Managing Conflict Of Interest In Healthcare: The Roles Of Professionalism And Regulatory Colleges

by

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A thesis submitted in conformity with the requirements for the degree of Doctor of Philosophy
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Abstract

Self-regulation relies on professionalism, which entails the existence of a specialized body of knowledge, associated activities best evaluated by those possessing this knowledge, the expectation that professionals act on behalf of their clients, and the potential for harm if the activities are not carried out well (Bayles 1986; Cruess & Cruess, 1997; Freidson 1994, 2001). A conflict of interest (COI) occurs when conditions may unduly influence an individual’s behavior or ability to carry out his/her obligations (Thompson, 1993; Carson, 1994). In healthcare, COI may interfere with patient care, and erode trust, undermining self-regulation’s effectiveness (Thompson, 1993; Cruess, Johnston and Cruess, 2002; Tonelli, 2007; Haines & Olver, 2008).

This study examined how four Ontario-based regulatory Colleges addressed financial COI. Incorporating a nested multiple-case study, part one, a descriptive study examined which health professions were self-regulated in Canada. Part two, a multiple-case study examined four health
professions’ Colleges in Ontario regulating: Audiologists and Speech-Language Pathologists; Nurses; Physiotherapists; and Physicians.

Part one’s results indicated differences amongst the provinces regarding legislative framework implementing self-regulation, and which health professions were granted self-regulation. Part two’s results indicated that the four Colleges had mechanisms in place to address financial COI, although the number of disciplinary hearings that related to financial COI was low, suggesting the number or importance of financially-based COI issues within these Colleges was low. It was also reflective of the disciplinary process which largely relies on complaints or concerns being submitted to the College.

The areas these Colleges perceived their members to have COI concerns could be related back to nature of work, work environment and remuneration. The Colleges viewed publicly-funded services as minimizing the risk for financial COI. The Colleges did not have oversight in determining fees, and pricing under any remuneration structure, nor did their mandates extend to non-professionally owned/managed businesses. Areas identified for further investigation to inform policy development included examining how accountability is maintained in areas related to financial COI for publicly-funded services. In addition, how Colleges might play a role in maintaining public interest and trust as profession-controlled markets are moving towards corporately-owned or controlled models warrants further study.
Acknowledgments

I am very grateful to have been given the opportunity to pursue my doctoral education and dissertation. It has been a tremendous learning experience for me both personally and professionally. During the course of working on this dissertation I have been an employee of Lifestyle Hearing Corporation. My dissertation and all associated research activities were conducted independently of my employer, and my views and comments are mine alone, and are not meant to represent the opinions or views of my employer.

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<tr>
<td>AUD</td>
<td>Audiologist</td>
</tr>
<tr>
<td>CASLPO</td>
<td>College of Audiologists and Speech-Language Pathologists of Ontario</td>
</tr>
<tr>
<td>CCAC</td>
<td>Community Care and Access Centres</td>
</tr>
<tr>
<td>CIHI</td>
<td>Canadian Institute for Health Information</td>
</tr>
<tr>
<td>CIHR</td>
<td>Canadian Institute for Health Research</td>
</tr>
<tr>
<td>COI</td>
<td>Conflict of Interest</td>
</tr>
<tr>
<td>CNO</td>
<td>College of Nurses of Ontario</td>
</tr>
<tr>
<td>CPSO</td>
<td>College of Physicians and Surgeons of Ontario</td>
</tr>
<tr>
<td>CPO</td>
<td>College of Physiotherapists of Ontario</td>
</tr>
<tr>
<td>CST</td>
<td>Canadian Social Transfer</td>
</tr>
<tr>
<td>FFS</td>
<td>Fee-for-service</td>
</tr>
<tr>
<td>HPPC</td>
<td>Health Professions Procedural Code</td>
</tr>
<tr>
<td>HPRAC</td>
<td>Health Professions Regulatory Advisory Council</td>
</tr>
<tr>
<td>ICRC</td>
<td>Investigations, Complaints and Reports Committee</td>
</tr>
<tr>
<td>IRB</td>
<td>Institutional review board</td>
</tr>
<tr>
<td>IVF</td>
<td>In vitro fertilization</td>
</tr>
<tr>
<td>MLT</td>
<td>Medical Laboratory Technologist</td>
</tr>
<tr>
<td>MRC</td>
<td>Medical Review Committee</td>
</tr>
<tr>
<td>NP</td>
<td>Nurse Practitioner</td>
</tr>
<tr>
<td>OHIP</td>
<td>Ontario Health Insurance Plan</td>
</tr>
<tr>
<td>PT</td>
<td>Physiotherapist</td>
</tr>
<tr>
<td>RHPA</td>
<td>Regulated Health Professions Act, 1991</td>
</tr>
<tr>
<td>RN</td>
<td>Registered Nurse</td>
</tr>
<tr>
<td>SLP</td>
<td>Speech-Language Pathologist</td>
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Chapter 1
Introduction

Overview of Study

Self-regulation is an authority-based policy instrument that may be used by government in the implementation of health policy (Doern & Phidd, 1992; Howlett, Ramesh & Perl, 2009). Self-regulation as a policy instrument allows the government to delegate responsibility for managing the creation, administration, and renewal of standards governing the activities of certain groups to non-governmental regulatory bodies (Deber, 2014b). It relies heavily on the concept of professionalism which includes such factors as the existence of a specialized body of knowledge, the recognition that good/bad practice is difficult to evaluate by those who do not have that body of knowledge, and an ‘agency’ relationship where the professionals act on behalf of their clients, plus the potential for harm if the activities are not carried out well (Bayles 1986; Cruess & Cruess, 1997; Freidson 1994, 2001).

In Ontario, the Regulated Health Professions Act, 1991 (RHPA), granted self-regulation to 26 healthcare professions and as such is a policy instrument used in the delivery of healthcare in Ontario. Each healthcare profession has a governing regulatory body that is responsible for ensuring all aspects of the RHPA are upheld. The Health Professions Procedural Code (HPPC) of the RHPA stipulates that the Colleges have a responsibility to "serve and protect the public interest" (1991, c. 18, Sched. 2, s. 3 (2)). Conflict of interest (COI) has the potential to negatively impact patient care, and erode trust in the profession, which in turn undermines self-regulation (Cruess, Johnston & Cruess, 2002; Haines & Olver, 2008; Thompson, 1993; Tonelli, 2007).

The aim of this study is to examine and compare how four regulatory Colleges that differed in terms of members’ scope of practice/nature of work performed, work environment and the remuneration structure addressed financial COI. The study incorporated a nested multiple-case study approach. The first part of the study entailed a descriptive approach that examined which health professions were self-regulated in Canada, and how this self-regulation varied across provinces. The second part of the study incorporated a multiple-case study focusing on four self-
regulated professions’ regulatory bodies in the province of Ontario: the College of Audiologists and Speech-Language Pathologists of Ontario (CASLPO), the College of Nurses of Ontario (CNO), the College of Physiotherapists of Ontario (CPO) and the College of Physicians and Surgeons of Ontario (CPSO).

1.1 Background and Statement of the Problem

Thompson (1993) defined conflict of interest as, “a set of conditions in which professional judgment concerning a primary interest (such as a patient's welfare or the validity of research) tends to be unduly influenced by a secondary interest (such as financial gain)” (p. 573). Secondary interests (such as remuneration) may be a necessary part of a profession, however it is the importance and weight these secondary interests have in the professional’s decision making that may be at issue and hinder the individual’s ability to fulfill his/her professional obligation (Carson, 1994; Thompson 1993). A COI may interfere with patient care, erode patient trust and undermine the effectiveness of self-regulation (Cruess, Johnston and Cruess, 2002; Haines & Olver, 2008; Thompson, 1993; Tonelli, 2007). Approaches that can be used to address COI include government oversight, and/or self-regulation.

COI among health professionals is often addressed by professional Colleges. In Ontario, the Colleges of the health professions that are granted self-regulation under the RHPA, are responsible for ensuring all aspects of the RHPA and the associated profession-specific legislation are upheld. The professions regulated by these Colleges vary in a number of ways, including the nature of work they perform, the type workplace settings under which they practice, and how they are remunerated. For example, the nature of work undertaken by a profession is in part determined by their scope of practice and right to perform controlled or restricted activities, as defined by health legislation. Scope of practice describes the type of work a profession does, and may be determined by a number of factors including eligibility requirements of the profession, what the profession is trained to do and authorized to do through legislation and the professions’ standards of practice, employer policies, and may be further defined in the provincial regulatory framework (Canadian Nurses Association, 2007).
Controlled or restricted activities have been legally defined by various provincial legislations as actions that, due to the risk of harm to the person associated with the activity, are legally authorized to a subset of professions to perform each in the provision of healthcare.

The professions’ defined scope of practice and authorization to perform any of the controlled acts will in turn impact their degree of autonomy and decision making, and may also influence the type of work environment under which a profession might practice. How a profession is compensated will be related to the nature of the work performed and the practice environment. These variations in the nature of work done, workplace environment and remuneration may result in the professional being exposed to different scenarios in which the potential for COI exists. The goal of this study will be to understand how professional self-regulation and the underlying concept of professionalism address financial conflict of interest.

1.2 Research Questions

The study has been designed to answer a number of research questions pertaining to self-regulation and COI. The first part of the study was designed to gain a general understanding of the Canadian regulatory environment for self-regulated health professions. After examining the regulatory environment across the provinces, closer examination was made of the Ontario regulatory framework. Specifically, the following questions were asked:

1. Which health professions were granted self-regulation within each province in Canada?

2. To what extent was there overarching/umbrella legislation across the professions and to what extent was the legislation profession-specific?

3. Where overarching/umbrella legislation existed, did it address college mandates, ethics, and complaint handling/investigations, protection of title and/or controlled or restricted activities?

4. How did the Ontario legislative framework set forward expectations for managing the conduct of the self-regulated health professions?
Within this context of the Canadian regulatory environment, the second part of the study focused on four specific Ontario-based self-regulated health professions’ regulatory Colleges and examined the following questions:

5. How did each College define COI and what specific scenarios or situations were incorporated in defining COI?

6. How did each College provide its registrants with guidance pertaining to financial COI? Was this guidance based on one-way communication from the College to its membership or was there two-way communication with input from the registrants in which the registrants could seek clarification from the College?

7. How did each College address allegations of professional misconduct related to financial COI?

8. To what extent was financial COI perceived to be an issue for the profession based on practice specific variables (nature of work, work environment, and remuneration)?

9. How important of an issue did the key informants think financial COI was as an issue and concern for the College? How effective did the informants feel the College was at addressing financial COI?

1.3 Structure of the Thesis

Chapter 1 provides a brief introduction to self-regulation, COI and financial COI along with the purpose of the study including presenting the research questions.

