

Rethinking Information Sharing in Professional Regulation and Patient Safety: Lining Up Accountability, Transparency and Fairness

Frances Picherack, Moderator  
President, Petrine Consulting Inc



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### Public Protection Agenda

*“Two objectives continue to dominate regulatory reform, the protection of the public interest, and the promotion and freedom of competition and development so that consumers can be protected, environments preserved, and corruption prevented.”* Braithwaite, J. Fasken Law Lecture, UBC Law, 2010

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### Regulatory and Enforcement Agencies: Sparrow

*“The important features that distinguish regulatory and enforcement agencies from the rest of government are precisely the important features that they share. The core of their mission involves the imposition of duties. They deliver obligations, rather than services.”* Sparrow, Malcolm. The Regulatory Craft, Brookings Institute, 2005

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### Sparrow cont' d

- *“How regulatory and enforcement agencies use their powers fundamentally affects the nature and quality of life in a democracy. Not surprisingly, regulators are scrutinized more closely and criticized more regularly for their uses and abuses of power than their stewardship of public resources”*



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### Regulation a Distinctive Form of Policy: Levi-Faur

*“One of the most important features of regulation is that its costs, and some suggest also its politics are opaque. The most significant costs of regulation are its compliance costs, which are borne not by the government budget, but mostly by the regulated parties...”*



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### Levi-Faur cont' d

*“The widespread distribution of these costs and their embeddedness in the regulatees budgets make their impact, effects and net benefits less visible and therefore less transparent to the attentive public.”*

Levi-Faur, D. Regulation and Regulatory Governance, in D. Levi-Faur (Ed). Handbook on the Politics of Regulation. Cheltenham, UK, Edward Elgar, p. 2



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### The Public Sphere

- *“Regulatory games for accountability and transparency on the one hand, and political and beurocratic responses to blame shifting on the other, are becoming central to our organizational, social and politlcal behaviour”* (Hood, 2010) in Levi-Faur
- **Connected citizens: Concerned citizens**  
Chapman, Chris. Connected Citizens: A Regulatory Strategy (Chair, Australlian Communications and Media Authority). Ericsson Broadband for all Seminar, 24-25 June 2013, Stockholm



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### Link to Regulatory Enforcement

*“Transparency,accountability,effectiveness recommended for inclusion with principles to describe nurse regulation”* Benton et al, J Nsg Review, 2013

*“The most high level principles of enforcement are consistency , accountability and transparency, and a risk-based and proportionate approach to regulation”* Australian Gov't Productivity Commission, Reg. Audit Framework, 2014



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### Complex, Many Elements

- Information Sharing
- Duty of Candour
- Patient Safety
- Fairness
- Consumer Protection



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### Speaker Contact Information

Frances Picherack, President  
Petrine Consulting Inc.  
Vancouver, BC, Canada  
604-8424909  
[fpicherack@gmail.com](mailto:fpicherack@gmail.com)



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### Rethinking Information Sharing in Professional Regulation

Rod Hamilton, Associate Registrar, Policy  
College of Physiotherapists of Ontario



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### Goals of this presentation

- To understand some of the pressures on regulators to provide the public with more information on regulatory outcomes.
- To understand some reasons why it is hard for regulators to respond.
- To offer some ideas as to how and why regulators should respond.



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### Environmental Pressures

- National scandals, e.g. - Canadian Senate Expense Scandal, military cost overruns
- Provincial scandals - Alberta, Ontario...
- Municipal government scandals - Toronto, Montreal, London, Brampton, Mississauga...
- Regulatory Scandals - Physicians and other regulated health professionals



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### Population Response

- Cynicism toward government and its agencies
- Lack of faith in government and its agencies to do what is right
- Willingness to accept new rules and obligations for government and its agencies



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### Government Response

- New rules for expenses, contracts, to require increased openness.
- New rules on increased openness for executive compensation and benefits
- New proposed laws requiring more open meetings of government ABCs - with the option to also apply to other agencies through regulations



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### Potential effect on regulators

- Government willing to actively respond to scandals, concerns or public desires
- Government less willing to respond to typical regulator arguments
- Public is more demanding of openness



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### And what does the public want?

- Polling research indicates:
  - The public wants more information on regulatory outcomes
  - They want to use this information to guide their choice of providers
  - The more significant the regulatory outcome, the more they want to know about it
  - Access, not information, is their main issue



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### What information is public now?

- Demographic information on members
- Referrals to discipline and summary of allegations
- Discipline findings, including a summary of the case and the penalty



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### What don't we make public?

- Quality assurance information
- Fitness to practise information
- Complaints about members
- Screening committee outcomes:
  - Agreements and Undertaking
  - SCERPS
  - Cautions



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### So - How should regulators respond?

