Scope of Practice

Participants in the Conversation on Health discussed scope of practice at great length. They touched on topics such as the requirements for multi-disciplinary care and the re-defining of practitioner scopes of practice. Discussion centered on the roles of nurses, doctors, dental and pharmacological care specialists. Here is a sampling of what British Columbians had to say about scope of practice.

Re-defining Scope of Practice

Many participants request that scopes of practice be re-evaluated as many of British Columbia’s health care practitioners are currently over-worked and under-utilized. They argue that devolving responsibilities or expanding the range of duties practiced by professionals, such as dental assistants, may aid in filling service gaps brought about by current labour shortages. Participants also suggest altering practice regulations to reassign duties as practitioners see fit, while others believe legislation is necessary to establish scopes of practice. The younger generation of practitioners are a resource for new and innovative ideas that could be promoted through open forums with decision-makers. Participants also argue that professional colleges should assist the transition from an uncoordinated training approach in universities and colleges to a more open network of communication and cooperation.

Empower all health professionals to reach their full scope of practice through regulatory changes that reflect their training and education.

-Health Professional meeting, Vancouver

Multi-disciplinary Care

Encouraging a team model of health care delivery may require a shift in scopes of practice. Many participants agree that complementary and alternative, not just traditional health professionals should be able to refer, assess, and possibly prescribe medication to patients. Further, they state that alternative and complementary care practitioners should be included as integral parts of multi-disciplinary teams. Many participants believe that the midwife is an underutilized and at times, persecuted member of the health care system. Increasing their numbers, roles, and privileges within the hospital setting would free up many doctors and nurses and provide women with a safe and comfortable method of birthing.
Removing barriers to Multi-disciplinary Care (MDC) implementation requires that regulatory bodies and professional associations be closely involved in any proposed changes to the scope of practice for allied health professionals who work with physicians.

-British Columbia Medical Association, Electronic Written Submission

Nurses

Nurses’ scopes of practice were widely discussed, and many participants believe that nurses are capable of taking on greater responsibility and authority within the health care system. In particular, participants suggest that the nurse practitioner’s role be significantly expanded to assume a role similar to that of a general practitioner’s. In order to for this to happen, Licensed Practical Nurses and care aides must assume a broader set of responsibilities in their fields of practice. Delegating tasks to Licensed Practical Nurses and care aides may also result in reducing overtime hours nurse practitioners currently work. To ensure these new scopes of practice are adhered to, some suggested delegating a supervisor in the form of a head nurse to each floor of the hospital or care facility.

Physicians

The Conversation on Health discussion provides many ideas about changing physicians’ scopes of practice. Some participants contend that doctors must be open to the delegation or devolution of their duties; something they may currently be hesitant to do. Some argue that general practitioners should share their role as gate-keeper to health services; doing so would result in a decrease in the number of visits to the doctor’s office for only referrals. Patients awaiting results or basic advice should be able to consult with their physicians over the phone, further shortening the need for visits to the office. Some propose the implementation of a physician’s assistant, who would be responsible for the elementary procedures a physician would normally carry out.

Many participants emphasize that physicians must be involved in the decision-making process when reform is necessary in the health care system.
Pharmacists and Pharmacology

Many participants question the role pharmaceutical companies play in the delivery of health services. The education a physician receives on a particular drug should not, they believe, come from a company representative, nor should they receive any type of bonus or reward from the company when prescribing their product.

Many participants also recommend changing prescription practices and scopes of practice. They suggest that doctors could approve longer prescription lengths by allowing for multiple refills of a single prescription. To address patient backlog at physicians’ offices, some suggest tasking long-term prescription renewal to nurse practitioners and pharmacists. Along with prescription renewal privileges, pharmacists could play a larger role in the care and management of long-term and chronic illnesses if granted access to a patient’s full medical records. Many participants consider the pharmacists an underutilized asset to the healthcare system.

In the current system, pharmacists expend most of their energy in dispensing medications from the bulk stock to individual packages. This is a waste of their talent. A large part of this exercise can be deputized to dispensers with special training but paid less expensive salaries.

-Email, Victoria

Conclusion

Many participants believe that the current roles and responsibilities practiced by health care professionals require change. Practitioners are being educated to meet an increasingly high set of standards, yet remain underutilized in their day-to-day practice. Re-defining and expanding our health professionals’ scopes of practice will allow them to provide a level of care more reflective of their qualifications, while increasing the efficiency and accessibility of British Columbia’s health care network.
Scope of Practice

This chapter includes the following topics:

- **Scopes of Practice**
- **Re-defining Scopes of Practices**
- **Multi-Disciplinary Care**
- **Physicians and Surgeons**
- **Nurses**
- **Pharmacists and Pharmacology**
- **Dental Care**
- **Eye Care Specialists**

### Related Electronic Written Submissions

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Related Chapters

Many of the topics discussed by participants in the Conversation on Health overlap; additional feedback related to this theme may be found in other chapters including: Primary Health Care; Health Care Models; PharmaCare; Public Private Debate and Medical Services Plan.

Scope of Practice

Comments and Concerns

Leadership and Governance

- **Comments on leadership and governance:**
  - The current management lacks positive behavioural tendencies of good leadership.
  - Behind-the-scenes administrations manage the current system from closed doors. They make decisions that affect the day to day work of professionals without any prior consultations or considerations of the repercussions of their decisions.
  - Staff workloads are so strenuous that there is no time for practitioners to take on a leader’s role.
  - The excessive workloads borne by practitioners are limiting their engagement in mentorship or preceptorships.
  - Filling the service gaps in health care is requiring health professionals to practice in areas that they may not be fully qualified for, which creates a lack of professional care.
  - Poorly defined objectives, duties, and time frames in hospitals lead to overworked employees.
  - Out-patient cancer care requires centralized physiotherapy services.
  - Initiate an independent audit on best practices and share the results with all health care practitioners.
  - Burn-out among health professionals can be attributed to a high occurrence of administrative work.
  - University graduates are in demand for positions that Care Aides and Licensed Practical Nurses could carry out.
  - Emergency rooms lack support services such as Physiotherapy.
• Residential Care aides may be lacking the appropriate education and necessary competencies to effectively carry out their duties within long-term care facilities.