Chapter 2 provides an overview of the conceptual framework of the thesis by presenting an overview on professionalism, including professionalism as it is applied in the delivery of healthcare. In addition COI is defined as it applies to the provision of healthcare and the notion of the social contract between the profession of medicine and society is discussed. Finally, the role of professional self-regulation is discussed in the delivery of healthcare and addressing COI.
Chapter 3 discusses the methodology used to answer the research questions. Specifically, nested multiple-case study methodology was used. The first part of the study was a descriptive study designed to provide an understanding of which professions were self-regulated across Canada and how the self-regulation was implemented in order to provide some context for the second part of the study, which focused on four Ontario-based health professions regulatory Colleges. The case study methodology used in the second part of the study focused on understanding how four colleges addressed financial COI. The questions were focused on answering how the Colleges addressed COI and whether there was any impact on the approach related to nature of work, work environment and remuneration of the registrants. The multiple-case study approached incorporated document analysis and key informant interviews.

Chapter 4 presents the results and findings of the document analysis for the first part of the study.

Chapter 5 presents the results and analysis of the multiple-case study, which focused on understanding how four health professions Colleges addressed financial COI.

Chapter 6 discusses the key findings and implications, along with study limitations. Final conclusions are summarized along with suggestions for future research.
Chapter 2
Conceptual Framework

Professionalism

2.1 Professionalism

Professionalism is the concept underlying self-regulation (Bales, 1986; Freidson, 1994, 1988, 2001) but has also been characterized as a method of defining occupational control of work (Freidson, 1986, 2001). A profession is an occupational group that organizes and controls its own work. Freidson (1994, 2001) discussed a model of logic of professionalism, comparing it to market and firm logics in terms of how work can be organized and controlled. Freidson wrote that professionalism existed when, “an organized occupation gains the power to determine who is qualified to perform a defined set of tasks, to prevent all others from performing that work, and to control the criteria by which to evaluate performance” (Freidson, 2001, p.12). He further described the institutional characteristics of ideal-typical professionalism. These characteristics included: 1) a unique and specialized knowledge and skill set that is explicitly recognized for the professional group; 2) an occupationally-based controlled division of labor; 3) an occupationally- or professionally-controlled labor market that requires training credentials for entry and career advancement; 4) an occupationally controlled training program which produces the previously mentioned credentials which are required for work and acceptance as a member of the profession; and 5) the ideology of professionalism which includes the professional ideology of service. He described the professional ideology of service as going beyond servicing others, “of serving some transcendent value which infuses its specialization with a larger and putatively higher goal which may reach beyond that of those they are supposed to serve” (Freidson, 2001, p.122). This professional ideology which included service and working for a greater good, combined with the specialized knowledge and skill set allows for what Tuohy described as a “principal-agent” relationship that results between the medical professional and their patient, where due to asymmetry of information and the patient’s inability to fully judge the quality or scope of work being done, they are relying on and trusting the professional to make the most appropriate decisions on their behalf (Arrow, 1963; Tuohy, 2003).
One implication of the first element Freidson used to define professionalism, the specialized knowledge and skill set that are unique to a profession, is that the professions are best suited to judge the work of their own members. However, when the profession is granted the authority to govern the work of their own, including credentialing and licensing requirements, this autonomy may also result in power and market dominance for these occupational groups (Freidson, 1994, 2001). The ability to control educational programs, education or knowledge requirements, and entrance to practice as a member of the profession provides the professional group with a certain market shelter (Freidson, 2001). Unlike a free market, where entrance is not restricted but based on market logics of supply and demand, the result is what Freidson refers to as an “organized autonomy” model, and implies that the profession is free from competition or regulation by other workers through its own control to entry and practice (Freidson, 1970b, 2001). Professional autonomy is viewed as an ultimate goal of professionalism, representing freedom to dictate how one performs work and freedom from the direction of others (Freidson, 1970a, 1970b). This professional dominance is part of what is often termed the “professional ideology” which focuses on the pursuit of self-interests including gaining control of the market, autonomy in work, increased status, ability to negotiate or control remuneration and other associated economic concerns that are driven by self-interests (Freidson, 2001; Light, 2004).

Scholars differ in how they see the balance between the self-interests that are part of the professional ideology and the normative aspects of professionalism, which stress the importance of a shared identity and value system that stresses the best interests of patients/clients (Evetts, 2003, 2006; Freidson, 2001; Tuohy, 1999). The underlying expectation is that due to the unique knowledge and skill set and the significant amount of discretion and occupational authority afforded to a profession that there would be a strong sense of moral dedication to uphold a high performance standards and maintain the public trust (Sullivan, 2000).

Professionalism has been characterized as a social contract between the profession and the public in which an occupational authority and professional independence had been granted to the profession (Cruess & Cruess, 2000, 2008; Sullivan, 2000). In exchange for this authority to
control the market and how the profession is trained, credentialed and licensed to operate within this market there lies the expectation and trust that the professions will maintain high standards of competency and moral responsibility (Sullivan, 2000). The concept of professional self-regulation is based on the premise that the professional system of collegiality will ensure that self-interests do not override the interests of the public that the professional is serving (Tuohy, 1999). The profession is thus responsible for setting appropriate standards, ensuring its members perform according to the set standards and taking action when these standards are not upheld (Freidson, 2001; Tuohy, 1999).

As noted above, the professional’s specialized knowledge and skill make it difficult for a lay person to judge the quality and performance of work done and render the profession best suited to judge the work of its own (Cruess & Cruess, 1997; Freidson, 1994, 2001). This specialized knowledge that requires a similarly trained individual to judge the quality of work done, combined with the element of placing the importance of doing serving the public interest over the importance of economic reward are the principles underlying professional self-regulation (Cruess & Cruess, 1997; Freidson, 1994, 2001). Professional self-regulation in turn provides the profession with market control where the profession has control over who provides services through determining training programs, training credentials for entry and career advancement, and acceptance as a member of the profession (Bayles, 1986; Freidson, 1994, 2001).

2.2 Professionalism in Healthcare: The Case of Medicine

One classic example of a profession is medicine. Professionalism has been suggested as the basis of medicine’s social contract, or relationship with society (Cruess & Cruess, 2008). Although it has been noted that professionalism is difficult to precisely define as it pertains to medicine, there are number of elements utilized in defining professionalism that elaborate on Freidson’s model and the professional ideology. One of these elements includes the notion that the physician has a responsibility that goes beyond the individual patient, to more of a commitment
to public service (MacKenzie, 2007; Sullivan, 2000). The Canadian Association of General Surgeons (CAGS) issued a position paper on professionalism that included a code of professionalism for Canadian surgeons. This code included the duty to consider first the well-being of the patient; and extended beyond the individual patient to include respect for patient, clinical autonomy and providing the highest quality of care; adoption of new technology, partnership with industry and participating in research that benefits patient care; care without discrimination; working with other professionals as a team for the benefit of patients; openness and honesty with the patient and disclosure of adverse events; accountability to the courts, licensing bodies, peers and hospitals; and balancing between professional and private life (Christian, Pitt, Bond, Davison & Gomes, 2007). The American Board of Internal Medicine’s Project Professionalism outlined a number of principles which included excellence – or a lifelong commitment to maintaining competence; humanism – a deep concern for humanity; accountability – taking responsibility for actions and decisions; and altruism – actions designed to benefit others (Green, Zick & Makoul, 2009; MacKenzie, 2007).

Cruess and Cruess reviewed the commonly used definition of medical professionalism in which society has granted medicine autonomy, self-regulation and occupational control in exchange for ensuring patient’s needs are placed above self-interests, ensuring competency through self-regulation, demonstrating morality and integrity and being devoted to a greater public good (2008). They further acknowledged the vagueness surrounding this social contract and proposed a framework under which the social contract could be further defined. In this framework two main groups were identified; the medical profession and society, each having bilateral expectations and obligations with each other (Cruess & Cruess, 2008). The medical profession was comprised of the medical institutions as well as individual physicians. Together this group would carry out the profession’s collective responsibilities (education, training, certification, etc.) which, as noted by Freidson (2001), are key elements supporting professionalism. This model was viewed as one in which individuals within this group and their associations interacted in order to develop a common consensus pertaining to the social contract.
The societal group identified in the proposed model consisted of individual patients, the general public and government stakeholders. The individual physician’s primary relationship in this model would be with individual patients, but influenced by society as a whole and government based on the delegation of power as in the case of self-regulation (Cruess & Cruess, 2008). Cruess and Cruess indicated that professionalism governed the interactions between all entities – medicine, patients and government (2008) and presented expectations that each party would have for each other. Patients’ expectations of medicine included competence, altruistic service and accountability and transparency, while patients’ expectations of government included quality healthcare and transparency. Medicine’s expectation on both patients and government were noted to include trust in the professional to meet patient’s needs, autonomy, and in the case of government, self-regulation. Government’s expectation on medicine included integrity, compliance with regulations, and accountability in terms of performance, productivity and cost-effectiveness. Expectations on the public included reasonable expectations, some responsibility for own health and support for public policy (Cruess & Cruess, 2008).

External influences outlined in this social contract model included the healthcare system, the mix of public and private services, the regulatory framework in place and the media. It was recognized that expectations of society and medicine continue to evolve. The example of government and commercial organizations requiring accountability in terms of performance, productivity, cost-effectiveness and competency were seen as influences on how this model worked in practice (Cruess & Cruess, 2008).

While helpful to conceptualize professionalism as a social contract in the delivery of healthcare, the competencies and elements or principles that define professionalism may still be viewed as abstract and difficult to put into practice at the individual practitioner level (Green, et al, 2009). A few studies have attempted to gain an understanding of physician attitudes towards professional norms as well as understand their values and behaviors. One such study was a United States-based national survey of 3,504 physicians, conducted with the objective of assessing physician attitudes towards professional norms and understanding behaviors that were
linked with these professional norms (Campbell et al, 2007). In this study, 1,662 of the eligible participants completed a survey in which they were asked to rate their agreement with statements regarding elements of professionalism. Two sections were of particular relevance to the research study at hand. One section had a question that was indicative of, “maintaining trust by managing conflict of interest”. Of those completing the survey 96% indicated that physicians should put the patient’s welfare above the physician’s financial interests (Campbell et al, 2007). The other section had questions related to, “fulfilling professional responsibilities, including self-regulation”. Of those completing the survey 96% indicated physicians should report all instances of significantly impaired or incompetent colleagues to hospital, clinic or other relevant authorities (Campbell et al, 2007). These survey results indicated that the professionals that participated in this survey recognized the importance of putting patient needs ahead of personal needs, as well as the responsibilities involved in self-regulation as they pertained to ensuring standards of conduct are maintained.