- Maintain the status quo? or
- Define a "new normal"



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### Arguments for doing nothing

- It's easy, cheap and quick!
- Complaints are only accusations
- Publishing complaints may turn them into weapons that may be used against members
- Educational outcomes work better if they are confidential



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**Arguments for doing nothing, cont.**

- Members will accept outcomes more willingly if they are kept confidential
- We can use confidential outcomes to manage matters we can't prove
- Panels won't use outcomes that are public
- Etc...

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**Is doing nothing the best option?**

“I'd rather attempt to do something great and fail than to attempt to do nothing and succeed.”

[Robert H. Schuller](#)

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**So what should regulators do?**

- Revisit what we provide to the public
- Give them (a lot!) more of the information they want and need
- Help them to understand it by putting it in context and explaining its significance.
- Do this in the context of our legislation and our regulatory models

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### Arguments for a new normal

- Its our job to represent the interests of the public
- When in doubt, the question of fairness has to be decided in favor of the public
- Members of the public want to know
- Members of the public believe they have a right to know



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### Arguments for a new normal, cont.

- The world is changing
- If we don't change with it willingly, we will be forced to change through rules imposed on us from outside
- We need to stop thinking like regulators and start thinking like patients, parents and children



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### Speaker Contact Information

Rod Hamilton  
Associate Registrar, Policy  
College of Physiotherapists of Ontario  
Toronto, Ontario Canada  
[rhamilton@collegept.org](mailto:rhamilton@collegept.org)



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**Towards a Duty of Candour**

Jonathan Bracken



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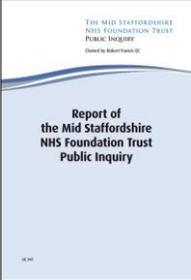
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**“I have made a great many recommendations, no single one of which is on its own the solution to the many concerns identified...”**

Robert Francis QC

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**NHS Foundation Trusts**

- public benefit corporations, led by board of directors;
- accountable to local community (membership open to anyone) who elect Governors to represent them;
- deliver services under contract with local clinical commissioning groups;
- may borrow, retain surpluses and determine services;
- free from government control but:
  - regulated by an economic regulator (Monitor) and facility regulator (Care Quality Commission);
  - annual reports and accounts laid before Parliament.

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**Openness, transparency and candour**

**Openness:** enabling concerns and complaints to be raised freely and fearlessly, and questions to be answered fully and truthfully

**Transparency:** making accurate and useful information about performance and outcomes available to staff, patients, public and regulators

**Candour:** informing patients where they have or may have been avoidably harmed by healthcare service whether or not asked



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**Francis: Recommendation 181**

A statutory duty of candour where treatment or care is believed to have caused death or serious injury, imposed upon:

- healthcare providers, to inform the patient or a duly authorised person
- registered health professionals, to inform their employer

Duty to be discharged as soon as is reasonably practicable

Ongoing duty to provide reasonable information and explanation

Compliance not evidence or admission of civil or criminal liability, but non-compliance should entitle the patient to a legal remedy



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**Candour: a legal novelty...**

**Powell v Boladz [1998] Lloyd's Rep Med 116**  
"Some kind of free standing duty of candour irrespective of whether a doctor-patient relationship exists in a healing or treating context, breach of which sounds in damages... would involve a startling expansion of the law of tort."

**R (Child Rights Alliance) v Justice Secretary [2013] EWCA Civ 34**  
"...there is no learning which remotely suggests that a non-State party, in any circumstances, might owe a duty to seek out or notify another of a claim which that other might have... Apart from anything else, the imposition of such a duty... would be repugnant to the common law's adversarial system of justice..."



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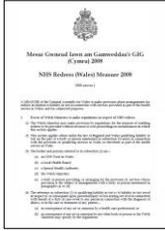
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### Wales: a different approach



**NHS Redress Policy Measure 2008**

1. The purpose of this measure is to provide a framework for the redress of NHS patients who have been harmed by NHS services.

2. The measure sets out the principles and objectives of the redress process.

3. The measure sets out the powers of the redress panel.

4. The measure sets out the powers of the redress panel to make recommendations.

5. The measure sets out the powers of the redress panel to make orders.

6. The measure sets out the powers of the redress panel to make awards.

7. The measure sets out the powers of the redress panel to make orders for costs.

8. The measure sets out the powers of the redress panel to make orders for interest.

9. The measure sets out the powers of the redress panel to make orders for damages.

10. The measure sets out the powers of the redress panel to make orders for costs, interest and damages.

Regulations must provide for redress ordinarily to comprise:

- an offer of compensation in satisfaction of any right to bring civil proceedings;
- the giving of an explanation;
- the making of a written apology; and
- the giving of a report on the action which has been, or will be, taken to prevent similar cases arising;



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### It needs more than words

“The Trust’s complaints procedure aims to deliver the six good practice values set out in the “Principles for Remedy” published by the Parliamentary and Health Service Ombudsman in March 2007. These include:

- Getting it right;
- Being customer focused;
- Being open and accountable;
- Acting fairly and proportionately;
- Putting things right; and
- Seeking continuous improvement.”