• Emergency room staff lack the necessary skills and training to work effectively with the mentally ill and elderly patients.

• Encourage the sharing of Aboriginal health best-practices and research between communities.

• Many professionals’ collective agreements unduly limit their operational capacity.

• Health professionals are overworked yet are under-utilizing their training, thus lowering practitioner morale.

• Highly trained professionals are not being utilized to the very limits of their training. The following are prime examples of poorly-utilized practitioners:
  a. Certified Dental Assistants;
  b. Dieticians;
  c. Pharmacists;
  d. Nurses;
  e. Midwives;
  f. Physiotherapists;
  g. Social workers; and,
  h. Speech Pathologists.

• Current legislation does not allow Registered Massage Therapists to practice to the full extent of their training. Broadening their scopes of practice in to match their training would assist patients, and fill a growing need for health care professionals in the province.

• The various fields of health care lack effective communication tools.

• Community-care workers do not have any connection to mainstream health practitioners.

• Nurse Practitioners, naturopaths and pharmacists should have the ability to refer patients to specialists.

• Health care providers are not delivering culturally appropriate care.

• Doctor’s practices and ethics are lacking supervision.

• Practitioners are making mistakes and have no way to communicate these mistakes to each other.

• Unregulated employees are operating in service delivery areas that only regulated employees should be responsible for.
• There should be no professional monopoly on work unless it is professionally justified that any other treatment method would qualify as dangerous to the patient.

• Midwives in private practice are on call 24 hours a day and seven days a week; this, combined with a lack of additional hospital privileges means they cannot easily network with other midwives to either give themselves coverage or allow them to take on more patients and grow their practices.

Ideas and Suggestions

Leadership and governance
Practice in the public and private sectors
Standards of care
The patient’s Role in Healthcare
Midwives

• Ideas about leadership and governance roles:
  • Engage regional Health Authority managers in the planning processes.
  • Managers must re-design workflow plans to address labour shortages.
  • Front-line workers must be included in the decision making process by administration.
  • Build capacity for more front-line leadership and increase the depth of organization including innovative planning from the front-line and just-in-time issues management.
  • Create more front-line supervision to discipline and support employees.
  • Implement the role of a floor supervisor who would be responsible for managing the duties of the nurse to the janitor.
  • Remunerate Health Chief Executive Officers (CEO)s in accordance with their Health Authority’s performance records.
  • Those currently in management positions should involve their staff in a discussion on how to effectively bridge the service gaps in health care.
  • There is a need to address the protectionist culture that exists between some professional colleges and their respective fields.
  • Assess what attracts and sustains senior leaders within the health care field.
  • Scopes of practice will expand with good leadership and management within the Health Authorities and educational institutions.
• Health Authority board members should be the champions of the health professions.

• Health Authority staff members should be required to have served some length of time in primary health delivery.

• Those who are allocating Health Authority budgets must possess the necessary business and financial qualifications.

• Elect Health Authority board members instead of appointing them.

• Establish a centralized, third party regulatory body for all health professionals including those that are self-governed.

• Encourage front-line practitioners to become more involved with the Health Authority bureaucracy, even sit on the regional boards.

• Administrative staff in the Interior Health Authority need to understand their own structure, policies, procedures, and how treatments interact.

• **Ideas about the private and public sectors:**

  • Regulate the amount of time professionals spend working in the public and private systems in order to maintain a balanced human resource pool.

  • Implement a rule that does not allow for employment in both the private and public sector, thus eliminating double billing by practitioners.

  • Allow employment of practitioners by any number of facilities and allow them to operate between those facilities, directed by demand.

• **Ideas about standards of care:**

  • Make the operating physician take responsibility for mistakes made during surgery. Offer other recourse to the patient other than writing to the College of Physicians and Surgeons.

  • Health professionals need a safe and secure environment to air their concern or report of mistakes made during practice. This forum could also hear reports of abuse or fraudulent use of the medical service plan billing system by professionals.

  • Implement the role of a health services ombudsman who would hear from patients, their concern or complaint regarding mistreatment or malpractice.

  • The Ministry of Health must maintain a public list of health service personnel who have committed medical infractions.
• **Ideas about the patient’s role in healthcare:**

  - Patients should be encouraged to ask more questions of their doctor regarding their treatment. This may doctors to undertake communications education.
  - Patients should have more control over their treatment.
  - Assist patients in their search for efficient care by providing them with a patient care representative or case manager. Efficient treatment options can be tailored to a particular patient’s needs and would eliminate any duplication in testing.
  - Patient outcomes should govern the salaries of health professionals.
  - Proper continuity of care allows for deeper relationships between the client, family and peripheral care aides.
  - Focus on allowing patients to be the experts in their care; the health professional’s role would be only that of a supervisor.
  - Strengthen and build new community-based patient education programs that promote wellness, prevention, and chronic disease self-management. Ensure that community family doctors are involved in the planning and management of these programs.

• **Ideas about midwives’ scope of practice:**

  - Initiate a publicity awareness campaign addressing the benefits of using a midwife.
  - Midwives require an expansion in their hospital privileges.

• Implement an emergency room triage individual responsible for directing lesser health issues towards a clinic while allowing emergency room admittance to those with genuine medical emergencies.