A second study, also conducted in the United States, was one that looked at defining physicians’ professionalism from the perspective of the patient, the physician, and the nursing staff, based on observed behaviors (Green et al, 2009). Part of the motivation behind this study was the authors’ report that unprofessional conduct resulted in more complaints against physicians than inadequate knowledge or skills. The goal of the study was to determine if professionalism could be defined in terms of tangible behaviors, rather than just the elements or principles provided in the charters. The authors designed a survey in which they asked participants to gauge the importance of behaviors relative to professionalism. Inclusion criteria for the survey were that the behaviors needed to be relevant to the physician-patient relationship and the behaviors needed to be transparent to the patient and thus easy to judge (Green et al, 2009). Participants in the survey included 415 patients, 237 nurses and 214 physicians. Using the inclusion criteria, 41 behavioral signs of professionalism were included in the survey. Results indicated that for all three respondent groups, “practices in an ethical manner”, ranked as most important, followed closely by the behavioral sign, “is honest”. The item, “works in the patient’s best interest, regardless of personal gain”, was ranked as 4th most important by the physician respondents, 9th
most important by the nurse respondents and 11th by the patient respondents (Green et al, 2009). These results indicated that both professional groups as well as patients placed a high importance in the underlying principle of professionalism that the professional places the patient interests ahead of self-interest.

2.3 Conflict of Interest (COI)

As noted above, COI has been defined to occur when circumstances might occur where personal benefit, or a secondary interest, might improperly influence professional judgement (MacKenzie & Cronstein, 2006; Thompson, 1993). Four areas were seen to impact the potential for COI: 1) the value of the secondary interest; 2) the observability of the COI being acted upon based on the specialization of the profession; 3) the transparency of the decision making process to others, including third party payers or patients; and 4) whether a long-standing relationship existed between the participants (Barnes & Florencio, 2002; MacKenzie & Cronstein, 2006).

Observability refers to the extent to which the work performed is directly observable by other professionals who have the knowledge and skills to judge the quality of work performed (Zelisko, Baumann, Gamble, Laporte & Deber, 2014). The primary interest is determined by the professional duties; in the case of healthcare this primary interest would usually be the health and well-being of the patient (Thompson, 1993; Norris, Homer, Ogden & Burda, 2011). The secondary interest may be a necessary interest or even one characterized as a beneficial part of professional practice and it may be financial or non-financial (Thompson, 1993). Examples of secondary interests might include conducting research, consulting arrangements and self-referral (e.g. recommending surgery).

Non-financial COI may relate to other personal interests including prestige and power (Thompson, 1993; Barnes & Florencio, 2002). Non-financial COI and incentives may also be tied to intellectual interests, where academic activities could result in an individual’s adherence to a specific viewpoint that may unduly impact their judgement (Norris et al, 2011). These types
of interests may tie into advancement in terms of publication, accessing research funding and advancement of medical science (MacKenzie & Constein, 2006; Norris et al, 2011). Non-financial incentives may also occur at the individual level or at an organizational level and may include enhancement of reputation, and development of new technologies and therapies (MacKenzie, & Cronstein, 2006).

COI may also extend beyond an individual and exist at an institutional level (Barnes & Florencio, 2002). Some examples of actions resulting from a COI in research at an institutional level included concealing research data, and concealing adverse effects associated with a study medication or device (Barnes & Florencio, 2002). Non-financial conflicts of interest have been characterized as being more subtle and pervasive and more difficult to identify (MacKenzie & Cronstein, 2006). A systematic review of studies examining COI in clinical practice guideline development was conducted looking at publications between 1980 to March 2011 (Norris et al, 2011) in order to understand how secondary influences might impact clinical practice guideline development. Of the 12 studies that were included in the analysis, all reported various financial relationships between guideline authors and pharmaceutical companies, but there were no studies reviewed that examined non-financial COIs (Norris et al, 2011).

Financial COI tied to industry may involve financial incentives and gifts, including research funding, honoraria, and consulting fees, continuing education sponsorship and support, guideline development, consultancy roles or other arrangements in which the service provider’s interests are rewarded in order to make them more aligned with that of industry than their patients (Brennan et al, 2006; MacKenzie, & Cronstein, 2006; Thompson, 1993; Tonelli, 2007). However, financially based COI may also affect individual practices. For example, service providers may be in an unavoidable COI with the clients they serve as a result of the remuneration structure under which they practice (Carson, 1994). When a professional is paid based on the services they provide, a conflict may arise from the inherent incentive to provide more services in return for greater compensation. A professional might provide and bill their patients for unnecessary services or “over treat” their patient such that they provide more
services than evidence based practice would indicate necessary. Variations in remuneration structure do not resolve this potential professional-patient COI (Deber, Hollander & Jacobs, 2008). Remuneration structures that are not based on payment for services provided may still have conflicts of interest, but instead of stemming from providing more services for more compensation, the remuneration structure might incent the professional to provide as few services as possible. For example, if the remuneration structure is based on a capitation system or a flat salary, a medical professional may be incentivized to roster the maximum number of patients, while ensuring that a high percentage of these patients are healthy with minimal treatment requirements, such that minimum services are required (Carson, 1994).

In healthcare COI is important because it undermines the social contract between medicine and society. This social contract relies on mutual trust between the profession and the public, where the professional will place the interests of his/her client/patient ahead of personal or secondary interests (Cruess & Cruess, 2008; Sullivan, 2000). COI may interfere with primary interests, including patient safety and care, and upholding the integrity of medical research (Barnes & Florencio, 2002) and erode patient trust, ultimately undermining the effectiveness of self-regulation (Haines & Olver, 2008; Tonelli, 2007). There have been attempts to understand the impact of COI at the clinician level, as well as at the institutional level. Cases have been brought forward involving research in human subjects where concerns over inadequacy of a treatment were deliberately concealed, as in the case of a study of an experimental vaccine for treating melanoma at St. John Medical Center in Tulsa, Oklahoma (Barnes & Florencio, 2002). In this particular example, the chair of the institutional review board (IRB) ignored a report from an outside consulting firm regarding severe deficiencies in the trial and instead stated in an annual report that there were no significant safety concerns and sent a misleading letter to study participants, indicating the study was being halted due to vaccine capacity supply issues (Barnes & Florencio, 2002).

However, it is often difficult to quantify if any COI or undue influence exists. For example, in a systematic review of studies of COI in clinical practice guideline development, financial
relationships were reported in 9 of the 12 studies included, but there was no empirical data on the effect of COI on the recommendations for the clinical practice guidelines (Norris, Homer et al, 2011). Another systematic review of interactions between non-physician clinicians and industry attempted to analyze the impact of industry interactions and resulting influence (Grundy, Bero & Malone, 2013); these authors conducted a search for articles from 1946 to 2013, involving non-physician clinician interactions with industry. Clinicians considered in this review were those that were involved in what were viewed as important care and decision points in patient care. These clinicians included nurses (of various designations including registered nurses, advanced practice nurses, nurse practitioners, clinical nurse specialists, midwives, certified registered nurse anesthetists), physician assistants, pharmacists, dietitians, and physical or occupational therapists. Data for the 15 studies that met the criteria looked at a number of outcomes including attitudes towards industry, and types of interactions with industry. The results indicated that clinicians across the disciplines met with industry representatives on a regular basis and relied on them for practice information. Interactions might have included the provision of gifts (which might have included meals and beverages), product samples or education. In general, the findings indicated that the clinicians believed this to be an ethical use of industry resources and believed they could distinguish between promotional or marketing influence and relevant information. Free samples were seen as positive and generally approved. Overall the interactions with industry were viewed in a positive light. The researchers concluded that the normalization of the industry-clinician relationship may be beneficial but may also create the potential for serious risks to the patient (Grundy et al, 2013). The authors went on to recommend policy development to address these non-physician clinicians in order to provide a structured approach to addressing potential issues.

Results of another more recent survey conducted in the United Kingdom on 1,078 doctors and in the United States on 1,891 doctors, was aimed at determining how closely aligned professional values and behaviors were and what extent they varied depending on the context of care (Roland et al, 2011). When surveyed, 82.3% of the UK doctors and 78.7% of the US doctors indicated that doctors should put patient’s welfare above own financial interests (Roland et al, 2011).
Results were less favorable pertaining to the doctors disclosing financial relationships with drug/medical device companies to their patients. Of the UK doctors, 58.9% indicated the relationship should be disclosed, while in the US 65.4% indicated the relationship should be disclosed. When asked to assess the statement that joint business ventures with patients are “never” appropriate, 60% of UK doctors agreed and 46.7% of US doctors agreed. The authors suggested that the US doctors were more accepting of potential conflicts of interest, believing that business relationships were appropriate. These results might suggest that although the general principle that patient needs should not be secondary to self-interests were understood, some of the more subtle types of financial arrangements that might influence behavior were not necessarily viewed as problematic even though they may in fact be a COI.

2.4 Professional Self-Regulation

As noted in sections 2.1 and 2.2, professionalism is the concept underlying self-regulation and fundamental in the social contract of medicine with society (Cruess & Cruess, 2008). Self-regulation is an authority-based policy instrument that may be used by government in the implementation of health policy (Doern & Phidd, 1992; Howlett et al, 2009). Self-regulation as a policy instrument allows the government to delegate responsibility for managing the creation, administration, and renewal of standards governing the activities of certain groups to non-governmental regulatory bodies (Deber, 2014b). Under this delegation the non-governmental regulatory bodies, which include professional regulatory colleges, become responsible for implementing the regulations mandated by government. Professional self-regulation accordingly relies heavily on the concept of professionalism described above, which includes such factors as the existence of a specialized body of knowledge, the recognition that good/bad practice is difficult to evaluate by those who do not have that body of knowledge, and an ‘agency’ relationship where the professionals act on behalf of their clients, plus the potential for harm if the activities are not carried out well (Bayles 1986; Cruess & Cruess, 1997; Freidson 1994, 2001).
2.5 Practice-Specific Variables of Interest

Professional self-regulation includes following government mandates to set and enforce standards of conduct and would therefore include COI. There are a number of health professions that have been delegated self-regulation in Canada and as such there are different regulatory bodies for these groups that will be analyzed in part I of this study. Given the diversity of these professions and the regulatory bodies, a conceptual framework was developed which outlined the sources for financial COI, the variables impacting the professional, and the role of self-regulation in addressing financial COI. This framework, the Framework for Managing Financial Conflict of Interest through self-regulation is shown in Figure 2.1. As discussed previously in section 2.1, secondary interests may influence professional behavior and negatively impact the outcomes for the primary interest, which in most cases would be the patient, although in healthcare research the primary interest may not be limited to an individual but an overall professional interest. In the conceptual framework (Figure 2.1), the secondary influences are depicted to interact with the practice variables under which a profession practices. These practice variables include nature of work done by the profession, the type of work environment in which they function and how they are paid for the work done, referred to as the remuneration structure. Each of these practice variables was depicted separately in this model, although in reality they are likely to be interrelated. These practice variables were separated because they may also differ within and across professions with respect to these variables; this will be described further in the methods section.