Mid-Staffordshire NHS Trust: Annual Report; 2007-8



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“*What can't be cured must be endured*” is the very worst and most dangerous maxim for a nurse which ever was made. Patience and resignation are but other words for carelessness and indifference. Contemptible if in regard to herself; culpable if in regard to her sick.”

Florence Nightingale  
*Notes on Nursing* (1860)



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**Speaker Contact Information**

Jonathan Bracken  
Special Counsel  
Bircham Dyson Bell LLP  
50 Broadway  
London SW1H 0BL

T: +44 20 7783 3408  
E: jonathanbracken@bdb-law.co.uk



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**Patient Safety, Transparency,  
Accountability -  
the Canadian Experience**

Brent Windwick  
Field Law, Edmonton, Canada



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**Objectives**

- Discuss collaborative efforts at systems level in Canada to shift to patient-centered, patient safety-oriented culture;
- Consider tensions within this shift and impact of these tensions on transparency and accountability of health care professionals;
- Identify legal and regulatory implications of these changes.



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### There Are Some Big, Unanswered Questions:

- Can reporting and disclosure be reconciled in the service of patient safety? Where does 'trust' meet 'just' ?
- Does disclosure undermine reporting and learning?
- Apology matters, but how can it stay that way?
- Does an emphasis on resolution help or hinder ?



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### What Role Does Law Play?

- Does: make some rules: eg. mandatory reporting
- Should: expose safety problems, but as yet no Canadian equivalent to [www.midstaffpublicinquiry.com](http://www.midstaffpublicinquiry.com)
- Should: remove obstacles to learning and improvement: eg. "quality assurance" legal protection
- Should: promote professional behaviour change, but as yet nothing as formal as a legal duty of candour
- Could: promote culture change, but is still an unfocused patchwork



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### Canadian Legal 'Tools'

- Legal Obligation to report (in some provinces)
- Legal Protection around reporting (universal)
- Legal obligation to disclose
- Legal Protection around disclosure
- Legal obligation to inform
- Legal obligation to be fair and just
- Professional/Organizational angst/fear about all of above (lawsuits, professional/employment sanction, reputational damage, etc.)



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## Apology - Opening the Door



SAY  
SORRY

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## Say Sorry, Because:



Say sorry, because:

1. It is the right thing to do
2. It helps the patient recover quickly
3. It helps restoring the trust of the patient in you, your institution and the health care services
4. Your relationship with the patient builds your mutual hope, respect and confidence
5. It may help you

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- “Mistakes have been made, as all can see and I admit.” Ulysses S. Grant, 1876
- “I recognize that mistakes were made along the way. In hindsight, there were many things I would have done differently. That said, I accept responsibility for all the decisions I have made.” Alison Redford (former Premier of Alberta), August 2014

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• “...the truth is that my colleague Giorgio Cheillini suffered the physical result of a bite in the collision he suffered with me. For this I deeply regret what occurred. I apologize to Giorgio Chiellini and the entire football family. I vow to the public that there will never again be another incident like this.” Luis Suarez



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### Encouraging Apology: Has Law Helped?

- Apology legislation BC, MB, ON, NS, NL
- Evidence Act amendments AB, SK
- Health Services Act amendments PEI
- No legislation: QB, NWT, YT, NV
- US: 36+ states



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### Consistency of Intent and Language is Key

- (1) “apology” means an expression of sympathy or regret, a statement that one is sorry or any other words or actions indicating contrition or commiseration, whether or not the words or actions admit or imply an admission of fault in connection with the matter to which the words or actions relate.
- (2) An apology made by or on behalf of a person in connection with any matter (a) does not constitute an express or implied admission of fault or liability by the person in connection with that matter, (b) does not constitute a confirmation or acknowledgment of a claim in relation to that matter for the purposes of the Limitations Act,



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### Consistency of Intent and Language Is Key

- (c) does not, notwithstanding any wording to the contrary in any contract of insurance and notwithstanding any other enactment, void, impair or otherwise affect any insurance coverage that is available, or that would, but for the apology, be available, to the person in connection with that matter, and (d) shall not be taken into account in any determination of fault or liability in connection with that matter.
- (3) Notwithstanding any other enactment, evidence of an apology made by or on behalf of a person in connection with any matter is not admissible in any court as evidence of the fault or liability of the person in connection with that matter.
- (4) This section does not apply to the prosecution of an offence.