• Registered Massage Therapists have extensive training specific to musculoskeletal conditions. This training should be better utilized by creating a primary care role for massage therapists.

• Increase the authority of Naturopathic doctors to allow for prescriptive rights and the ability to admit patients to the hospital.

• Increase the resources dedicated to training care aides to better their education and allow for a broader operational capacity.

• Para-medics require the authority to triage their patients and decide upon their destination if they require further assistance.
• All medical staff should abide by the guidelines of care outlined by the Canadian Diabetes Association when treating diabetic patients.

• Occupational and Physical Therapists need to be available more than Monday to Friday, 8:30am to 5:30pm.

• Re-instate the Orderly back into hospitals.

• The Ministry of Health should require that health professionals carry the credentials necessary for work in palliative care facilities.

• Create a Care Aide specializing in the support of those suffering from mental illness and developmentally challenged children in public schools.

• Primary care workers must be trained to operate in a more collaborative and cohesive manner.

• Change the scopes of health care professionals to better suit the recruitment of new professionals.

• There must be an increase in the amount of intermediate health care professionals practicing in British Columbia.

• Social workers working within mobile street clinics should be well versed in both mental health and criminal justice care.

• Incorporate front-line staff in finding holistic solutions to issues in their field.

• Thoroughly integrate alternative care into a patient’s treatment instead of using it as a last resort.

• The gate-keepers to healthcare services should be those practicing para-medicine.

• Eliminate all unnecessary bureaucratic paperwork.

• Peer support groups help those with potentially terminal and chronic care diseases on an emotional level; a highly educated and trained professional cannot always offer such an exemplary level of compassion to their patients.

• Utilize nutritionists much more effectively to educate patients on proper nutrition.

**Re-defining Scopes of Practice**

**Comments and Concerns**

• Implementing change in scopes of practice will be challenging. Management will be advising new professionals that the current practitioner’s operational limits are
not what they want to be emulating, yet these students will be placed into clinical settings where there is no evident change.

- The professional colleges hold different ideas concerning scopes of practice than those actually working in the field.

- Canadian researchers have looked long and hard for evidence to suggest that devolving a task, whether it is endoscopy to nurses or some long-term care to Licensed Practical Nurses or primary care from physicians to Nurse Practitioners, has caused harm to the patient. They have found none. The scope of practice regime in Canada is inaccessibly rigid. There is too much turf protection. The ability of professionals to acquire new competencies and use them to good effect for the public and patients is severely constrained by limits placed by colleges and associations.

- The challenges lay in pushing authority downwards and at the same time providing recognition to those front-line workers.

- It is very difficult for personnel to acquire new competencies in a modular format as has been recommended time and time again.

**Ideas and Suggestions**

- Re-design the health professionals' scope of practice around their necessary competencies and population needs. Analyze what certain professions have to offer and how to balance and reduce duplication in the system.

- Implement a new model of care that is able to cope with a growing market for care and a shrinking human resource pool. This could be assisted by a detailed analysis of what allied health care providers can do for the system.

- Increase the effective and available entry points into the health care system. This would include assessing and delegating who can order tests, who can monitor the follow-up, what is the best use of a professional’s training and expertise and would include alternative methods.

- Doctors should not be the sole gate-keeper to health care. This position would benefit from delegation to a variety of well-qualified practitioners.

- Elimination of the educational and management silos within health care would allow practitioners a much wider scope of practice.

- The education system must take more responsibility in the expansion of health professional’s scopes of practice.

- Create more flexibility within the roles of health professionals.
• Conduct a critical path analysis on the widening scopes of practice and address the issues that are blocking the path of this expansion.

• Ensure the intimate involvement of the Ministry of Advanced Education when adopting new scope of practice policy.

• Changes in practitioner scopes of practice will require legislative change.

• Empower all health professionals to reach their full scope of practice through regulatory changes that reflect their training and education along with the provision for funding and appropriate resource allocation.

• Government should review and test restrictions placed on professions by their professional associations.

• The Province should rely more on pilot projects when changing scopes of practice.

• Create an international body to mandate and regulate professional operating standards.

• Initiate a set of general practice standards and evaluate health professionals based on those standards.

• The regulated professions should possess a wider scope of practice; those unregulated professions should continue in their narrower practice.

• There are protocols such as the Transfer of Function, whereby a professional can delegate duties to another professional by implementing training and supervision.

• There is an effort in northern British Columbia to train x-ray technicians to perform basic laboratory work in order to create a full-time workload for one professional, which is a good example of widening scopes of practice.

• Relax scope of practice legislation that lacks objective evidence.

• Health professionals need a better understanding of what each individual profession is responsible for in order to maintain an effective work environment.

• Invest in a thorough analysis of what health professionals are doing day-to-day and request options to optimize their performance.

• More workload planning is necessary in order to safely expedite the entry and exit of patients into and out of hospitals.

• Listen to the innovative ideas offered by front-line workers when evaluating scope of practice changes.
Multi-Disciplinary Care

Comments and Concerns

- Doctors may be resistant to changing their roles as the gatekeepers of the healthcare system.
- The Canadian Medical Protective Association is putting physicians in a scenario where they feel they cannot engage others as employees because of the liability risks they are assuming.
- Physicians work primarily as independent practitioners rather than co-operatively with Nurse Practitioners, Physiotherapists and Pharmacists, which would be more effective and less costly.
- It will be a challenge to change into a more multi-disciplinary system when some doctors are operating within a small-business model of healthcare delivery.
- The sharing of information between professionals is ineffectual or non-existent.