The practice variables of interest in this study are positioned in this model to illustrate the hypothesis that they directly influence self-regulation, which in turn impacts the practice variables as depicted by dashed arrows leading back to the practice variables. This representation is designed to provide a visual representation of how the mechanisms utilized by the College as represented by self-regulation reflect the specific requirements of the professions that are derived from the practice variables. The dashed arrows indicate feedback from self-regulation to the practice variables, illustrating that mechanisms under which self-regulation is
operationalized (which include regulations, standards and guidelines designed to define expectations, educate/inform the membership and enforce conduct), should reflect any changes that occur in the professions’ practice variables. For example, if significant changes occur in nature of work, work environment or remuneration structure, the regulatory body or College may need to alter or update the regulations, standards and guidelines in place and provide the appropriate communication to its membership to ensure expectations are defined, education is provided and enforcement mechanisms are in place.

Legislation is represented in this model as the overall mandate from government to the professions delegating self-regulation. It is shown as a direct influence on self-regulation as the government delegation may change based on changes in legislation.

The bottom right box in the model is the final outcome, the behavior of the professional, and is positioned in this manner because it is conceptualized as the outcome of the mechanisms of self-regulation that are in place to reflect practice variables and secondary influences thus influencing or responding to actual behavior. There is a solid arrow going back to self-regulation because the behaviors of the profession in relation to specific directives should impact the mechanisms of self-regulation. There is also a line connecting behavior to the practice variables, which represents situations where a professional disregards any directives of the College, which would be represented in the self-regulation section. The behavior would in turn impact self-regulation directly. For example, if a professional breaches an element of the professions’ mandated conduct, then as a response to these behaviors, the enforcement mechanisms within self-regulation would further interact with the profession.

The next sections will describe the practice specific variables in more detail along with the rationale for examining each area.
The first practice related variable, nature of work performed by the profession, directly affects the sources of COI to which a healthcare provider might be exposed. Regulated health professions vary in their defined scope of practice, decision making authority regarding treatments and services, and any restricted activities that require special authorization to perform. For example in some provinces the legislation has defined ‘restricted activities’ or ‘controlled acts’, which, if not performed by a competent person pose a high risk of harm (Health Professions Regulatory Advisory Council, 2001). Regulated professions are authorized to
perform controlled acts based on the profession-specific legislation that governs them (Government of Alberta, 2000b; Government of British Columbia, n.d.; Health Professions Regulatory Advisory Council; RHPA, 1991). For example, the RHPA includes the controlled act of prescribing a hearing aid, which, only physicians and audiologists are authorized to perform (RHPA, 1991). Harmful outcomes associated with inappropriate prescription of hearing aids include the delay of treatment for a medically treatable condition; further damage to hearing due to excessive amplification; pain associated with over amplified sounds; negative impact on educational and vocational development and outcomes as well as, potential negative impacts on emotional and psychological well-being (College of Audiologists and Speech-Language Pathologists, 2000).

A profession’s authorization to perform these controlled acts may vary considerably, ranging from no authorization over any controlled acts to authorization over most of the controlled acts. For example, in Ontario physicians have the broadest scope of practice and are authorized to perform all but one of the controlled acts outlined in the Regulated Health Professions Act, or RHPA (1991). Nurse practitionerers have the second broadest scope of practice with a large number of controlled acts within their authority, while audiologists have a small scope of practice and are authorized only for the controlled act of prescribing a hearing aid (RHPA, 1991). As a result of these variations in scopes of practice, a health professional will likely be exposed to different potential secondary influences or sources of COI. For example, physicians may be exposed to industry-based incentives related to consulting with a pharmaceutical company, while audiologists and physiotherapists may be exposed to industry-based incentives related to selling a product or device as part of their service delivery model. The regulatory Colleges for each health profession are responsible for outlining the practice standards and expectations pertaining to their registrants’ scopes of practice and controlled acts, in addition to ensuring ethical conduct and accountability to the public (RHPA, 1991). As a result, the Colleges are also responsible for defining and addressing potential COI scenarios. The second part of this study will attempt to identify how the Colleges addressed nature of work when addressing COI.
The second practice related variable being investigated was workplace environment of the professions. Healthcare professionals may practice independently and have complete autonomy over their daily work, they may work in a collaborative interprofessional team environment where other professions participate in the provision of services, and/or they may work in a setting where their work is directed by management or other professionals. Workplace environment is related to and impacts the type of work a professional undertakes and may also be tied to economic incentives. For example, if healthcare providers are working in a solo practice they are likely to be autonomous in how they provide services; this may also be reflected by the remuneration structure which will likely be fee-for-service (FFS). In contrast, healthcare providers practicing within an interprofessional team in which healthcare professionals with various backgrounds and scopes of practice work together in making treatment decisions may not be as autonomous in their actions but may be impacted by similar incentives or remuneration. Workplace environment has been shown to impact professionalism. For example, workplace environment did have an impact on the self-reported professionalism in nurses, in that those who had access to resources, information and were properly supported were likely to feel a high level of accountability (Baumann & Kolotylo, 2009). Evidence also suggests that workplace protocols or practice guidelines may not be adhered to for a number of reasons (Hanneman, 2003; Puffer & Rashidian, 2004), and that strong interprofessional relationships impact nursing autonomy overall (Kramer & Schmalenberg, 2004a, 2004b). However, there is very little written about how COI in these scenarios are identified or addressed. This study will examine further how the four Colleges that were examined addressed work environment as it pertained to financial COI.

The third practice-related variable of interest was the remuneration structure under which a profession worked. To simplify, health professionals may be reimbursed through various combinations of the following models: FFS, capitation, and/or salary (Deber et al, 2008). In a FFS structure, compensation is based on a fixed amount per service. In a capitation-based structure remuneration is based on a fixed value per patient rostered, while salary is based on a negotiated compensation for services provided over a defined time period. Blended models are common, which use two or more of these reimbursement models. For example, salaried models
may or may not include incentives to perform various activities or meet particular targets. Payment may come from various combinations of public and private sources, including out of pocket payment. Professionals may be paid directly (including from public or private insurance plans), and/or paid by organizations. In general, physicians are paid directly, through a variety of models, which usually include FFS components. Nurses, and physiotherapists working in hospital settings, are typically remunerated through a salary-based model, whileaudiologists and physiotherapists practicing privately are remunerated predominantly through a privatized FFS structure that may involve third party payers such as insurance companies or salary-based model with incentives based on company performance objectives. To complicate the remuneration model further, some health professions, including both audiologists and physiotherapists, may also be remunerated through the sale of products recommended or prescribed for their patients in addition to the services provided.

An example of a FFS model occurs when physicians directly bill an insurance plan for each insured procedure done in the course of treating a patient. These professionals have the potential to either increase their compensation by providing more services or providing services more efficiently to increase productivity (Carson, 1994). In contrast, when remuneration is based on flat salary, the COI exists in that the professional may perform the minimal amount of work, or provide partial services for their patients and still receive the same compensation (Carson, 1994), meaning that COI can arise not just from increasing efficiencies or providing unnecessary products or services, but also from providing the least amount of services possible for a flat fee. For example, nurse practitioners might not be compensated through a FFS model, but through a salary-based model in which they would receive the same remuneration regardless of the amount of work performed.

The sale of products combined with services might also introduce potential financial COI. An example of this might occur when an audiologist directly bills a patient for a hearing aid evaluation and also charges them for fitting services (prescription and dispensing) in addition to selling them a hearing aid. In this scenario, where an audiologist prescribes and sells hearing
aids, the potential for COI exists if the decision to prescribe a hearing aid is based on personal gains the audiologist might receive from selling and fitting a device or particular product instead of patient benefit derived from the device.

Further, financial COI may exist for any profession outside of their standard remuneration structure if industry partners, which might include product suppliers such as pharmaceutical companies, or equipment/product manufacturers, offer incentives or training sponsorship. The concept of professionalism asserts that professionals will provide the appropriate services for their patient irrespective of any opportunities to maximize personal gains (Cruess & Cruess, 1997).

The last part of the Conceptual Framework depicted how self-regulation, which is delegated from government legislation, impacts the behavior of its registrants by using regulations, standards, policies and guidelines to define expectations, educate the membership and enforce expectations. In this Conceptual Framework, the practice variables under which the registrants provide professional services are variables that the regulatory body (i.e. College) needs to take into account when setting conduct mandates and expectations. In turn, the regulatory body may influence these practice variables or as a minimum the conduct of the professional. The actual behavior of the professional – that is whether or not they act on a conflict of interest will in turn impact the self-regulation component in so far as the College is mandated to enforce its regulations, standards, policies and guidelines. The regulatory Colleges are responsible for the ethical conduct of their membership and are mandated to have the appropriate mechanisms in place. From the scenarios just described these mechanisms might include regulations, standards, guidelines and policies surrounding appropriate services and acceptable standards of care and professional behavior as well as processes related to address breaches of these mandates. This study attempts to understand and compare how the four Colleges identify situations where there is the potential for financial COI to arise and how these situations are addressed.
Chapter 3
Methods

A nested multiple-case study methodology was used. The first part of the study was a descriptive study which incorporated an analysis of all regulated health professions across Canada, in order to gain an understanding of the health professions that were delegated self-regulation, the criteria used in the delegation process, and how consistent the results were across the provinces. The analysis focused on comparing the self-regulation of health professions across the provinces because the administration of healthcare falls under provincial jurisdiction such that any legislation pertaining to self-regulation would be implemented at the provincial level. The analysis did not include the territories, due the differences in size and resources. Part I of the study also put into context professional self-regulation of the health professions in Canada. The second part of the study incorporated multiple-case study methodology. The goal of part two of the study was to understand how four regulatory Colleges in Ontario – The College of Audiologists and Speech-Language Pathologists of Ontario (CASLPO), The College of Nurses of Ontario (CNO), The College of Physiotherapists of Ontario (CPO) and The College of Physicians and Surgeons of Ontario (CPSO) addressed financial COI.

3.1 Part I: Self-Regulation of Health Professions in Canada

3.1.1 Research Questions and Approach

The first part of the study incorporated a descriptive study as outlined by Sandelowski (2000) in order to provide a comprehensive summary of the self-regulated health professions in the provinces of Canada. Specifically, the following questions were used to guide and direct the approach:

1. Which health professions were granted self-regulation within each province in Canada?
2. To what extent was there overarching/umbrella legislation across the professions and to what extent was the legislation profession-specific?

3. Where overarching/umbrella legislation existed, did it address college mandates, ethics, and complaint handling/investigations, protection of title and/or controlled or restricted activities?

4. How did the Ontario legislative framework set forward expectations for managing the conduct of the self-regulated health professions?

