC) Objective Structured Clinical Examination (OSCE) or have been assessed under other specified provincial regulatory authority programs.

The pharmacists selected to participate in the September 2003 program were advised in March, 2003, and during April, May and June, 2003, seventeen orientation sessions were held throughout the Province to further inform registrants about the new program.

PDAP starts with a self-assessment, after which the pharmacist selects one of two options: a Knowledge Assessment, or a Learning and Practice Portfolio. The Self-Assessment tool permits registrants to compare their practice to a blueprint of good practice described in the Framework

of Professional Practice. Pharmacists selected for self-assessment will submit this document to the College; others need not do so.

On the basis of the self-assessment, pharmacists may choose to participate in the Knowledge Assessment, which is an open book exam of 2.5 hours on pharmacy practice knowledge and problem-solving skills. It will be held at least three times a year in communicates across the province. Feedback will be made available by way of a score and detailed report. Alternatively, pharmacists may choose to complete the Learning and Practice Portfolio. This may be most relevant for pharmacists working in direct patient care, and enables the participant to determine what is to be learned, how it will be learned, and how the new learning will impact practice and/or patient outcomes. Feedback will be provided within three months.

Completion of the self-assessment and either the Knowledge Assessment or Learning and Practice Portfolio requirements constitute Phase 1 of PDAP. Pharmacists who are unable to meet the program requirements for Phase 1 within 18 months will enter Phase 2 of the program, which includes taking the same assessment option (the Knowledge Assessment or the Learning and Practice Portfolio) or another option, either the Practice Audit or the OSCE. Professional and peer support will be provided for those who wish to have it during Phase 2. Pharmacists who are unable to meet Phase 2 requirements would move on to Phase 3, which is an individualized program of remediation and reassessment.

Physical Therapy

The College of Physical Therapists of British Columbia has regulated the practice of physical therapy since its establishment on December 6, 1994 by regulation under the *Health Professions Act*. The profession was first regulated in 1946 under the *Physiotherapists and Massage Practitioners Act.* Published figures indicate there are about 2700 physical therapists in the province.

The College's Quality Assurance Committee is responsible for issuance and revision of Clinical Practice statements which include statements on Clinical Records, Electrotherapy, Consent to Treatment, Sexual Misconduct, Infection Control, and Acupuncture. An Acupuncture Credentialing Sub-committee which reviews and approves physical therapists' acupuncture credentials.

The College's QA initiatives are delegated to a number of College committees.

The Continuing Competency Sub-committee recently introduced a continuing competency program. Registrants will be required to complete a professional portfolio, beginning fall 2003, on an annual basis in order to maintain their registration. A web version of the professional portfolio is under development and a Clinical Practice Statement will be issued regarding the professional portfolio. In addition, to maintain registration, registrants must accrue 1200 practice hours over a rolling 5 year period, as outlined in the College's cCclinical Practice Statement. An audit process for the continuing competency program will be developed.

The Continuing Competency Sub-committee also provides ongoing information to registrants via newsletters, website (www.cptbc.org), and presentations, and by responding to registrants' phone and email inquiries. The College's website publishes the College Bylaws, Clinical Practice Statements, and Advisory Statements as well as an overview of the continuing competency program and frequently asked questions.

Finally, the Patient Relations Committee makes recommendations to the Board regarding the administration of a patient relations program to seek to prevent misconduct of a sexual nature. This program includes establishing educational requirements for registrants, establishing guidelines for conduct of registrants with their patients, and informing the public about registrants' responsibilities and the role of the College in the investigation of complaints about sexual misconduct.

Podiatry

The BC Association of Podiatrists is established pursuant to the *Podiatrists Act* to superintend the practice of podiatry. The Act also establishes a Board of Examiners in Podiatry. Approximately 80 podiatrists are registered.

The BCAP has a Continuing Medical Education (CME) Committee that it considers as equivalent to a QA Committee, and sees QA as being a consideration of all its committees. The primary QA mechanism is a CME program, requiring the completion of 60 hours over two years, and CPR training. The BCAP notes this requirement is among the most demanding in North America and is on a level with the College of Physicians and Surgeons of BC.

CME credit is primarily based on course/seminar attendance. Self-guided journal reading, accredited and tested correspondence courses, lecture development, x-ray conferences, and teaching, are all additional sources of CMEs. All members' CME reports are reviewed by the Executive Director for totals, credit distribution, accreditation, and relevance. Any reports in question are then reviewed by the CME Committee Chair, and if found failing in relevance or accreditation, are disallowed. This formal process is recognized within the profession both in Canada and in the United States.