Ideas and Suggestions

- Support the integration of health care professionals.
- Inter-disciplinary health care models would improve the quality of a patient’s initial interaction with the health care system.
- House many different practitioners under one roof and establish a formal and informal network of communication between professionals. The informal network would consist of a willingness to flatten out the hierarchy within the system.
- Increase the collaboration between traditional and non-traditional medicines.
- A basic model for a primary care team consists of three Registered Nurses working under a doctor’s supervision.
- Multi-disciplinary teams including: academics, physicians, health authority representatives, aboriginal liaison, staff, union and the volunteer sector would keep the focus on holistic treatment.
- Each one of these health care teams must analyze the needs of those they are serving and assign work to those best qualified to maximize efficiency.
- Physicians may need to hold the legal liability for these teams.
- A qualified medical practitioner and a traditional healer should assist in First Nations mental health assessments.
• Blend the rigid hierarchy of specialist, doctor, Registered Nurse, Licensed Practical Nurse, and Registered Care Aide.

• Removing barriers to multi-disciplinary care implementation requires that regulatory bodies and professional associations be closely involved in any proposed changes to the scope of practice for allied health professionals who work with physicians.

• The College of Physicians and Surgeons requires education regarding the implementation of integrated care methodology.

• The government must support the redesign of health professionals’ fee structure in order to facilitate a more collaborative model of care.

• Create a web-log and allow fellow practitioners to come together in conversation without having to travel.

• Practitioners in the health care field must have an equal stake in the system to allow for better communication and integration of services.

• Provide incentives to practitioners for the set up of multi-disciplinary care networks.

• Involve pharmacists with physicians to check for potential drug interactions upon a patient’s discharge.

• Develop a common language for use by practitioners across all health sectors.

• Call on volunteers and retired nurses instead of doctors to perform blood pressure and blood sugar testing in long-term senior-care facilities.

**Physicians and Surgeons**

**Comments and Concerns**

• The gate-keeping of British Columbia’s health care by physicians must change.

• Doctors may be blocking their professional allies from practicing to their full potential.

• Physicians are not taking full advantage of allied health services.

• Health care may be unduly centred on the methodology of the physician.

• Physicians may be discontinuing care to patients who choose a Registered Midwife for their services during childbirth.

• Physicians may be withholding referral of their patients to certain fields of practice due to a lack of personal respect for their methods.
• Doctors may be hesitant in relinquishing some of their practicing responsibilities to Registered Nurses.

• Physicians may not be conducting referrals over the phone to a lack of remuneration for this service.

• Many family doctors are opting out of birthing as part of their practice.

• A doctor should be the only practitioner to write prescriptions.

• There is an abundance of specialist practitioners yet far too few general practitioners in British Columbia.

• The health care system is pushing the family doctor out of the continuum of care.

• An overwhelming demand for cosmetic surgery is consuming surgeons.

• Only 20 per cent of general practitioners provide child delivery services in British Columbia.

• Some doctors may not be recognizing and utilizing alternative medical treatments.

• There are fewer doctors accepting new patients.

• The rushed environment of the doctor’s office is leading to over-prescription and less actual counselling and advice by physicians to their patients.

• The physician’s toolkit of pharmaceuticals, surgery, nuclear medicines and wait-and-see is extremely concerning to some.

• Physicians are responsible for admitting and discharging patients to and from acute care hospitals and ordering diagnostics. Many of these diagnostic tests are unnecessary and do not advance the health of the individuals receiving them.

• Doctors are restricted to one visit per patient, per day.

• The rule employed by some physicians of one-issue-per-visit does not address those with an interrelated series of medical issues or concerns.

• Surgeons are not limited in their practice by a lack of resources, but by a budget of operational time that quickly expended.

• With general practitioners no longer practicing in emergency rooms, health care now employs emergency room physicians but at a premium cost. The general practitioner’s role in hospital has been broken down into many, more expensive specialty fields.

• The shortage of available family doctors is putting a large strain on emergency room staff.
• Encourage general practitioners to use all their expertise for the benefit of their patients by ensuring the availability of support staff, equipment, and facilities for their use. This would include:

  • Increasing access to acute, rehabilitation, psychiatric and long-term care beds;
  • Increasing operating room capacity in community hospitals to reduce surgical wait-times and to provide emergency obstetrical support; and,
  • Increasing diagnostic imaging capacity such as ultrasound, Computerized Tomography (CT) and Magnetic Resonance Imaging (MRI) in every region. Remove barriers to general practitioners ordering these tests and where possible use mobile and remote technology to reduce travel for rural residents.

• There is a severe shortage of available operating room time offered to surgeons.

• Physicians are physically exhausted due to excessive workloads.

• The amount of time a doctor is allotted to a patient is not enough to properly assess their needs and issues.

• Physicians are operating outside of the medical system’s methodology.

• The ability for a physician to pick and choose their patient lists represents an unethical use of their authority.

• The act of running a physician’s office, and practicing within that office constitutes a conflict of interest.

• Re-assess the list of reserved acts for certain health professionals.

• Physicians see themselves primarily in a treatment role rather than that of a practitioner who can help prevent illness and disease before it occurs.

**Ideas and Suggestions**

• The provincial government must realize and appreciate the importance of family medicine. Family doctors provide most of the care in this province and are involved in cradle-to-grave care, promotion of health prevention, well being, mental health, acute care and much more.

• Address the current labour shortages by increasing the number of general practitioners and allow them an increased field of operational duties.

• Involve doctors in the decision making process when allocating health care funding.

• Re-engaging doctors in the system will allow doctors to take ownership in their system and to align their incentives with those of the public system. They would
drive health care systems towards efficiencies based on effective ways of providing care.