Data collection focused on publicly available documents. An environmental scan of public documents, including those issued by regulatory Colleges, and provincial governments was done. Key search words used to find provincial legislation included “regulated health professions”, “self-regulation and health professions”, health act with the province name noted, and “Ministry of Health – regulating healthcare”. Searches on each province’s ministry of health website were done as well as on professions’ governing body’s websites. The professions were determined based on the provincial government legislations outlining which professions were granted self-regulation. In addition, online searches for provincial professional associations or profession specific regulatory bodies were done when the number of professions represented under the provincial legislation was less than those listed for another province to ensure that none were overlooked or omitted since not all provinces had overarching/umbrella legislation for self-regulated health professions. In order to find the regulatory bodies for the professions, searches using the profession titles were done along with the province name.

Areas of analysis included: which of the health professions were granted self-regulation and how this varied across provinces, the nature of work performed by these professions, the controlled acts delegated to the professions and how they varied by province. In the second part of the study, a more in depth analysis of four self-regulated health professions that vary in their scopes of practice or work performed, the degree of self-direction they have in their work and exposure to various economic incentives was conducted.
3.1.2 Data Analysis

Data collected from the searches for part I of the study were organized and summarized first by province so that comparing the results across provinces would be facilitated.

3.2 Methods Section: Part II A Multiple Case Study of Four Colleges Addressing COI

3.2.1 Case Study Methodology: Conceptual Description

Case study methodology is a qualitative approach to research employed in social science research (Yin, 2011, 2014). Case study methodology allows for the exploration of a phenomenon, which is known as the “case”, in its context, using a variety of data points or sources (Baxter & Jack, 2008; Yin, 2003, 2009, 2014). Using multiple data sources is important in ensuring that the phenomenon is explored under more than one lens (Baxter & Jack, 2008). The number of cases examined may vary, as may the type of data analyzed. Case study methodology is well-suited to research where the researcher has little or no control over any behavioral events and the questions being asked are “how” and “why” types of questions (Yin, 2009, 2014).

In defining case studies, Yin noted that a major focus of a case study is to understand a decision or set of decisions within its real-life context; in contrast to experimental studies, the researcher has no control over these decisions (Yin, 2003, 2009, 2014). A case study is considered appropriate when the goal is to answer “how” or “why” questions under the context of investigation, the behavior of those involved cannot be manipulated by the researcher, and the boundaries are not always clear between the context and the phenomenon of investigation (Baxter & Jack, 2008; Yin, 2003, 2009, 2014). For example, one of this study’s questions was, “how did each College provide its registrants with guidance pertaining to financial COI?” The question cannot be manipulated by the researcher and is based within the context within which the College is functioning. The case study methodology is comprehensive in that it covers the
logic and incorporates the theory behind the study design, the data collection techniques as well as the data analysis (Yin, 2009, 2014).

The case study’s strength is in its ability to deal with multiple sources of data input and current sources of evidence (Yin, 2014). For example in this study multiple sources of data include public documents including government legislation, College guidelines and practice standards, key informant interviews, College archives including summaries of discipline hearings as well as multi-media pieces such as educational videos and learning modules.

3.2.2 Multiple-Case Study Methodology: Conceptual Description

The multiple-case study approach to this research project was treated as a variation of the single-case study methodology as outlined by Yin (2009, 2014). As a variation of the single-case study methodology one of its main advantages is that because evidence is drawn from more than one case the findings may be considered more powerful when generalizing propositions (Firestone, 1993; Herriott & Firestone, 1983, cited in Yin 2014). However, the resources required for a multiple-case study approach may be considerably greater, making the conduct of such research difficult (Yin, 2009, 2014). The design of the multiple-case study also requires some attention to the replication logic in selecting cases (Yin, 2009, 2014).

There are two approaches to replication logic. The first approach is literal replication, in which each case is carefully selected so that it predicts similar results (Yin, 2014). The second approach, theoretical replication is used when cases are selected to predict contrasting results that were anticipated in the study design (Yin, 2009, 2014). Literal replications require only a few cases, whereas theoretical replication requires additional cases along with a revision of the initial propositions that were tested out in the initial set of cases to explain the contrasting results (Yin, 2014). However, a multiple-case study may also be designed such that only a few cases are chosen, but the cases are chosen due to the contrasting circumstances, such that a direct replication was not being sought, but rather a start towards theoretical replication (Yin, 2014).
Inherent in case-study design is that the replication procedure that is used should be based on the underlying theory (Yin, 2014).

Multiple-case study methodology is illustrated schematically in Figure 3.1, which has been adapted from Yin (2009, 2014) in order to reflect this study. The multiple-case study methodology has been broken down into three stages. The first stage is the “define and design” stage, in which the questions and theory are developed and the cases selected. In the second stage, the “prepare, collect and analyze” stage, the case study data collection is conducted and individual cases reports are developed. In the “analyze and conclude” stage the cross-case conclusions are made, theory is modified and any policy implications developed. The cross-case and final report is also completed in this phase.
3.3 Part II Study Design: Multiple-Case Study Approach

3.3.1 Purpose of the Study

A multiple-case study was used in part two of this study. The overarching goal of this study was to understand how different regulatory Colleges defined and addressed financial COI under the parameters being investigated. Each College had its own context due to the differences in College registrants in terms of remuneration structure, workplace environments and the nature of the profession’s work.
The multiple-case study approach was designed to compare differences and similarities between cases (Baxter & Jack, 2008; Yin, 2003; 2009). The framework for the case study methodology is outlined in Figure 3.1. The College of Physicians and Surgeons of Ontario (CPSO), the College of Nurses of Ontario (CNO), the College of Physiotherapists of Ontario (CPO) and the College of Audiologists and Speech Language Pathologists of Ontario (CASLPO) were selected as the four cases in this study on the basis of theoretical replication. Choosing cases which differed according to size and years established, and membership characteristics including the three practice variables that were of interest (type of work or scope of practice, work environment and remuneration), was done in order allow for a comparison of different types of conditions and a comparison to the theory and propositions or hypotheses underlying the study (Yin, 2009, 2014). Some Colleges may have registrants who would not be exposed to COI based on these practice variables. For example, Medical Laboratory Technologists (MLTs) typically work in a laboratory setting, as a salaried employee and would not typically be exposed to financial COI scenarios (College of Medical Laboratory Technologists, n.d.).

The four Colleges were selected in order to compare Colleges that varied along these three practice variables of which each might impact exposure to COI. For example, the CPSO was selected because the registrants of this College had a very large scope of practice with the authorization to perform most of the controlled acts, worked in environments which varied from independent practice to hospital settings, and in general were remunerated under the publicly-funded system in which registrants were compensated for the services these provided. The CNO was selected because the registrants had fairly broad scopes of practice, worked in varying work environments, and were generally remunerated through a salary-based system. CPO was selected as a case because registrants of CPO had a more restricted scope of practice compared to CPSO and CNO, and worked in environments which included hospital-based clinics and as well as independent clinics. CPO registrants were also remunerated under models in which fees were based on services provided as well as salary-based models and were also involved in the sale of products related to services provided. CASLPO registrants had much narrower scopes of practice, worked in varying practice environments including school boards, hospitals and
independent clinics. CASLPO registrants were remunerated under various models including salary-based models, as well as scenarios under which remuneration was tied to the sale of products.

Using professional self-regulation as the underlying concept, the multiple-case design allowed for a comparison within and across the different professions selected and their regulatory bodies in terms of how financial COI was addressed. Research questions and analyses initially focused on each case separately, and then the results for each case were compared across the cases to draw further conclusions and address the underlying theoretical questions pertaining to professionalism.

The five components that are important in designing case-study research include identifying the case study’s questions, outlining any propositions, determining the units of analysis, explaining how the data are linked to the propositions and documenting the criteria for interpreting the findings (Yin, 2014). Each of these design components will be outlined as they pertain to this study.

3.3.2 Multiple-Case Study Questions

The overarching question behind the study was to understand how these four regulatory Colleges of self-regulated health professions in Ontario addressed financial COI. This question covered a number of areas, including how COI in general terms was defined. The focus then narrowed to financial COI to determine how the College provided to the registrants directives specific to financial COI (which might include regulations, by-laws, practice guidelines, and/or policies), and how the College informed or educated the registrants about financial COI. The final part of this question was to understand how financial COI was addressed when it did occur.

More specifically, the following key questions formed the basis for the multiple-case study approach:
5. How did each College define COI and what specific scenarios or situations were incorporated in defining COI?

6. How did each College provide its registrants with guidance pertaining to financial COI? Was this guidance based on one-way communication from the College to its membership or was there two-way communication with input from the registrants in which the registrants could seek clarification from the College?

7. How did each College address allegations of professional misconduct related to financial COI?

8. To what extent was financial COI perceived to be an issue for the profession based on practice specific variables (nature of work, work environment, and remuneration)?

9. How important of an issue did the key informants think financial COI was as an issue and concern for the College? How effective did the informants feel the College was at addressing financial COI?

These were well-suited to case-study methodology as they were designed to gain an understanding of the phenomenon in its real-life context (Yin, 2009, 2014). To further ensure the units of study or “cases” were appropriately selected, the underlying proposition was outlined in order help clarify the practice specific variables that were being examined in question four. Specifically, the underlying theoretical proposition guiding the case study was that the Colleges would differ in how they addressed financial COI and these differences could be linked back to the practice-specific variables nature work, work environment and remuneration. Case selection was made with the goal of selecting Colleges in which the registrants varied along these practice-specific variables.

The College of Physicians and Surgeons of Ontario (CPSO), the College of Nurses of Ontario (CNO), the College of Physiotherapists of Ontario (CPO) and the College of Audiologists and Speech Language Pathologists (CASLPO) were selected as the four cases in this study on the
basis of theoretical replication. The aim of the study was not just to understand how a regulatory college of a self-regulated health profession addressed financial COI, but how regulatory Colleges that differed along specific practice-related dimensions addressed financial COI in order to better understand how these variables had an impact on the process. Specifically, nature of work, remuneration and workplace environment of the College registrants were specific practice variables of interest. In addition, the size and maturity of the College itself was an item that was factored into the cross-case analysis. Choosing cases which had differing circumstances was done in order allow for a comparison of different types of conditions and a comparison to the theory and propositions or hypotheses underlying the study (Yin, 2009, 2014).

Table 3.1, provides a summary of the key features for each of the Colleges that were considered when selecting which cases to include. These features include basic College demographics including size and age of the College as well as items relating more to the practice-specific variables, such as number of controlled acts, type of work done by the professional, typical work environments and typical remuneration structure. The CPSO and CNO were both larger and older Colleges. It should be noted that the table references whether the Colleges were established prior the RHPA, 1991. This is not meant to imply that there were no regulations prior to this for the professions or that all of the Colleges were founded in 1991. For example, the CPSO was founded in 1866, and the CNO was established in 1964. Prior to the RHPA, 1991, other legislation, such as the Health Disciplines Act, 1975, and the Drugless Practitioners Act, 1925 provided the regulatory framework for the CNO and CPO registrants respectively (Government of Ontario, 1980a, 1980b).