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### What the Offended Party Wants

- Sincerity 98%
- Remorse 87%, empathy 85%, forgiveness 84%
- Trust 80%
- Dialogue 71%, dignity 69%, explanation 68%
- Cared for 65%, acknowledgement 62%
- Catharsis 57%, “not your fault” 55%
- Retribution - to see the offender suffer 12%



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### Reporting and Learning - Opening Inwards



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### Reporting Is Mandated by Law in Some Canadian Jurisdictions

- SK: "critical incidents" to RHA; RHA reports to Minister
- QB: "incident" or "accident" to executive director; ED reports to regional board (de-identified)
- ON: "critical incident" to hospital administration and medical advisory committee



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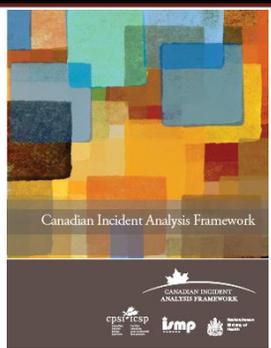
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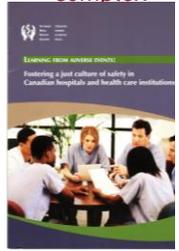
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### Balancing psychological safety and accountability is complex



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### Disclosure Is Legally Mandated in Various Ways

- Legislated: "critical incident" must be disclosed to patient eg. Public Hospital Act Reg 423/07 (ON)
- Court-adjudicated standard of care: eg. *Shobridge v. Thomas 1999 Canlii 5986 (BCSC)*
- Policy non-compliance as proof of breach of standard of care
- Professional accountability: CPSBC, CPSA, CPSS, CPSO standards and policies



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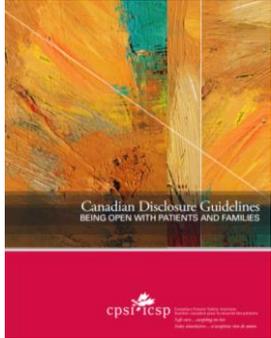
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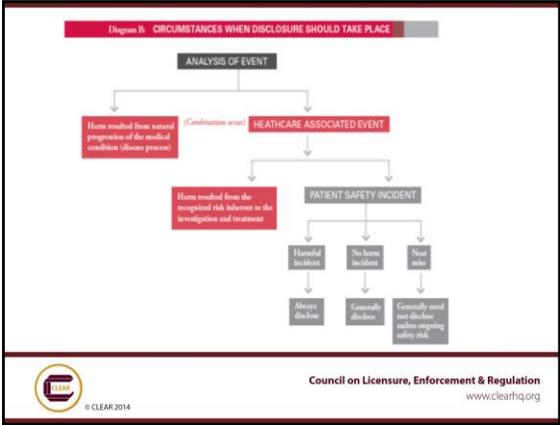
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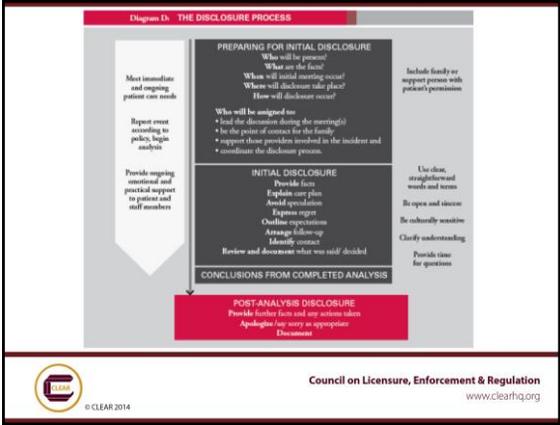
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### “Resolution” - Is It Properly Part of Patient Safety?

- ‘Practical support’ is increasingly common
- Compensation typically is excluded

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### Reviews Are Mixed on the Impact on Other Levers

- Full compensation offers did not decrease likelihood of seeking legal advice
- Full compensation offers increased perception that disclosure and apology motivated by desire to avoid litigation
- Hospitals, physicians, malpractice insurers may benefit from separating disclosure and compensation discussions

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### Looking Ahead: Changing the Pattern

- Individual commitment remains fragile
- Expectations of patients and healthcare providers are still not in sync
- Practices are still inconsistent
- Language of reporting and disclosure is still imprecise
- 'Legal' fears remain prominent



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### Key Challenges to Disclosure

- The challenge of putting policy into large-scale practice
- The conflict between patient safety theory and patient expectations
- The conflict between legal privilege for quality improvement and open disclosure
- The unexpected challenge of aligning open disclosure with liability compensation
- The gap in measurement of the occurrence and quality of disclosure discussions.



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### Some proposed solutions

- Making apology laws consistent across jurisdictions, including providing "blanket" cover for admissions of fault
- Preventing insurers voiding contracts when apologies are made, either through self-regulation or legislation
- And by inserting OD obligations into different structures within the health system.



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### More proposed solutions

- No-fault compensation fund (as in New Zealand/Scandinavia)
- Mandatory disclosure (duty of candor) tied to (a) a clear apology law that protects all aspects of the disclosure discussion and (b) a provision for mediation (outside the legal process) to cover cases in which disclosure fails to meet stakeholders' expectations
- A requirement for organizations to include interested patients in incident/outcome reporting, incident investigation, and clinical improvement initiatives (original patient, representative, or any consumer)
- A national, public clinician registry (as in Australia) that is protected from legal action in which information about all practicing clinicians is brought together and in which details about their certification, specialization, achievements, as well as incident disclosures and disciplinary actions can be accessed.