- Implement a system of rewards to physicians for taking on difficult cases, for going above the call of duty, and for referring non-urgent cases to a medical clinic rather than letting them populate emergency waiting rooms.
- General practitioners should be offered incentive for taking on patients in a family practice.
- If physicians were able to practice to their full potential patients would not continually be coming to see them.
- Doctors should be able to teach their patients strategies in health prevention.
- Preventative health is delivered by a paediatrician up until the mid-teenage years in Argentina; a general practitioner could provide these services in Canada.
- Increase the physician’s role in smoking cessation.
- Stop the provincial government from restricting the physician’s choice in treatment options to those that are relatively inexpensive.
- Physicians require the education and knowledge to be able to focus on the more obscure types of cancer.
- Physicians should have the ability to refer patients to peer support groups.
- Physicians attending to cancer patients must be more compassionate in their methods of communication. These patients should have a choice in how they hear results and opinions.
- Grant oral surgeons hospital admitting privileges under the hospital act; they currently require a physician to co-admit their patients which creates redundant costs within the system and puts the patient’s safety at risk.
- Pay physicians to review tests or x-rays and allow them to consult the patient via e-mail or over the phone.
- Expand the amount of daily hours a physician may work.
- Remove the limits on the number of patients a physician can treat or assess per day.
- Doctors should have the authority to charge more for extended visits in their practices in order to fully assess their patients.
- Hire clerical staff to take over the typing duties of doctors and relieve the expensive training time doctors require on these typing systems.
- Doctors must perform their own typing.
• The family physician should remain as the coordinator of care.

• Whilst still in training, educate doctors of the roles and content of other professions to provide more knowledge when referral is necessary.

• Doctors should be encouraged to work in groups and take some of the overtime stress off nurses.

• Encourage specialists to carry out common treatments and procedures and relegate the more complex cases to exceptional general practitioners.

• Scale back the role that major pharmaceutical companies have in drug education.

• A practitioner other than a physician should be responsible for the renewal of long term prescriptions.

• Allow for more home-visits by doctors.

• Doctors must have contingency plans for all of their patients when they choose to relocate their practice.

• Emergency rooms require the presence of more doctors or specialists.

• Hospitals require stand-by practitioners at peak hours of operation.

• The time a surgeon or physician receives in the operating room should be proportional to the time they practice in their clinics or hospitals.

• Create a network of patient co-management through the use of accessible electronic health records.

• Replace doctors with computers and make nurses liaise between the patient and the computer.

• Patients should posses the ability to correspond via e-mail with their doctors.

• Reimburse specialists for consulting with family doctors over the phone.

• Patients should have the option to relay diabetes self-test results over the phone to their general practitioner.

• Physicians in Canada have more autonomy when it comes to wait-list management than in any other jurisdiction.

• Doctors possessing the appropriate training to treat those patients with mental illnesses are in high demand.

• Doctors may not possess the financial training required for budgeting tasks so make them accountable to a board or panel comprised of experienced business professionals.
• Doctor should be responsible for a proportionate cross-section of their community instead of hand-picking patient lists.

• A Physician’s Assistant is medically trained for surgery and general practice while under the auspices of a general practitioner. They operate with certain autonomy and free up the general practitioner to attend to more acute or complex cases. British Columbia would benefit from their implementation alongside physicians.

• Minor procedures such as mole-removal being relocated to within the doctor’s office would prove to be a significant savings.

• The expectations that doctors keep to their scheduled appointments should be raised. Doctors should be rewarded for their own efficiency and doctors who think it is alright to come in late should be penalized.

Nurses

Comments and Concerns

• Nurse Practitioners are not doctors and do not have the expertise or education to deal with all specialties and illnesses.

• Be careful with Nurse Practitioners. Although an experienced Nurse Practitioner, willing to make tough decisions would do a good job at less cost than a physician, there may be downfalls to allowing them the authority. First, the Nurse Practitioner will see the patient and then simply send them on to the doctor. Second, the Nurse Practitioner will spend an hour seeing a patient with a simple sore throat. Both factors result in increased costs rather than savings.

• There is little public knowledge of the different roles and practices that nurses carry out in British Columbia.

• Nurses, who are staffing hospitals twenty four hours seven days a week, take on the Physiotherapist’s role, the Occupational Therapist’s role, and the Registered Massage Therapist’s role when they are not present.

• Nurses have to carry out the duties of a porter due to a lack of support resources.

• High wage earning nurses are emptying laundry baskets.

• Nurses and nurse’s assistants are over-worked and tired.

• Nurses working long overtime hours are sustaining the current health care system.
• The twelve hour shifts that nurses are working are not effective both in cost and patient outcome; nurses are less productive after ten hours of work due to exhaustion.

• Nurses are spending too much time caring for elderly patients awaiting placement when they should be dealing with other issues.

• The Registered Nurses’ union lobbied aggressively against Licensed Practical Nurses, yet a few years later, Registered Nurses went on strike when their workload dramatically increased.

• It is difficult to reactivate a Registered Nursing license and the Registered Nurses Association of British Columbia is not actively assisting nurses who are in this situation.

• There is no colour coding in the dress of nurses and licensed nurses and many employees will wear their identification badges inside their pocket for their convenience. This may lead to a family member searching for hours to find the nurse in charge of care for their family member.

• Due to shortages in staff, nurses are offered promotion far too quickly. They become overwhelmed with their responsibilities and leave practice after a very short period of time.

• There may be no work for an expanded nurse’s role within the health care system.

• Nurses lack a clear and defined leader within the workplace.

• It is challenging to find nurses willing to take on leadership positions due to a recent drop in wages.

• The professional bodies that govern Licensed Practical Nursing and Registered Nursing retain sole control of curriculum, licensing and field of practice regulations.

• The contracting-out of cleaning and sanitation services has unduly shifted these responsibilities to nurses.