In terms of selecting the case Colleges, the goal was to select Colleges that varied in size, type of work done and scope of practice as well the types of environments and remuneration structure under which they worked. The CPSO registrants had the broadest scope of practice and the authorization to control all of but one of the controlled acts, CNO also had a fairly broad scope of practice with fewer controlled acts, while the CPO was a larger College, with a narrower scope of practice and less authorization to perform controlled acts. CNO registrants were more
likely to be on a salary compensation structure with over half of all registrants working in a hospital setting (Canadian Institute for Health Information, 2013a), while CPSO members had varying remuneration structures within the publicly-insured model including fee-for-service (FFS), and blended which might include a mix of FFS and population based funding (Canadian Institute for Health Information, 2014a).

In contrast, CASLPO had the smallest number of registrants of the cases, and represented two professions (Audiologists and Speech-Language Pathologists or SLPs) with different and much narrower scopes of practice. Only audiology (AUD) registrants with the CASLPO had the authority to perform a controlled act. The SLP registrants of CASLPO predominantly worked in school board settings, while the AUD registrants predominantly worked in private practice (CASLPO, 2013a). As a result, registrants with the CASLPO were remunerated under a variety of structures including salary, as would be the case for school board employees, and a pay structure related to providing services and selling products as might be the case for up to 41% of the CASLPO AUD registrants. The CPO registrants also worked in a variety of settings, with 45% working in a hospital setting, while 21% worked in a professional practice setting (Canadian Institute for Health Information, 2013c). As a result of these different types of work environments CPO registrants would have varying remuneration structures, ranging from flat salary as might be the case in a hospital setting, to a compensation structure which would relate directly to the services provided.
<table>
<thead>
<tr>
<th>College</th>
<th>Number of Registrants in 2012</th>
<th>Established before or after the RHPA in 1991</th>
<th>Number of Controlled Acts</th>
<th>Type of Work</th>
<th>Work Environment</th>
<th>Remuneration</th>
</tr>
</thead>
<tbody>
<tr>
<td>CASLPO</td>
<td>Total 3,595: 643</td>
<td>lawed in 1991 as part of the RHPA, 1991</td>
<td>1 (AUD), 6 (SLP)</td>
<td>Audiologist includes measurement of auditory function, treatment and prevention of auditory dysfunction. Speech Language Pathologist includes assessment of speech and language functions and the treatment and prevention of speech and language diseases or disorders.</td>
<td>AUD Includes private practice (41%), hospital (29%), health-related industry (10%), other (10%). SLP includes school-based (12%), hospital (18%), children's treatment center (12%), private practice (9%), other (24%).</td>
<td>Includes private, public, third party reimbursement, funding models, salary, publicly insured fee-for-service only, through physicians supervised (and billed) services</td>
</tr>
<tr>
<td></td>
<td>Audiology (AUD), 2912 Speech Language Pathologist (SLP).</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CNO</td>
<td>Total 13,1073: 112,154</td>
<td>prior to the RHPA, 1991</td>
<td>5 - 9</td>
<td>Nursing scope of practice may vary according to type of registration. Includes medical-surgical, psychiatric, mental health, pediatrics, maternal newborn, geriatric, long-term care, critical care, community health, ambulatory care, home care, occupational health, operating room recovery room, emergency care, nursing in several clinical areas, oncology, rehabilitation, public health, patient care (95% in direct care).</td>
<td>Includes hospitals (57%), community health agency (12%), LTC facility (6%), other place of work (33%), business industry/occupational health office, private nursing agency/private duty, self-employed, physician's office, family practice, urgent care center, association (government).</td>
<td>Includes publically funded models (for fee-for-service or FFS, alternative models), salary, block funding, personal, population-based primary care including capitation &amp; FFS blend, contractual, income share collection, limited third party insured and private models.</td>
</tr>
<tr>
<td></td>
<td>Registered Nurses (RNs) prior to the RHPA, 1993 (CNO)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Registered Practical Nurses (RPNs)</td>
<td>2,925 Nurse Practitioners (NPs).</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CPSO</td>
<td>20,227</td>
<td>prior to the RHPA, 1993</td>
<td>12</td>
<td>Medicine scope of practice includes: Family/Medicine (51%), Clinical Specialist (13%), Laboratory Specialist (2%), Surgical Specialist (12%), Medical Scientist (1%).</td>
<td>Includes hospital, independent practice, group practice (in various models as outlined in remuneration models including Family Health Teams, Family Health Organizations, Local Health Integration Networks).</td>
<td>Publicly funded models (fee-for-service or FFS, alternative models), salary, block funding, personal, population-based primary care including capitation &amp; FFS blend, contractual, income share collection, limited third party insured and private models.</td>
</tr>
<tr>
<td></td>
<td>(CPSO was established in 1865)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CPO</td>
<td>7,524</td>
<td>legislated in 1991 as part of the RHPA, 1991</td>
<td>7</td>
<td>Physiotherapy scope of practice includes: General practice (defied as providing services focused on a range of general physical health issues), Musculoskeletal-integumentary systems include sports in recreation, orthopedics, rheumatology, bursa and wound management, plastics and peripheral. Neurological system includes neurology and vestibular rehabilitation. Non-clinical practice and other areas of practice include cardiovascular and respiratory systems, musculoskeletal, physical therapy, and wellness and non-clinical practice.</td>
<td>Includes hospitals (45%), community (14%), professional practice (21%), other post-secondary educational institutions, association on government, para-governmental, industry, manufacturing and commercial and other employer types not otherwise specified, 20%.</td>
<td>Includes publically funded models, third party insured models.</td>
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The next step in the study design was to further elaborate on the practice-specific variables of interest in order to help further develop the questions being asked and the interview process.

### 3.3.3 Practice-Specific Variables of Interest

Profession-specific regulations existed for all of the self-regulated health professionals based on their legislated scopes of practice and obligations (Government of Ontario, 1991i). Due to the diversity of these professions there were a number of variables impacting the potential for financial COI and there were a number of sources or scenarios in which the potential for a financial COI might arise. A conceptual framework outlining the sources for financial COI, the variables impacting the professional and the various tools that a self-regulated body might use in addressing COI was outlined in chapter 2, Figure 2.1 (Chapter 2). The tools a self-regulating body might use include setting up rules or directives to the registrants to meet regulatory guidelines, communication/education processes and then enforcement methods. In terms of the self-regulated health professions, the RHPA (Government of Ontario, 1991i) mandates specific requirements for Colleges to follow in terms of enforcing regulations and legislation. The study examined the impact of the practice-related variables for these Colleges.

### 3.4 Data Collection Methodology

#### 3.4.1 Sampling and Recruitment

As indicated earlier, four health professions regulatory Colleges, the CASLPO, the CNO, the CPSO and the CPO were selected as the units of study or cases in this study. Multiple sources of evidence were used to assist in corroborating or identifying key themes and phenomenon (Yin, 2009, 2014). The sources of data for each case were key informant semi-structured interviews and document analysis. The next section will describe the sampling strategy used for the interview process.
A purposive sampling strategy was employed for each case included in this study, selecting key informant participants (Dobrow, Goel, Lemieux-Charles & Black, 2006; Yin, 2009, 2014). Initial contact was made with the College registrar, through a letter of explanation and invitation to participate in the study. A sample of the letter of invitation is in Appendix A. The goal was to gain participation from approximately 1-3 key informants from each College for each case. Follow up contact was made with each College’s office of the registrar in order to confirm participation and to ensure potential participants were knowledgeable in the areas of focus for the study. Potential participants that were sought included College employees involved in quality assurance, discipline, registrars or associate registrars, or College employees who provided practice advice to the membership. The College Registrars were apprised of the objectives behind the study, and type of knowledge required by the key informants in order to ensure the participants were knowledgeable in the subject matter. The Registrars ultimately made the decision as who would participate from their College. Prior to commencing the study ethics approval was obtained from the Office of Research Services, University of Toronto. All participants were advised that all data collected would be kept in confidential storage and that every effort would be made to ensure anonymity understanding that the roles of the participants and the public nature of information discussed might present some challenges (Kaiser, 2009). All participants were required to provide written consent prior to participating in the study.

Document analysis was also used for each case in the study (Zelisko et al, 2014). The documents used in this part of the study were in the public domain. In addition to documents cited or referenced by the key informants, documents pertaining to legislation relevant to COI and other COI documents for each College were obtained through online searches. Key words used in the searches for each College included: “code of ethics”, “conflict of interest”, “professional misconduct”, “practice guidelines – conflict of interest”, “by-laws conflict of interest”, “conflict of interest guidelines”, “conflict of interest regulations”, “billing – conflict of interest”, and “financial conflict of interest”. A review of disciplinary hearings for the year in which the most recent annual report was published (2012 or 2012-2013, depending on the
College publication periods) was also done to determine if there were any disciplinary hearings pertaining to professional misconduct allegations that were specifically related to COI breaches.

3.4.2 Data Collection

The CASLPO case was considered a pilot case study and interviews were conducted with CASLPO participants prior to contacting the other Colleges. CASLPO was chosen as a pilot because at the time of the study the author, an audiologist, was a registered member of the College and on executive council as an elected member. As a result, the author had substantial knowledge of some of the processes the CASLPO had in place to address COI and there was likely an inherent bias as a professional member of the College. This study was part of Accountability in Healthcare Grant, funded by the Canadian Institute for Health Research (CIHR) and the CASLPO was also invited to participate as a partner in the study. For the CASLPO pilot case, a request to have 4 key informants participate was made in order to determine whether different positions within the College would impact the detail of information provided and ability to speak to the questions posed. The key informant functional positions within the College could not be revealed in order to ensure participant confidentiality, but they represented positions within the College that were involved with or had intimate knowledge of professional practice standards, professional conduct, as well as overall College mandates. At the time of the study there were no CASLPO employees on staff that were also audiologists; however, the key informants provided information related to both professional registrant categories.

The interview questions were designed to gain an understanding from each of the participants how the College defined COI, and how each of the practice-related factors impacted how the College defined and addressed COI with the focus moving from a general definition of COI to financial COI. For example, one of the questions queried how the College defined COI. Subsequently participants were asked to comment on how the College has addressed financial COI first from an educational or preventive standpoint and then from a corrective or disciplinary standpoint. Interview questions also touched on the participant’s opinion of the effectiveness of
the tools that were in place to address financial COI and any personal experiences they may have with this area from a College perspective. The interview guide is provided in Appendix B.