CME accreditation is achieved via prior review of content, quality, and relevance. The BCAP accepts for CME credit courses approved by the Canadian Council of Podiatric Medical Education (CCPME), and notes that the accreditation of courses is a complex process best carried out by an external party. CCPME is the nationally recognized body that is assigned the task of formal accreditation of CMEs for podiatrists.

There are a number of mechanisms to review or audit individual practices. The Patterns of Practice Committee conducts reviews and audits on general aspects of practice. A separate Peer Review Committee plays a very important part in the BCAP's QA program. The Peer Review Committee's mandate is to review all complaints received from patients and other practitioners.

Using information obtained from reviewing the complaints, the Peer Review Committee, through its investigation of complaints and recommendations based on its findings, sets standards for conduct of podiatrists. These standards are important in assuring continuing quality in the practice of podiatry

These processes are primarily complaint-driven but can be on the Committees' own initiative. The general nature of the processes is disciplinary, but the outcome of these processes could include undertakings which have a QA or continuing competence aspect, e.g. to take seminars (including "hands on" seminars) or work in association with another member in surgery practices.

The BCAP takes the view that ongoing evaluation of its members by their peers is an important QA tool. However, it expressed serious concerns as to the validity and accuracy of self-assessment tools, and cited this as a reason it requires confirmation and testing of correspondence courses, and accreditation and confirmation of CME hours.

The BCAP acknowledges it does not have an ongoing program which tests, audits or surveys its membership, noting this concept is not mandated by its current bylaws or the *Podiatry Act*. In the past, practice auditing and review was performed by, and paid for by, the Medical Services Plan (MSP). BCAP members were hired to perform these audits based on billing information from MSP, and any deficiencies that were found were shared with both the Patterns of Practice Committee and Peer Review Committee. As a number of podiatric services have been de-insured by MSP, this information is no longer available and is now limited to the MSP billing patterns of podiatrists who have a surgical practice. On this basis, the Surgical Committee of the BCAP does on site visits. Consideration is being given to whether an auditing procedure will need to be established, as MSP billing information is no longer available. The BCAP expressed concern about a lack of communication from MSP regarding future plans for practice auditing.

The Surgical Committee is also in the process of instituting measures to evaluate its members who are currently approved to do surgery. For 2004 license renewal, members will have to complete a questionnaire regarding case numbers for the year 2003. Starting in 2004, members performing surgery in BC will be required to keep a surgical log of all cases. Copies of the log will be required to be submitted each year for license renewal. This will allow the Surgical Committee to ensure that members approved to perform surgery are keeping up their skills. The Surgical Committee also investigates complaints about surgeons and makes recommendations to the Executive Committee. In addition, new applicants for surgical privileges are now required to have a two-year or greater surgical residency that is approved by the US-based Council of Podiatric Medical Education (CPME), and will be expected to attain Podiatric Surgical Board (American Board of Podiatric Surgery) Certification within seven years.

Generally, the BCAP does not itself become involved in course development, although it does sponsor an Annual Scientific Conference, for which the Canadian Podiatric Education Foundation (CPEF) takes the lead in course design and content. The BCAP notes this occasion is when development of formal learning plans is undertaken. The continuing education credits/contact hours (about 22 hours) that are provided to the delegates are approved by CPEF, which is the only sponsor of continuing podiatric medical education nationally approved by both

the CPME and the CCPME. Also, every five years the BCAP hosts the Region 7 seminar (a scientific seminar offered by an association of members of Western Podiatric Associations, both American and Canadian), and many of its members attend this seminar every year. The BCAP notes that conferences of this kind are the standard for podiatry CME in North America.

The BCAP stated that as an organization it takes CME very seriously, noting that most CPEF working members are from BC and all of those are BCAP members. On behalf of each member, the BCAP contributes $50 per year to Region 7 and $100 per year to the Canadian Podiatric Education Fund (via the Canadian Podiatric Medical Association). These payments are used to fund continuing education programs in which all members can participate.

Throughout the academic year there are also monthly meetings held for local podiatrists in the greater Vancouver area. These academic meeting are held in conjunction with the surgical podiatry residency within the post-graduate residency-training program, based out of Vancouver General Hospital and the University of British Columbia. Most of these meetings focus on group discussion of "special problem" cases or unique pathological findings. These meetings benefit both those bringing in their cases, in order to get various "expert" opinions all at one time, but also they benefit those that attend to watch and learn. Attendance records are kept, and CME credits are issued.