• Nurses and doctors dominate the current culture of healthcare; this culture lacks critical reflection about its influence and power within the healthcare community.

• Some aid station personnel are probably forced to operate beyond their scope of practice.

• Nurses do not spend enough time providing support and education to patients and their families. Post-operative monitoring is also inadequate.
Ideas and Suggestions

Nurse Practitioners
Licensed Practical Nurses

• Ideas about Nurse Practitioners:
  • A greater reliance on Nurse Practitioners, alternative and complimentary therapies can save the system money.
  • A Nurse Practitioner can provide all the services that a general practitioner is responsible for.
  • The health authorities and the provincial government should set up clinics throughout British Columbia staffed by Nurse Practitioners to deal with routine examinations such as blood pressure, wound dressings, ear, nose, throat, and other minor problems.
  • Within isolated communities, Nurse Practitioners could provide a wide range of medical services in lieu of a doctor, including medication prescriptions and attending to emergencies.
  • Include Nurse Practitioners in gaining information on patient needs which may aide in diagnosis.
  • The list of Reserved Actions should put clear limits on what a Licensed Practical Nurse can do and shrink their scope of practice.
  • Many elderly patients will benefit from the more holistic method of care adopted by Nurse Practitioners.
  • Challenge the current culture of only allowing Nurse Practitioners employment in safe, low-risk scenarios.
  • The Nurse Practitioner is able to take the time to give patients the attention they require.
  • Nurse Practitioners should not be doing administrative tasks such as answering telephones and the filing or filling out of paperwork.
  • Nurse Practitioners should make house calls.
  • Nurse Practitioners have been extremely successful in the operating room. They are responsible for the pre-operation and post-operation work, which frees up the doctor to perform other operative services.
  • Allowing Nurse Practitioners to practice medicine independently will only result in more referrals and longer wait-lists resulting in a higher overall cost to the system.
• Allow the Nurse Practitioner to become the primary point-of-entry into the health care system.

**Ideas about Licensed Practical Nurses:**

• Do not replace Nurse Practitioners with full-scope Licensed Practical Nurses since this would constitute a danger to the public.

• Licensed Practical Nurses can provide patient education, intervention, and assessments in lieu of a doctor’s presence with that patient.

• Chronic disease management should be governed by Licensed Practical Nurses who have the time and opportunity to engage in discussions of non-critical matters with the patient.

• In some cases, nurses have gained some autonomy; for instance, a nurse will demand an x-ray to ensure that there is an issue before bringing in a doctor.

• Create specially trained nurses to deliver a wider array of services.

• Replace the doctor’s role in the health care system with a Registered Nurse, and replace Registered Nurses with Licensed Practical Nurses.

• The enhancement of Care Aides would allow Registered Nurses to perform more in accordance with their training.

• Nurse’s aides and Licensed Practical Nurses should bear more of the nurse practitioner’s workload in order to cut back on their expensive need for overtime.

• Increase the availability and role of the prevention nurse within small communities.

• A health services navigational nurse would guide a patient through treatment options and avoid duplication of testing; providing a significant cost savings to the health care system.

• Nurses practicing in emergency rooms require more authority and autonomy.

• Introduce or expand existing school nurse programs in public grade schools.

• Administrative support services are required to assist nurses in their administrative duties.

• Establish a floor supervisor responsible for operation of a certain floor within a hospital.

• Train some nurses to be responsible for the treatment of a single type of cancer; for example, one nurse would be solely responsible for breast cancer patients, while another nurse would be responsible for treating those with lymphoma.

• Nurses should not be restricted from working under private contract.
• Nurses do not require, nor should they be authorized for any further authority within the medical system.

• Those with chronic diseases benefit from increased exercise and proper nutrition; the appropriate service provider should replace the doctor in these roles.

• Transform the role of the older, experienced nurses into that of an educator. They would educate patients and their families concerning available resources and where to find them in the health care system.

• Allow nurses the authority to set broken bones and suture wounds.

• Promote the Nurse Hotline more; they may be able to resolve a lot of issues over the phone before.

• Raise the authority level of Southern British Columbian nurses to equal that of those in the North.

• Develop a system of care that utilizes an Advanced Practice Nurse, trained in the principles of primary health care.

• If the prevention nurses were the sole administrators of vaccines, there would be a decrease of general practice visits and, therefore, a cost savings.

• Determine and implement a benchmark nurse-to-patient ratio.

• There is a need for more privately owned supervision and control of cleaning services within hospitals; it is not the nurse’s responsibility to check on the cleaners’ thoroughness.

Pharmacists and Pharmacology

Comments and Concerns

• The relationship between physicians and the pharmaceutical companies has been deemed inappropriate:

  • Physicians are receiving gifts and free trips for prescribing based on brand and quantity;

  • Doctors may feel obliged to favour one drug over another due to an influence by pharmaceutical representatives; and,

  • The education a physician receives regarding certain drugs is almost entirely provided by a pharmaceutical brand representative.
• Doctors should not prescribe vitamins because they do not have the time available to do an in-depth assessment for vitamin requirements and doctors would need to retrain education on vitamins.

• Most doctors are still in the habit of hand-scribbling prescriptions; this may have something to do with tradition but does nothing for the quality of patient care. On two occasions over the past two years, a particular pharmacist had to phone the prescribing doctor to clarify his writing. There is no downside to electronic preparation and transmission of prescriptions.

• Prescriptions are increasing at an alarming rate; focusing on more preventative methodology will decrease the public’s need for pharmaceuticals.

• Non-clinical issues are overwhelming community pharmacists.