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### Potential Solutions - recent suggestions

- Health worker education coupled with incentives to embed policy into practice
- Better communication about approaches beyond the punitive
- Legislation that allows both disclosure to patients and quality improvement protection for institutions
- Apology protection for providers
- Comprehensive disclosure programs that include patient compensation
- Delinking of patient compensation from regulatory scrutiny of disclosing physicians
- Legal and contractual requirements for disclosure
- Better measurement of its occurrence and quality.

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### Acknowledgements and Resources

- Canadian Patient Safety Institute  
[www.patientsafetyinstitute.ca](http://www.patientsafetyinstitute.ca)
- Canadian Medical Protective Association  
[www.cmpa.org](http://www.cmpa.org)
- Articles footnoted in this presentation

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**Questions?**

Brent Windwick, QC  
Partner  
T (01) 780 423 7696  
[bwindwick@fieldlaw.com](mailto:bwindwick@fieldlaw.com)

With **FIELD LAW**



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Rethinking Information Sharing in Professional  
Regulation and Patient Safety: Lining up  
Accountability, Transparency and Fairness  
Debbie Tarshis, WeirFoulds LLP



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**Goal**

- Raise questions
- Fairness to members



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### Background

- Series of articles in Toronto newspaper in January, 2013
- “Doctors, dentists, pharmacists: The mistakes you can’t know about”
- “The warnings issued to them are kept secret by their regulatory colleges because they aren’t required to tell you about them”



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### Transparency Initiative

- Advisory Group for Regulatory Excellence (AGRE) established
- 8 principles to guide regulatory college discussions about making more information publicly available



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### Transparency Initiative (Cont’ d)

- Need to achieve an appropriate balance of public protection and accountability with fairness and privacy



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### Recent Debate

- Summer of 2014 debate again in public arena
- Ontario Hospital Association
- Ontario Trial Lawyers Association
- Patients Canada

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### Other Developments

- Canadian Civil Liberties Association (CCLA) Report: False Promises, Hidden Costs
- Non-conviction records frequently disclosed on police record checks

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### Other Developments (Cont' d)

- “The widespread release of non-conviction records runs counter to the presumption of innocence; violates individuals’ privacy; and leads to discriminatory, stigmatizing exclusion from employment, education and community opportunities”

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### Other Developments (Cont' d)

- CCLA recommendations



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### Screening Process for Complaints and Reports

- Regulatory bodies have a screening committee (or committees)
- Complaint about the conduct or actions of a registrant/member
- Mandatory reports or other information that comes to the attention of the regulatory body



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### Screening Process for Complaints and Reports (Cont' d)

- Screening committee conducts an investigation
- Screening committee decides how to dispose of a complaint and/or report
- Types of disposition



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### What is a Caution?

- Educational and advisory in nature
- Not a sanction
- Not a reprimand



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### Ontario Courts and Cautions

- *Silverthorne vs. Ontario College of Social Workers and Social Service Workers*
  - “The Committee does not make findings of fact nor determine whether discipline is warranted; rather, it weighs the evidence to determine whether there is sufficient evidence to refer the matter to the



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### Ontario Courts and Cautions (Cont' d)

Discipline Committee or the Fitness to Practise Committee. It is those bodies which will make findings of fact.

While the Complaints Committee can itself caution a member, a caution is not a sanction. It is advisory in nature and intended to be remedial (*citation omitted*). A caution is not recorded in the public registry of the College nor publicized by it.”



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**Ontario Courts and Cautions  
(Cont' d)**

- *Fielden v. Health Professions Appeal and Review Board*
  - *“The decision of the Committee to caution the applicant in person is not a ‘sanction’. Cautions are entirely remedial in nature and intended to assist the applicant to improve his practice. A caution administered by the Committee is not a penalty and must be*

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**Ontario Courts and Cautions  
(Cont' d)**

contrasted with the range of penalties that can be imposed by the Discipline Committee of the College consequent to a finding of professional misconduct. The Discipline Committee of a College can impose a variety of sanctions, which may be recorded on the permanent and public record of a member. By contrast, a caution is remedial only, cannot involve any

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**Ontario Courts and Cautions  
(Cont' d)**

finding of professional misconduct (a finding which is outside the jurisdiction of the ICRC and the Board), and does not appear on the register or in any public document of the College.”

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**Ontario Courts and Cautions  
(Cont' d)**

- *Ren v. College of Massage Therapists of Ontario*
  - “As to the second issue, we agree with Mr. Frost that the caution was delivered in firm language. However, the panel made no findings of misconduct but rather was prepared once again to accept that the unfortunate articulation by the applicant of the nature of her services, both in the

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**Ontario Courts and Cautions  
(Cont' d)**

brochure and subsequently orally was not deliberate but rather inadvertent.