The BCAP anticipates that the pending amendments to the *Health Professions Act* will provide a means to update and mandate its QA tools. However, as with many small colleges, it expressed concern that elaborate QA programs could be too costly to implement and could overburden its volunteer-based committee structure.

Psychology

The profession has been self-regulated since the enactment of the *Psychologists Act* in 1977. The College and professional association diverged in 1993. Since January 2000 the profession of psychology has been self-regulated under the College of Psychologists of British Columbia since 1999, pursuant to the Psychologists Regulation under the *Health Professions Act*, and the concurrent repeal of the *Psychologists Act.* The College regulates approximately 1000 registrants.

The College noted that the profession's concern with QA predates its current regulatory structure under the *Health Professions Act*. In particular, the Quality Assurance Committee had reviewed empirical research on continuing education programs, and concluded that there was no evidence to support the view that increased continuing education would result in fewer practice complaints.

Accordingly, the Committee focussed its attention on developing a self-assessment tool for the use of practitioners. The *Self-Assessment Guide* (November 2001) is a 63 page document of checklists and guidelines in the four areas of Business Practice, Professional Client Services, Research Activities, and Teaching. These four areas are further subdivided into specific

elements: for example under Professional Client Services there are subheadings for Assessment Procedures, Intervention Procedures and seven other topics. Each of these is supported by specific references to various published standards, codes of conduct, bylaws, legislation and other referenced sources. Questions are posed in regard to each topic, to guide the practitioner in self-assessing against these standards.

The *Self-Assessment Guide* is reported to have been well accepted by practitioners. The results of the self-assessment remain with the practitioner and are not submitted to the College. It is felt that requiring the submission of the results of self-assessment would pose difficulties insofar as the College must also exercise a disciplinary function which could be inconsistent with the review of this material.

The Quality Assurance Committee of the new College will be considering a policy on a continued competence program which will establish minimum annual hourly requirements for participation in workshops, conferences, self-study and informal or interactive activities. It is expected that within the overall total requirement, minimums will be set for particular activities such as professional ethics. Achieving the minimum standards will be a condition of renewal of registration, and registrants will be required to keep records of their attendance or participation in activities. Subject to legislative authority being in place, the College may conduct random audits to confirm the completion of these requirements. At the time the interview was conducted, the draft policy (though not yet approved) contemplated introducing these requirements in January 2004 to coincide with 2005 registration renewals.

The College has expressed concerns similar to a number of other colleges that appropriate evidentiary restrictions be placed on information gathered for QA purposes.

The College also plans to develop further QA material ("Frequently Asked Questions") to be published on its website to inform and educate registrants.

There are no formalized peer review activities, although it was noted the consultation among psychologists happens already and is endorsed in the Code of Conduct. It is also possible that some sort of peer supervision could be ordered as remedial measure arising out of disciplinary actions.

Registered Nursing

The profession has been self-regulating under its own Act since 1918. The Registered Nurses Association of British Columbia is the regulatory body established pursuant to the *Nurses (Registered) Act*. There are approximately 30,000 practising registered nurses in British Columbia.

The Continuing Competence Program is the outcome of a lengthy process of consultation, development, member education, voluntary and ultimately mandatory participation in the

program. It was identified as Board priority in 1995 and was first introduced on a voluntary basis in 1999, and became mandatory in 2000.

The Continuing Competence Program as articulated in Part 6 of the *Nurses (Registered) Act Rules* establishes two requirements as preconditions to renewal of or conversion to practising membership: completion of a minimum number of hours of practice within the preceding five year period, and meeting the requirements of a personal practice review. There are no mandatory continuing education requirements, although it is noted that there are a variety of educational opportunities available to nurses (including courses and programs sponsored by the RNABC) and that some employers may mandate participation in educational activities. It is further noted that continuing education is one of the main types of learning activities used by registrants in meeting the requirements.

The continuing competence requirements are couched within the framework of the *Standards for Nursing Practice in British Columbia.* The RNABC has articulated six standards: Responsibility and Accountability, Specialized Body of Knowledge, Competent Application of Knowledge, Code of Ethics, Provision of Service to the Public, and Self-Regulation. These are published in a document which includes, for each Standard, a number of indicators which are further divided into indicators appropriate for clinical practice, education, administration and research areas.