I ideas and Suggestions

Pharmacists

• Ideas about pharmacists:
  • Pharmacists should be solely responsible for writing and handling prescriptions.
  • Pharmacies do a good job in educating the patient on the proper use of their prescription.
  • Pharmacists are well versed in the proper utilization of medication; they are concerned when drugs are unnecessarily prescribed to people and with no explanation of their side effects.
  • Pharmacists should be able to refill prescriptions and/or prescribe medication for chronic illnesses. One pharmacist comments that he has made drug therapy the focus of all of his education yet he cannot prescribe. On the other hand, a family physician, trained in diagnosis, has minimal knowledge of the medications they are able to prescribe.
  • Pharmacists should not be able to prescribe medication or refill prescriptions for the following reasons:
    a. Family physicians need to be able to recall a patient to monitor their health and the medication that they are taking;
    b. It hinders a family physician’s ability to keep track of all the medications that a patient is taking, even with the communication that has been established over the years between specialists and family physicians; and
c. If you introduce another person who can also prescribe medication, it will be even more confusing and more difficult than it is now and that it is a real problem in family practice.

- In Europe, pharmacists are able to make routine prescriptions that save on doctor visits.
- Authorize licensed pharmacists to re-issue prescriptions. They could renew prescriptions and notify the doctor for inclusion in a patient file using electronic prescribing assisted by decision support software.
- Pharmacists should be responsible for educating doctors about pharmaceuticals and their side effects.
- A consultation by a pharmacist could help prevent hospitalization.
- Pharmacists should be able to renew prescriptions for up to one year before a patient needs to see their doctor again or the patient’s circumstances change.
- Pharmacists should review a person’s dispensing history and follow-up with those to make sure they are finishing their drug therapy.
- Allow pharmacists access to patients records to better monitor their conditions.
- People should rely more on their pharmacists for health information because they possess a vast wealth of knowledge.
- Pharmacies should be able to assess and help treat conditions as a primary care facility.
- Patients should not have to visit a doctor in order to have prescriptions refilled. Pharmacists should be able to refill prescriptions and have access to patient records to guide them.

- A nurse should be responsible for carrying out simple blood pressure tests prior to renewing a prescription.
- The public should be able to renew a prescription over the phone
- Pharmacists and Nurse Practitioners should be able to prescribe medication.
- The process of writing repeat prescriptions for those with chronic diseases should be transferred to the authority of a suitably trained nurse.
- Reward doctors who keep their patients healthy and free of pharmaceuticals.
- A nurse should be able to fill prescriptions over the phone after a mandatory check up. In this case, the physician would get a discounted rate of pay.
Dental Care

Comments and Concerns

Certified Dental Assistants

- Comments on Certified Dental Assistants:
  - Certified Dental Assistants are well suited to the provision of safe and effective public oral health services. However, the draft dentists’ bylaws and the requirements for supervision prevent Certified Dental Assistants from practicing their profession to the full extent of their capabilities, which limits access to care.
  - Certain concerns were raised over Certified Dental Assistants who may have failed the national exam, have not met national standards and have not finished their training yet are being allowed to practice.
  - One profession (Certified Dental Assistants) being regulated by another profession (the College of Dental Surgeons of British Columbia) has far too many inherent conflicts of interest.
  - The proposed by-laws for the College of Dental Surgeons of British Columbia on classes of Certified Dental Assistants may prove to be very confusing. A clinic could potentially have four different classes of dental assistants:
    a. Practicing certified;
    b. Temporary certified;
    c. Limited certified; and,
    d. Dental assistants.
  - Certified Dental Assistants receive education relating to preventive health. However, the circumstances in which a Certified Dental Assistant may legally provide oral health promotion and preventive services are limited to the public outside of the private dental office.
  - The draft dentists’ bylaw perpetuates a situation wherein dentists may delegate a critical task such as infection control for the entire dental office to someone who is potentially untrained and has not demonstrated a recognized standard of performance or competency in this task.
  - Dental assistants have been recognized as an independent and self-regulating profession in a number of other provinces. However, British Columbia reinforces outdated regulations that place dental assistants in a position where their employer may also regulate their profession.
• Current legislation prevents Dental Hygienists from operating to their full capacity. There is a need for independent Dental Hygiene practices but the current legislative restrictions create road blocks in the profession’s ability to provide a viable program. Dental Hygiene is a separate entity from Dentistry.

• The by-laws proposed by the College of Dental Surgeons of British Columbia are confusing, hard to read and thus not meeting the requirement of public transparency.

• The proposed by-laws by the College of Dental Surgeons of British Columbia place intra-oral skills in the so-called public domain. These skills are consistently taught in dental assistant programs across Canada and are authorized acts for licensed dental assistants in the rest of Canada. The placing of these skills within the public domain does not occur in any other jurisdiction in Canada.

• Dental Hygienists cannot bill directly to a patient's dental plan which again hinders access to care because it adds another complication to preventive care.

• The bylaws for Registered Dental Hygienists limitations on practice require a client be examined by a dentist during the initial visit or prior, up to 365 days, to clinical services being provided. This by-law is restrictive to home-bound and handicapped clients who cannot access a regular dental office. Many registered dental hygienists are willing to provide care to clients in their homes or at alternatives to a regular dental office, but are limited by the requirement for a dentist to provide an exam.

• Concern was aired regarding the possibility that dental offices may be discouraging clientele on income assistance from seeking dental services. General dental practices may not be accepting dental insurance assignments from individuals who are receiving Income Assistance.

Ideas and Suggestions

Certified Dental Assistants

• Ideas about Certified Dental Assistants:
  • It is the Certified Dental Assistants of British Columbia’s assertion that regulation of Certified Dental Assistants be removed from the authority of the College of Dental Surgeons of British Columbia.
  • A Certified Dental Assistant can efficiently, effectively and safely maintain a clinical practice.
The Certified Dental Assistant provincial curriculum instructs the student in current standards of dental practice. This education leads to the practical application of knowledge demanded by this profession.