The interviews for each participant were recorded and transcribed. For the pilot case group, the CASLPO, the author was conscious of potential bias and made a conscious effort to stick to the interview guide questions, refrain from asking leading questions and only respond to the information provided by the key informant in order to minimize the impact of any bias. The author transcribed the CASLPO interviews in order to gain a full appreciation for interview style and improve interviewing techniques for subsequent cases. For each interview, notes were also made as a back-up in the event there was an issue with the tape recording. The pilot data collection was also done to determine if further refinements should be made to the interview guide. Subsequent to the initial pilot case, the interview guide was modified only slightly to ensure the focus was on the theoretical propositions. Specifically, a question directly pertaining to the concept of professionalism was eliminated from the interview guide.

In the pilot case, the key informants all had substantial knowledge on the subject matter and information provided by all four was very similar, indicating saturation (Yin, 2014). As a result it was concluded that because the participants were key informants and had substantial knowledge on the subject matter, saturation was generally reached with the second participant so the number of participants in the subsequent cases was limited to 2 key informants. One College, the CPSO, only provided one participant, but the participant asked for the questions in advance in order to ensure the information provided was sufficient.

3.4.3 Data Analysis

The analytic strategy followed the theoretical proposition that was developed to help to shape and guide the research questions and interview guide. The analysis focused on the key practice-related variables and how they factored in to how the Colleges each defined and addressed COI with its registrants. Relying on the theoretical proposition and practice variables as a guide, pattern matching was the analytic technique used. Pattern matching is similar to the theoretical
thematic analysis described by Braun and Clarke (2006) in which the underlying theory guides the analysis. In pattern matching, common themes that might arise from the variables of interest are coded and tracked (Yin, 2009, 2014). An overall pattern might be predicted using this approach which the results either confirm or refute the theoretical proposition.

The transcribed interviews were analyzed using NVivo software. The approach used to analyze the data involved pattern matching (Yin, 2009, 2014). Transcribed interviews were coded and the key themes were identified for each participant in each case separately. Coding was done in a manner that the data could then be collapsed across cases and still be able to compare across cases. The data coding was cross-checked by another researcher to ensure inter-researcher reliability.

The author also recognized that an inherent bias might exist as a result of her registration with CASLPO and her position on the College’s Executive Council and various College committees including the Quality Assurance Committee and the Discipline Committee. The author acknowledged that her interest in the subject matter resulted from her being exposed to changing practice variables and wanting to understand how these related to COI including financial COI. The author acknowledged that because of her involvement with the College she was very familiar with certain pieces of legislation and knew how to search for certain types of documents on College websites. The author also knew prior to commencing data collection that no discipline hearings occurred at CASLPO in the year under study and that pending discipline hearings were scheduled, although as a member of the Discipline Committee the author would not have any information on pending hearings that were not published on the College website. Steps were taken to suppress personal bias; this initially entailed a conscious effort to focus questions on the interview guide and base follow-up questions on the information provided by the key informants. The author also made a conscious effort to focus on the evidence as presented in the document analysis and the interviews as well as ensuring the information for both professions was represented and compared to the other Colleges. It was noted that in the course of interviewing the key informants and analyzing the data, the author focused on both
professions, which helped because the practice specific variables (type of work done, and remuneration) were different and the researcher only had a detailed working knowledge of one of the professions.

Once the analyses were completed for each case, the study participants were contacted to review written summaries of their comments or responses to questions as part of the process to help ensure construct validity (Yin, 2009, 2014). Care was taken to ensure the key informants received excerpts of the analysis pertaining only to their comments in order to ensure confidentiality of all respondents. Key informants were asked to confirm they agreed with the summaries of their interview and provide clarification where they felt necessary. All key informants participated in the process. Once this part of the analysis was completed the case reports were finalized along with the cross case analyses and the final write up was completed.

The underlying theoretical proposition guiding the case study was that the Colleges would differ in how they addressed financial COI and these differences could be linked back to the practice-specific variables nature work, work environment and remuneration. Using the theoretical proposition to guide the analysis, it was hypothesized that the Colleges might differ in their approach to addressing financial COI, which could be explained by the differences that each College’s membership faced with respect to the practice variables.

The following section provides an outline of how each of the questions was addressed and subsequently coded. Each of the key research questions is re-iterated below along with the strategy and technique used to answer the question.

5. How did the College define COI and what specific scenarios or situations were incorporated in defining COI?

In looking at how a College might define COI the first step was to analyze the approaches and tools that comprised the regulatory framework from which the Colleges operated. The regulatory framework that formed the foundations from which the Colleges operated was based on the Regulated Health Professions Act (RHPA), 1991, along with the profession-specific acts.
In addition, there were by-laws developed by the Colleges, as well as standards, guidelines and policies which were tools the Colleges used to direct the membership. The first part of the document analysis was focused on confirming if COI was included in legislation pertaining to professional misconduct. Once this was established the next part of the analysis determined if COI was explicitly defined and how this was documented including whether any specific scenarios or examples were provided that related to financial COI.

In terms of defining COI, College guidelines were assessed in terms of how they were structured according to the practice-specific variables (nature of work/scope of practice, work environment and remuneration). Since the Colleges posted documents on their websites including reference documents, policies, standards and guidelines, published by-laws, regulations, and legislation, if there was an explicit definition for COI and more specifically documents related to financial COI, the type of document or material it was contained within was considered an important element in answering the question. One common matrix summarizing the documents in which COI was defined was developed in order to track for each case and allow for an easy cross-case comparison.

In order to answer this question an online search was conducted on the College-specific websites, the Ministry of Health website as well as a general search using key words “conflict of interest”, “code of ethics”, “professional misconduct”, “practice guidelines – conflict of interest”, “by-laws conflict of interest”, “conflict of interest guidelines”, “conflict of interest regulations”, “billing – conflict of interest”, and /or “financial conflict of interest” to determine what documentation was in place to address this question. For the searches that were conducted outside of the College-specific website, the regulatory college name, the regulated health profession and “Ontario” were also incorporated with the terms noted earlier.

The key informants were also asked how the College defined conflict of interest. This was done to ensure all relevant documentation was analyzed and also to understand in practice how the College’s representative(s) defined conflict of interest.
6. How did the College provide its registrants with guidance pertaining to financial COI? Was this guidance based on one-way communication from the College to its membership or was there two-way communication in which registrants could seek clarification from the College?

In addition to documented policies, practice standards and/or regulations being in place pertaining to registrant requirements one goal of the study was to understand how the College ensured its registrants were aware of the expectations for them regarding their knowledge and behavior relative to financially related COI matters. Areas that were explored in answering to this question included the type of guidance that was available, the types and format of educational tools that were used, communication methods and whether the communication the College employed was one-way with the College providing information to the membership as a collective group (passive), or whether the communication was two-way with either the membership contacting the College to obtain guidance or information pertaining to financial COI or the College reaching out to the membership to offer additional educational opportunities in which both parties might interact further (active). Key informants were asked to provide any typical scenarios that the College encountered when providing membership guidance on financially-based COI matters.

The document analysis incorporated the educational and practice advice information found in the initial searches in addition to any documents referenced by the key informants.

7. How did the College allegations of professional misconduct related to financial COI?

The RHPA (1991), outlined the mandatory process required of all Colleges when addressing allegations of professional misconduct (Government of Ontario, 1991i). Allegations of COI would constitute professional misconduct and would be subject to this mandatory process, which included in the most extreme cases, referral of the specified allegations to the Discipline Committee. Given only items that were referred to the Discipline Committee for a discipline hearing become part of the public domain this question was designed to understand how the College handled issues in this area up to and including a discipline hearing.
Document analysis was done to review what process was documented to address financial COI. In addition, a review of the Colleges’ website postings and the annual reports for 2012 (2012-2013 for CPO due to reporting differences) was done for illustrative purposes, to determine if there were any discipline hearings pertaining to financially-based COI matters.

During the key informant interviews participants were asked how the College enforced and addressed financially-related COI issues. Participants were also asked to comment on whether they felt that self-regulation and the College processes were effective in addressing financial COI.

8. To what extent was financial COI perceived to be an issue for the profession based on the practice-specific variables examined in this study (nature of work, workplace environment, and remuneration)?

Document analysis was also done to determine if the practice specific variables impacted the COI guidelines/regulations or the published processes that the Colleges had in place to address financial COI.

The participants were asked specifically about how of the practice-specific variables impacted potential for financial COI, and how it might be addressed. Key informants were also asked the general question how much of an issue financial COI was for the members. The purpose behind this line of questioning was to ensure that if the practice specific variables were not formally addressed in earlier questions that they would be explicitly addressed during the interview process.

9. How important of an issue did the key informants think financial COI was as an issue and concern for the College? How effective did the informants feel the College was at addressing financial COI?

The participants were asked to comment on how important an issue financial COI was for their College and how effective they felt the processes in place were in addressing financial COI.
Chapter 4
Results: Part I

Descriptive Study Results

The questions addressed were as follows:

1. Which health professions were self-regulated within each province in Canada?

2. To what extent was there overarching/umbrella legislation across the professions and to what extent was the legislation profession-specific?

3. Where overarching/umbrella legislation existed did it address college mandates, ethics, and complaint handling/investigations, protection of title and/or controlled or restricted activities?

4. How did the Ontario legislative framework set forward expectations for managing the conduct of the self-regulated health professions?

4.1 Health Professions Granted Self-Regulation in the Canadian Provinces

In Canada, the Constitution mandates that healthcare falls under provincial/territorial jurisdiction (Deber, 2014a). The Canada Health Act outlines the principles that provincial/territorial governments must follow to receive full federal funding. The federal government is responsible for setting and administering these national principles, as well as providing financial support to provinces through fiscal transfers (the Canada Health Transfer and the Canada Social Transfer); they also have responsibility for providing healthcare services to specific groups including First Nations, Inuit and veterans (Government of Canada, 2004, 2005).

To receive full federal funding, the provinces must insure what is deemed as medically necessary hospital, diagnostic and medical services, and often this is referred to as Medicare (Marchildon,
2009, 2013). The provinces administer the reimbursement mechanisms for Medicare and also determine whether or not other health services will receive any funding or coverage as well as ensure that professional licensure and educational requirements are set. It is within these principles that the regulatory framework for self-regulation of the health professions has been implemented at the provincial level. For example, in order to practice nursing in Ontario, an individual must apply and meet the registration requirements outlined by the CNO, which is part of the regulatory framework under which they function (CNO, 2014). The requirements include educational and registration criteria and successful completion of a jurisprudences examination. If an applicant is trained outside of an approved training program in Ontario, or in the case of the registered nurse registration classification, outside of an approved Canadian university offering a baccalaureate degree in nursing, the CNO assesses the educational program on an individual basis to ensure the educational standards are met (CNO, 2014).