The Standards are also published in a document, *Professional Development: A Short Guide to Meeting Continuing Competence Requirements* which provides a self-assessment questionnaire against the standards, guidelines for obtaining and giving peer feedback, and suggestions for implementing a learning plan. This document also sets out the minimum practice hours, and identifies further resources.

In order to meet the requirements of the personal practice review, the registrant must make a written declaration stating that a self-assessment using the Standards has been completed, peer feedback has been sought and received, a learning plan has been implemented, and the impact of the learning on practice has been evaluated. Aside from this declaration, the information contained in the self-assessment, peer feedback and learning plan is confidential and is not disclosed to the College.

The College does, however, conduct an annual audit to verify participation in the continuing competency program. This does not involve submitting the personal practice review to the College; rather, an audit form must be completed and returned to the College. It is the intent that the audit form could only be completed if a person had actually participated in the continuing competency program as set out. The audit is designed to assess how the registrant completed the process and this information is used to assess the effectiveness of the resources available to registrants. Like a number of other Colleges, the RNABC has concerns about blurring the competency program with the College's disciplinary processes.

The RNABC carries out a variety of other activities which promote the general standard of nursing practice and address the particular needs of nurses and the public. These include:

- publication of Nursing Practice Guidelines
- a number of other publications and guidelines

- operation of a nursing library
- providing advice and consultation to respond to inquiries from nurses, through the services of five nursing practice consultants and eleven nurse advisors
- publication of a Continuing Education Calendar including teleconferences and workshops
- offering an Agency Consultation Program to assist nurses, administrators and their employer agencies to apply continuous quality improvement principles to their workplace
- a Consumer Relations Representative who assists members of the public and others regarding complaints about registered nurses.

Registered Psychiatric Nursing

The profession has been regulated under legislation (the *Psychiatric Nurses Act of British Columbia*) since 1951, and since 1999 by the College of Registered Psychiatric Nurses of British Columbia, pursuant to the Registered Psychiatric Nurses Regulation under the *Health Professions Act*. Prior to its 1999 repeal, the *Nurses (Registered Psychiatric) Act* was the authority for professional regulation. There are approximately 2500 registrants.

Participation in the Continuing Competency Program became a registration requirement in 2000. The Program requires completion of a self-assessment based on standards of practice, development of a learning plan, evaluating the outcomes of the learning plan, and reporting annually to the College regarding participation in the Program. In addition, there is a requirement to practice 1400 hours as a psychiatric nurse in the five years preceding renewal (or complete a refresher course, or graduate from a diploma or degree program in psychiatric nursing).

The self-assessment is conducted within the framework of the *Standards of Psychiatric Nursing Practice*. The College publication, *Continuing Competency Program for Registered Psychiatric Nurses* lists the ten standards, their rationales, and sets out criteria against which the nurses can self-assess. In addition to providing a format for conducting the self-assessment, this publication provides a format and advice on developing the learning plan, and retaining supporting documents. All material in the self-assessment is confidential and is not provided to the College. Although the College may conduct random audits, these are by way of requiring completion of a summary form; the College has indicated its intent to keep the actual self-assessment material confidential.

The College promotes the general competence of the profession through a variety of other activities, including publication of professional practice guidelines and position statements on a variety of issues; providing a regular newsletter to the profession; and participating in annual education days and other conferences and congresses.

Traditional Chinese Medicine and Acupuncture

The College of Traditional Chinese Medicine Practitioners and Acupuncturists of British Columbia was established in December 2000, pursuant to the Traditional Chinese Medicine

Practitioners and Acupuncturists Regulation under the *Health Professions Act*. Previously, acupuncture was a self-regulating profession pursuant to the 1996 Acupuncturists Regulation under the *Health Professions Act*. The College presently regulates about 750 acupuncturists, and, as traditional Chinese medicine practitioners become registered, it expects its total membership to grow to 900 to 1000.

The Quality Assurance Committee for this College has been appointed but had not yet met at the time of the interview (it is expected to meet for the first time in 2003).

The College has defined the Core Competencies of acupuncturists and of traditional Chinese medicine practitioners. It is intended that the Core Competency document be used for a variety of purposes, including development of the QA program.

In regard to acupuncturists, a policy of mandatory continuing education was established by the predecessor College of Acupuncturists of British Columbia, requiring completion of 25 hours of continuing education every two years, in the areas of acupuncture practice, practice management, or clinical knowledge enhancement. The number of hours was to be reported at renewal of registration.