Certified Dental Assistants possess formal training in cardiopulmonary resuscitation (CPR) and first aid.

Review the draft dentists’ bylaws about Certified Dental Assistants’ practice in public health. Create standards for enhanced education and training for expanded dental assistants.

Develop vision for certified dental assisting practice in public health.

Create bylaws reflecting the importance of access to care and sustainability that allow certified dental assistants to practice most effectively in the wider public domain in the area of oral health promotion and delivery of preventive services.

Produce a recognized College of Certified Dental Assistants under the Health Professions Act.

All dental assistants should be Certified Dental Assistants.

Ensuring appropriate autonomy of Certified Dental Assisting regulation requires:

a. Embracing a definition of public interest that not only guarantees lack of bias or apprehension of bias but also guarantees a demonstration of professionalism through rigorously established standards.

b. Entering into a discussion about and agreeing upon valid determinants for decision making about appropriate autonomy in regulation for certified dental assisting. These determinants must include placing as much weight on aspects of public interest mentioned in number 1 as are placed on the risk of harm.

c. Place the profession of certified dental assisting in the best position to articulate statements about its regulation in the public interest because it knows itself best.

d. Removing certified dental assisting regulation from the authority of the Certified Dental Assistants and support the creation of a college of certified dental assistants under the Health Professions Act (HPA).

e. Engaging with the Certified Dental Assistants to determine a new approach for the regulation of certified dental assisting in order to find new ways to guarantee access to safe, sustainable care for all British Columbians.

Recognize only one standard of dental assisting in regulation which is that of an educated and qualified dental assistant certified by the regulator. Modify references
to dental assistants in the dentists' draft bylaws with this single standard as the
benchmark.

- Dental Hygienists should be considered the primary care gateway to dental health.
- Halt the approval of the proposed by-laws by the College of Dental Surgeons of
  British Columbia until the Conversation on Health has concluded.
- Access to preventive dental hygiene by registered dental hygienists is an integral
  part of overall health.
- The system whereby a dental hygienist refers a patient for examination not only
  improves oral health, but increases the likelihood that those disadvantaged patients
  will access dental care at some point.
- Remove the requirement for a patient to have seen a dentist within 365 days in
  order to receive treatment by a dental hygienist.
- Dental assistants in Saskatchewan have been regulated since 1969 and self
  regulated since 1998. This has contributed to all practitioners operating to their full
  scopes of practice while working as part of a multi-disciplinary team.
- Include public health programs, their evaluation and monitoring, and the evaluation
  of personnel.
- Through collaborative research, create standards for enhanced education and
  training for expanded dental practice in long-term care, seniors' residential care and
  home care environments.
- Provide an update on existing research in the areas of children's dentistry and the
  enhancement of dental health for First Nations, tobacco users, and the working
  poor.

**Eye Care specialists**

**Concerns and Comments**

- Optometrists in all but two jurisdictions in North America can prescribe medications.
  British Columbia comprises one of the two provinces that disallow this practice.
- New regulations regarding sight testing place Opticians under the control of
  Optometrists, their market competitors. This may force the closure of many
  Opticians’ doors.
• British Columbian optometrists are restricted from practicing to the full extent of their training by not being able to prescribe therapeutic pharmaceuticals. This leads to the over-utilization of physicians and emergency resources.

• An Optician is not allowed to check their client’s visual acuity and dispense new corrective lenses, even with only a slight modification. This means the client who wanted to be assured of their visual acuity is now required to return to the Ophthalmologist or Optometrist for a sight exam, but would also in receive and unnecessary eye health exam.

• Our aging population brings with them an increased incidence of chronic eye disease. This demographic will require a greater need for ophthalmologists’ services; the subsequent waiting lists for procedures such as cataract surgery will only lengthen.

• There is a growing awareness that the ratio of ophthalmologists to patients is falling and is particularly acute in the non-urban and rural settings of British Columbia.

I ideas and Suggestions

• Optimizing vision care requires permitting optometrists to practice to the limits of their training and abilities. They must be able to prescribe therapeutic drugs to aid in the treatment of chronic eye disease.

• Clearly defining the general practitioner’s, optometrist’s, and ophthalmologist’s scopes of practice may enhance the efficiency of vision care provision. These designations may also free up ophthalmologists to perform services that only they are trained to provide, thereby helping to maintain waiting lists at more acceptable levels.

• A working group in Nova Scotia focusing on eye care has developed an integrated vision care initiative for the management and treatment of patients with red eye and diabetes based on explicit delineation of scope of practice for general practitioners, Optometrists, and Ophthalmologists.

• Permitting Doctors of Optometry to practice to the full extent of their training and adopting a policy of service-based rather than provider-based coverage will increase the efficiency of health care systems by reducing redundant billing.

• Many agree that an automated sight test, also called auto-refraction, has been scientifically proven to be a safe, reliable and reproducible test. It uses equipment and a sophisticated computer program to test and measure visual acuity. It also calculates whether clients would see more clearly with the help of corrective lenses and determines the strength of lenses needed.
• The College of Opticians of British Columbia believe the amendment to the Opticians Regulation will provide a safe and effective service, will better inform the public about issues of eye health and will increase the identification and appropriate referral to other eye specialists of potential vision problems in citizens that might otherwise go unidentified.

• The College of Opticians of British Columbia has designed multi-level screening program to exclude from automated sight testing those individuals at higher risk for eye health problems, who instead need to have complete eye health exams. Clients will also be screened on the basis of the results of the sight tests and those persons identified who require a complete eye health examination will be referred for further investigation.