On the other hand, given the seriousness of any deliberate claim by her to be able to cure serious medical conditions, it was not inappropriate to caution her in strong language not only for the protection of the public but also for her own protection to be very careful in explaining her services to the public.

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**Ontario Courts and Cautions  
(Cont' d)**

- We agree with Mr. Frost that the panel was not authorized to issue a reprimand in the nature of discipline, but only to issue remedial guidance. We are not, however, persuaded that the panel crossed over the line in the circumstances of this case.”

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### Decision-making Process of Screening Committee

- Investigation
- Are allegations serious enough to warrant referral to Discipline Committee for a hearing?
- Sufficient evidence to warrant referral to Discipline Committee for a hearing?

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### Screening Committee and Caution

- Caution is remedial and advisory in nature
- No finding of professional misconduct

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### Making Caution Publicly Available

- Fairness to member, given process of screening committee?
- Caution turned into a penalty through publication?
- What is impact on a registrant's current employment, future employment, professional standing?

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**Making Caution Publicly Available (Cont' d)**

- Should all cautions be made publicly available or only cautions of a serious nature?
- How would a regulatory body ensure that there was consistency in its own application of "serious" and consistency with other regulatory bodies?

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**Making Caution Publicly Available (Cont' d)**

- How would a regulatory body ensure that the public understands that a caution is different from a reprimand? That for a caution there has been no finding of professional misconduct after a hearing.

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**Making Caution Publicly Available (Cont' d)**

- Would a caution that is published be perceived by the public as any different from a reprimand made after a finding of professional misconduct?
- Would the impact on the member's employment and professional standing be any different?

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### Making Caution Publicly Available (Cont' d)

- Does a regulated professional have any expectation of privacy with respect to advice of a remedial nature?
- Does making this advice publicly available defeat its purpose insofar as the health professional is concerned and in effect turn a caution into a penalty?



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### Speaker Contact Information

Debbie Tarshis  
WeirFoulds LLP  
(416) 947-5037  
dtarshis@weirfoulds.com



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### Transparency, Accountability, and Consumer Protection in Healthcare Regulation: The U.S. Experience

Georgia Roberts, Esq. Program Director  
Colorado State Board of Nursing



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**“It is wrong and immoral to seek to  
escape the consequences of one’s  
acts.”**

**Mahatma Gandhi (1869 - 1948)**



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**Common  
concerns**

**Challenges**

**Interests**



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**Public safety is paramount**

Shared interests may include

- Patient privacy
- Privacy of the individual healthcare provider
- Transparency *by* the regulatory body in carrying out its Consumer Protection Mission
- Accountability *of and to* the healthcare provider
- Accountability *of* the regulatory entity



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EXIT 23 →

ACCOUNTABILITY  
STRAIGHT AHEAD

Accountability of the healthcare provider  
= Practice requirements & compliance  
enforcement

Accountability to the healthcare provider  
= providing due process if adverse action  
may occur

Accountability of the regulatory entity

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**Nursing in the United States: An Open Book**

- U.S. Professional Practice is “an open book”.
- National Council of State Boards of Nursing (NCSBN)
- NURSIS - national database for verification of nurse licensure, discipline and practice privileges for registered nurses (RNs), licensed practical/vocational nurses (LPN/VNs), and advanced practice registered nurses

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- National Practitioner Data Bank (NPDB)
- Nurse Licensure Compact (NLC)
- Healthcare Professions Profiling Program (HPPP)
- Prescription Drug Monitoring Program (PDMP)
- Sunset Review by State Legislature
- Open Records Acts (vary by state; public & media access balanced with individual privacy protection)

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### National Council of State Boards of Nursing (NCSBN)

- The National Council of State Boards of Nursing is a not-for-profit organization and the “collective voice of nursing regulation in the U.S. and its territories”.
- Disseminates nurse licensure data
- Maintains the Nursys.com database, which coordinates national, public nurse licensure information
- Provides eNotify services to employers



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•NCSBN membership comprises boards of nursing in the 50 U.S. states, the District of Columbia and four U.S. territories (American Samoa, Guam, Northern Mariana Islands, and the Virgin Islands). NCSBN also has 16 associate members.

•In 1997 the future of Nurse regulation became NCSBN's focus. In 2000, NCBSN launched a new initiative to expand the mobility of nurses as part of our nation's healthcare delivery system.



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### Nurse Licensing Compact

- The Nurse Licensure Compact (NLC) allows nurses to have one multistate license, with the ability to practice in both their home state and other party states.
- Based on Mutual Recognition & Trust
- Is state based, but borderless
- Practice occurs where patient is located
- Allows Single State License where needed



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The diagram is a 3D-style box titled "Mutual Recognition Regulatory Model". It is divided into three vertical columns. The first column contains the text: "Unity of Mission", "Identify Individual State Interests", "Common Concerns", and "Align Interests". The second column contains: "Generosity of Spirit", "Licensee accepted to practice within the regulatory model". The third column contains: "Stay in Own Lane", "Licensee declares PSOR", and "Individual state authority to discipline".