Under this policy, registrants were responsible to evaluate the qualification of lecturers, who were required to have 7 years' experience in the subject matter, or a university degree plus 3 years' experience, or a credential recognized by the College. The educational component of participation in conferences could count towards this credit. Registrants were required to maintain a file containing details of programs and evidence of attendance, to be available upon request by the College.

It was noted that the identification of appropriate courses is a matter for the professional judgment of registrants; the College does not pre-approve specific courses. In part, this is viewed as a consequence of a diverse registrant base.

The College has established a standard of mandatory hours of practice: 200 visits must be conducted in a 24 month period.

It is expected that the QA Committee, when it meets, will look at a variety of issues. These could include development of a registrants' handbook, and establishing policies or standards on clinical record-keeping. In common with a number of other interviewees, concerns were expressed that reconciling the College's disciplinary functions with QA's educational role would require the careful articulation of functions and policies.

APPENDIX C: MEETINGS AND TELECONFERENCES

Health Profession	Date of meeting*	Persons interviewed
Chiropractic	March 26, 2003*	Dr. Don Nixdorf, Executive Director, British Columbia College of Chiropractors
Dental Hygiene	March 17, 2003	Nancy Harwood, Registrar, College of Dental Hygienists of British Columbia; Fern Hubbard, Deputy Registrar
Dental Technology	March 18, 2003	Rosemary Ishkanian, Registrar, College of Dental Technicians of British Columbia
Dentistry	March 25, 2003	Dr. John Henry, Registrar, College of Dental Surgeons of British Columbia; Dr. John Silver, Deputy Registrar
Denturism	March 4, 2003*	John Mayr, Registrar, College of Denturists of British Columbia
Dietetics	March 18, 2003	Patricia McCuaig, Interim Registrar, College of Dietitians of British Columbia; Susan Miller, President, British Columbia Dietitians' and Nutritionists' Association (BCDNA); Mary Blackwell, Registrar, BCDNA
Emergency Medical Assisting	March 31, 2003	Ian Brethour, Registrar, Emergency Medical Assistants Licensing Branch
Hearing Aid Dispensing	n/a**	
Licensed Practical Nursing	March 12, 2003	Kirk Mitchell, Board Member, College of Licensed Practical Nurses of British Columbia
Massage Therapy	March 3, 2003*	Douglas M. McRae, Registrar, College of Massage Therapists of British Columbia

Health Profession	Date of meeting*	Persons interviewed
Medicine	March 24, 2003	Dr. Morris VanAndel, M.D., Registrar, College of Physicians and Surgeons of British Columbia
Midwifery	March 19, 2003	Jane Kilthei, Registrar, College of Midwives of British Columbia
Naturopathy	March 28, 2003	Dr. Lorne Swetlikoff ND, President, College of Naturopathic Physicians of British Columbia; Salim Kaderali, Registrar
Occupational Therapy	March 6, 2003	Kathy Corbett, Registrar, College of Occupational Therapists of British Columbia
Opticianry	March 11, 2003	M. Jane Lepinski, Registrar, College of Opticians of British Columbia; Annika Redford, Education/Exam Coordinator
Optometry	n/a**	
Pharmacy	March 13, 2003*	Brenda Osmond, Deputy Registrar, College of Pharmacists of British Columbia; Doreen Leong, Director of Assessment Programs
Physical Therapy	March 3, 2003*	Susan Paul, Practice Advisor, College of Physical Therapists of British Columbia
Podiatry	March 19, 2003	Dr. David Brooks, Secretary, Board of Examiners in Podiatry; Michael Choi. Secretary Treasurer, BC Association of Podiatrists (BCAP); Patricia Evans, Executive Director, BCAP
Psychology	March 20, 2003	Dr. Andrea M. Kowaz, Registrar and CEO, College of Psychologists of British Columbia

Health Profession	Date of meeting*	Persons interviewed
Registered Nursing	March 24, 2003	Laurel Brunke, Executive Director, Registered Nurses Association of British Columbia
Registered Psychiatric Nursing	March 12, 2003	Donna Higenbottam, Executive Director and Registrar, College of Registered Psychiatric Nurses of British Columbia
Traditional Chinese Medicine and Acupuncture	March 20, 2003	Randy Wong, Registrar, College of Traditional Chinese Medicine Practitioners and Acupuncturists of British Columbia

* Indicates meeting by teleconference or email exchange; other meetings were in-person.
** n/a = interview or teleconference could not be arranged during the term of the contract.

APPENDIX D: LITERATURE REFERENCES

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