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### Interstate Compacts

- Compact - A hybrid of contract law and statutory law; takes precedent over state law; and is specifically authorized under the "Compact Clause" of the U.S. Constitution (Article I, Section 10, Clause 3).
- Black's Law Dictionary defines as "Formal agreement between 2 or more states to remedy a problem of mutual concern."
- Enacted through legislation at state level

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- To date 24 of the 50 United States belong to the NLC. 22 other states, along with the District of Columbia and 4 Territories (American Samoa, Guam, Northern Marianna Islands, and the Virgin Islands) "participate" in a number of NLC features without belonging to the compact, leaving only 3 of the 50 United States not involved in some manner in this compact.
- Compacts are not new!!

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**Other U.S. Healthcare Compacts**

- **Advanced Practice Registered Nurse Compact (APRN)**  
In 2002 NCSBN began addressing the need to promote consistent access to advanced practice nursing care within states and across state lines. This is a significant step forward toward increasing mobility for APRNs and access for the public to qualified APRNs.

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**Timeline for APRN Compact**

- 2010-2012: An APRN Compact Implementation Group formed and met regularly. The group included the Executive Directors of state boards of nursing in states that passed the legislation (TX, IA and UT) but never implemented it, as well as from Idaho which has interest in future APRN Compact membership.
- January 1, 2016: The anticipated implementation date of the APRN Compact.

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- **Federation of State Medical Boards (FSMB)**
  - Drafting in progress; anticipated draft completion 2015
  - Needs 7 states to implement

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- National Association of EMS Officials
  - Drafting in progress; anticipated draft completion 2015
  - Need 10 states to implement



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- Federation of State Boards of Physical Therapy
  - Advisory stage; drafting expected to commence late fall 2014



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- Association of State and Provincial Psychology Boards
  - Advisory stage; drafting expected to commence late fall 2014



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**NURSYS**

- Nursys is the only national database for verification of nurse licensure, discipline and practice privileges for registered nurses (RNs), licensed practical/vocational nurses (LPN/VNs), and advanced practice registered nurses (APRNs) licensed in participating boards of nursing, including all states in the Nurse Licensure Compact (NLC).

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- Boards of Nursing (BON) who participate in Nursys send scheduled updates of information to Nursys. 54 BONs participate in providing licensure data to Nursys. All of NCSBN's 58 (RN and PN) Member Boards share disciplinary data through Nursys. AL, HI, LA PN, and OK are non-participating).
- Provides online verification to a nurse requesting to practice in another state and nurse license lookup reports to employers and the general public

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- Nurse License Verification service enables nurses to verify their license(s) from a Nursys licensure participating board of nursing when applying for endorsement into another state.
- Designated as a primary source equivalent database through a written agreement with participating BONs.
- Nursys data is entered by individual states
- All updates are reflected immediately - includes licensing information, status, and any public discipline, as well as "Nurse Alerts".

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### ENotify

- Institutions / employers who subscribe to this free service do not have to proactively seek licensure or discipline information about their nurses. The information is sent automatically.
- Alerts when modifications are made to a nurse's record, including changes to: License status (i.e. expirations, renewals, alerts/notifications); and public disciplinary action/resolutions along with access to available documents.



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### National Practitioner Data Bank (NPDB)

- Federal data bank which was created to serve as a repository of information about healthcare providers in the United States.
- This data bank collects and discloses only to authorized users negative information on healthcare practitioners, including malpractice awards, loss of license or exclusion from participation in Medicare or Medicaid.



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- Mandatory timely reporting is required
- Prior to May 6, 2013, the Data Bank comprised the National Practitioner Data Bank and the Healthcare Integrity and Protection Data Bank (HIBDB). The two were consolidated by Section 6403 of the Affordable Care Act of 2010, Public Law 111-148.



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### What Data is Collected?

- Medical malpractice payments
- Any adverse licensure actions
- Adverse professional society membership actions
- Exclusions from Federal or State healthcare programs
- Any negative action or finding by a State licensing or certification authority
- Peer review organization negative actions or finding against a health care practitioner or entity



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- Private accreditation organization negative actions or findings against a health care practitioner or entity
- Licensing and certification actions
- Criminal convictions (healthcare-related)
- Adverse clinical privileging actions
- Other adjudicated actions or decisions (formal or official actions, involving a due process mechanism and based on acts or omissions that affect or could affect the payment, provision, or delivery of a health care item or service)



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### Who Reports to the Data Bank?

- Medical malpractice payers
- State health care practitioner licensing & certification authorities
- Hospitals
- Health plans
- Federal and State Government agencies
- State entity licensing & certification authorities
- Peer review organizations
- Professional societies with formal peer review, HMOs, managed care organizations, etc.



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### Who may access reports?

- Hospitals
- Other health care entities, with formal peer review
- Professional societies with formal peer review
- State entity licensing and certification authorities\*
- State health care practitioner licensing and certification authorities (including Medical and Dental Boards)
- State agencies administering State health care programs\*



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### Who else?

- State Medicaid Fraud Units\*
- U.S. Comptroller General\*
- U.S. Attorney General and other law enforcement\*
- Federal and State Government agencies
- Agencies or contractors administering Federal health care programs\*
- Researchers (statistical data only)
- Health plans
- Quality Improvement Organizations\*



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### Did we leave anyone out?

- Healthcare practitioners (self query)
- Plaintiff's attorney/pro se plaintiffs\*
- \* The Act defines the limits



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### Healthcare Professions Profiling Program (HPPP)

- States take consumer protection, practitioner transparency and accountability even further.
- In 2007 Colorado passed the Michael Skolnik Medical Transparency Act, to provide important information about the quality of Colorado healthcare providers. First, only applied to physicians.
- Colorado physicians helped pass the law.



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- The Act required physicians to complete online questionnaires or “profiles”. The intent behind this law was for the consumers in Colorado to have access to information about their physicians so they could make more informed healthcare decisions.
- In 2010, the Colorado legislature passed the Michael Skolnik Medical Transparency Act of 2010, expanding the profiling requirement to include 22 additional license types.
- Profile questions vary based on license type.



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#### Now in 2014 ....

- Acupuncture
- Addiction Counseling
- Athletic Training (New)
- Audiology
- Certified Nurse Aides (New)
- Chiropractic
- Dental (New)
- Medical
- Direct-Entry Midwifery
- Marriage and Family Therapy
- Massage Therapy (New)
- Nursing
- Occupational Therapy
- Optometry
- Pharmacy (New)



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- Psychology
- Respiratory Therapy (New)
- Physical Therapy (New)
- Podiatry
- Professional Counseling
- Naturopathy
- Speech-Language Pathology
- Psychotherapy
- Psychiatric Technician - Developmentally Disabled (New)
- Psychiatric Technician - Mentally Ill (New)
- Social Work
- Surgical Assistants and Technologists



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### HPPP Highlights

- The Healthcare Professions Profiling Program or HPPP was created to monitor the healthcare profiling requirement in Colorado.
- Information provided in profiles is submitted by the individual licensee (state staff monitors).
- Healthcare Professions Profiles must be updated within 30 days of a change or reportable event.
- Inaccurate, untimely, or other noncompliant reporting subject to \$\$ fine.



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### Prescription Drug Monitoring Program

- Pursuant to CRS 12-42.5-403, all Colorado licensed prescribing practitioners who possess an individual DEA registration and all Colorado licensed pharmacists are required to register an individual user account with Colorado's Prescription Drug Monitoring Program (PDMP).
- Pharmacists, DEA-registered Advanced Practice Nurses, DEA-registered Dentists, Veterinarians, Optometrists and Podiatrists; and DEA-registered Medical Board licensees



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### Balancing Privacy

**Privacy**

- Individual Provider's Rights
- Economic Effect of Public Discipline

**Transparency**

- Accountability
- Patient Safety
- Informed Consumer

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**THE PRIVACY TRAIN WRECK**

WHEW FOR THE WOOD!  
LET'S GET THE PRIVACY WRECK!  
LET'S GET THE PRIVACY WRECK!

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**“When it comes to privacy and accountability, people always demand the former for themselves and the latter for everyone else.”**

**David Brin, 2014 (American author)**

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### Regulating the Regulator (Transparency and Accountability)

- Involves all three Branches of Government
  - Regulatory agency is created by Executive Branch
  - Subject to scheduled Legislative Sunset Review
  - Judicial Review (Due Process for the licensed provider adversely affected by regulatory action)



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### Open Records Acts

- Vary by state
- Common features
- What's open and what's protected



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<http://www.npdb.hrsa.gov/>  
Phone Main 1.800.767.6732 (1.800.SOS.NPDB)  
Outside US 1.703.802.9380  
TT/TDD 1.703.802.9395
- NCSBN - <https://www.ncsbn.org>
- NURSYS - <https://www.nursys.com/>
- NLCA - <https://www.ncsbn.org/nlc.htm>
- HPPP - [www.dora.colorado.gov/professions/hppp](http://www.dora.colorado.gov/professions/hppp)  
Phone (303) 894-7855 or (800) 886-7675 Toll Free



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### Speaker Contact Information

Georgia Roberts, Esq., Program Director  
State Board of Nursing  
Dept. of Regulatory Agencies (DORA)  
Division of Professions & Occupations (DPO)  
1560 Broadway - Suite 1350  
Denver, CO 80202  
T: (303) 894-2819  
E: georgia.roberts@state.co.us

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