Under the Canadian Constitution, the provinces have jurisdiction for both healthcare and education. In a manner that is not entirely dissimilar from the transfer payments and credits associated with healthcare, the federal government provides the provinces with the Canadian Social Transfer (CST) under which funding towards postsecondary education is included, however there is no national oversight over higher education (Government of Canada, 2014a). In 2014, Statistics Canada reported the population of Canada to be over $35.5 million people, with 86% residing in Ontario, Quebec, British Columbia or Alberta (Government of Canada, 2014b). In contrast, the territories (Nunavut, North West Territories and Yukon) accounted for .3% of the population. The federal government provided equalization payments to the less wealthy provinces to help ensure what is referred to as “reasonably comparable” levels of health care, education, and welfare in all the provinces (Government of Canada, 2014a). The analysis focused on comparing the self-regulation of health professions across the provinces and did not include the territories, due the differences in size and resources.

The provinces all differed somewhat in the regulatory framework that was employed for self-regulating health professions. The document analysis indicated that the provinces were not
consistent in the titles used for some professions, so, these related professional titles were combined into one professional category. These combined classifications were based on either the grouping of the legislation, the practice descriptions or scope of practice found during the searches. Specifically, respiratory technologist and respiratory therapist were combined into one category, hearing aid dispenser and hearing aid acoustician were combined into one category and traditional Chinese medicine and acupuncture practitioners were combined into one category. Chiropody and podiatry were not combined because of the distinction between the two professions that was made in Ontario by Health Professions Regulatory Advisory Council (2014). The various titles that were used for subsets of the nursing profession were kept separate due to the differences listed for scope of practice, and or registration classification. It is worth noting that education and training programs are determined at the provincial level, hence the differences in some of these professional designations and scopes of practice. As a result for nursing there were four categories: licensed practical nurse, registered nurse, nurse practitioner, and registered psychiatric nurse.

Based on the legislative framework for the provinces, a total of 37 professions were represented and delegated self-regulation in at least one province as of November 2014. Table 4.1, summarized for each province the number of professions that were delegated self-regulation and the associated legislation. Professions noted in the legislation that were awaiting proclamation, were also included in this listing. Of the 37 professions, all but one province (Prince Edward Island) delegated self-regulation to over 20 professions. Prince Edward Island delegated self-regulation to 18 professions while Alberta granted self-regulation to the most professions, delegating self-regulation to 31 professions. The remaining provinces delegated self-regulation to between 23 and 28 professions, indicating a fairly consistent representation across the remaining provinces. All of the provinces had fewer profession-specific pieces of legislation than professions. This was because more than one professional group was grouped together in some of legislation and the associated regulatory college. For example, in the eight provinces where audiologists and speech-language pathologists were granted self-regulation they were
granted self-regulation under the same legislation. Likewise, registered nurses and nurse practitioners were addressed under the same legislation.
## Table 4.1 Summary of Provincial Legislative Framework for Self-Regulated Health Professions

<table>
<thead>
<tr>
<th>British Columbia</th>
<th>Alberta</th>
<th>Saskatchewan</th>
<th>Manitoba</th>
<th>Ontario</th>
<th>Quebec</th>
<th>New Brunswick</th>
<th>Nova Scotia</th>
<th>Prince Edward Island</th>
<th>Newfoundland &amp; Labrador</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Summary</strong></td>
<td>21 Regulations Of Which 26 Fall Under The RHPA. Social Workers Under A Separate Legislation</td>
<td>29 Regulations Of Which 26 Fall Under The RHPA. *Acupuncturists, Midwives &amp; Paramedics Not Covered Under The RHPA</td>
<td>22 Regulations</td>
<td>27 Regulations, Of which 26 fall under the RHPA of which 3 were unproclaimed. Social Workers under separate legislation.</td>
<td>Professional Code - 26 Provides Regulatory Structure For 26 Professions. Of These 12 Professions Also Had Additional Regulations Cited And Available In English.</td>
<td>23 Regulations, 1 Bill yet to pass (Massage Therapy)</td>
<td>22 Acts, of which 21 fall under the RHPN. Paramedics workers do not fall under RHPN but separate legislation.</td>
<td>15 Acts</td>
<td>22 Acts of which 6 fall under the HPA.</td>
</tr>
<tr>
<td><strong>Total Number of Self-Governed Regulatory Bodies</strong></td>
<td>20 Self-Regulated Under RHPA + 1 Outside</td>
<td>29 Self-Regulated Under RHPA + 3 Outside</td>
<td>22 Regulatory Bodies</td>
<td>27 Regulatory Bodies</td>
<td>Undetermined</td>
<td>23 Regulatory Bodies</td>
<td>22 Regulatory Bodies</td>
<td>15</td>
<td>22</td>
</tr>
<tr>
<td><strong>Total Number Of Self-Regulated Professions</strong></td>
<td>26 Professions Covered (Nurse Practitioner, Licensed Practical Nurses and Registered Nurses Under One College; Audioligists, Speech Language Pathologist And Hearing Aid Practitioners Under 1 College; Dental Assistants and Dentists under 1 College)</td>
<td>31 Professions Covered (Nurse Practitioner And Registered Nurses Under 1 College; Audiologists And Speech Language Pathologists Under 1 College)</td>
<td>28 Self-Regulated; 5 dental health-related professions covered under 1 act; Audiologist and Speech Language Pathologist covered under 1 act; Nurse Practitioner and Registered Nurses covered under 1 act.</td>
<td>24 Professions Covered (Nurse Practitioner And Registered Nurses Under 1 College; Audiologists And Speech Language Pathologists Under 1 College)</td>
<td>29 Professions Covered including 3 not yet proclaimed (Nurse Practitioner And Registered Nurses Under 1 College; Audiologists And Speech Language Pathologists Under 1 College)</td>
<td>25 Professions Covered (Nurse Practitioner And Registered Nurses Under 1 College; Audiologists, And Speech Language Pathologist Under 1 College), and 1 profession pending (Massage Therapists)</td>
<td>24 Professions Covered (Nurse Practitioner And Registered Nurses Under One College; Dental Hygienists, Dental Assistants and Dentists under 1 College)</td>
<td>18 Professions Covered (Nurse Practitioner And Registered Nurses Under 1 College; Audiologists, And Speech Language Pathologists under 1 College). Of these, 7 profession fall under the HPA (Audiologists and Speech Language Pathologists grouped together in the HPA framework).</td>
<td>24 Professions Covered (Nurse Practitioner And Registered Nurses Under 1 College; Audiologists, And Speech Language Pathologist Under 1 College). Of these, 7 profession fall under the HPA (Audiologists and Speech Language Pathologists grouped together in the HPA framework).</td>
</tr>
</tbody>
</table>

NOTE: The Regulated Health Professions Act (RHPA) (2010) For 7 Professions, Others Are Covered Under Own Legislation As Indicated Below
Table 4.2 summarizes the total number of provinces in which each profession was granted self-regulation. Fourteen professions were granted self-regulation in all provinces. These professions included chiropractors, dental hygienists, dentists, denturists, dieticians, registered nurses, occupational therapists, opticians, optometrists, pharmacists, physiotherapists, physicians, psychologists and social workers. It should be noted that social workers were included because both Alberta and Nova Scotia, included them as a regulated health profession, while the other provinces may have allowed for self-regulation, but not necessarily under the health professions legislation. Kinesiology, chiropody, and homeopathy were the professions that were least granted self-regulation, with each only being delegated self-regulation in one province. Of the 37 professions represented 25 (68%) were self-regulated in more than half of the provinces.

For the professions that were not self-regulated at a higher consistency across provinces, there were a couple of notable findings. First, where overarching/umbrella legislation existed, there were differences across provinces in whether professions were considered health professions. For example, paramedics were regulated in four provinces including Alberta and Nova Scotia in which they were delegated self-regulation status but under different legislation than the overarching legislation that was in place for most health professions in these provinces. Second, provinces had differences in how they classified and set forth regulation for various professions. Of note was that registered psychiatric nurses were recognized as a separate classification in three provinces while the nursing classification considered a registered classification in all provinces indicating a difference in how the nursing profession was recognized and classified from a regulatory perspective at the provincial level. Another example where professions might be classified differently was evident with the dental professions. While some provinces allowed for Colleges that regulated each profession separately, other provinces including British Columbia, Saskatchewan, Nova Scotia and Prince Edward Island had more than one dental health profession fall under a common legislation and regulatory College. These variations and nuances need to be considered when comparing absolute number of professions that granted self-regulation across the provinces.
Table 4.2 Number of Provinces in Which Each Profession was Granted Self-Regulation

<table>
<thead>
<tr>
<th>Profession</th>
<th>Total Number of Provinces Granting Self-Regulation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chiropractors</td>
<td>10</td>
</tr>
<tr>
<td>Dental Hygienists</td>
<td>10</td>
</tr>
<tr>
<td>Dentists</td>
<td>10</td>
</tr>
<tr>
<td>Denturists</td>
<td>10</td>
</tr>
<tr>
<td>Dieticians</td>
<td>10</td>
</tr>
<tr>
<td>Occupational Therapists</td>
<td>10</td>
</tr>
<tr>
<td>Opticians</td>
<td>10</td>
</tr>
<tr>
<td>Optometrists</td>
<td>10</td>
</tr>
<tr>
<td>Pharmacists</td>
<td>10</td>
</tr>
<tr>
<td>Physical Therapists/Physiotherapists</td>
<td>10</td>
</tr>
<tr>
<td>Physicians &amp; Surgeons/ Medicine</td>
<td>10</td>
</tr>
<tr>
<td>Psychologists</td>
<td>10</td>
</tr>
<tr>
<td>Registered Nurses</td>
<td>10</td>
</tr>
<tr>
<td>Social Workers</td>
<td>10</td>
</tr>
<tr>
<td>Midwifery</td>
<td>9</td>
</tr>
<tr>
<td>Nurse Practitioner</td>
<td>9</td>
</tr>
<tr>
<td>Audiologists</td>
<td>8</td>
</tr>
<tr>
<td>Dental Assistants</td>
<td>8</td>
</tr>
<tr>
<td>Medical Laboratory Technologists</td>
<td>8</td>
</tr>
<tr>
<td>Respiratory Therapists/ Technologists</td>
<td>8</td>
</tr>
<tr>
<td>Speech Language Pathologists</td>
<td>8</td>
</tr>
<tr>
<td>Dental Technology</td>
<td>7</td>
</tr>
<tr>
<td>Licensed Practical Nurses</td>
<td>7</td>
</tr>
<tr>
<td>Podiatrists</td>
<td>6</td>
</tr>
<tr>
<td>X-Ray Technologists/Medical Radiation Technologist</td>
<td>6</td>
</tr>
<tr>
<td>Naturopaths</td>
<td>5</td>
</tr>
<tr>
<td>Traditional Chinese Medicine &amp; Acupuncture Or Acupuncture</td>
<td>5</td>
</tr>
<tr>
<td>Hearing Aid Practitioners/Acousticians</td>
<td>4</td>
</tr>
<tr>
<td>Nursing Assistant</td>
<td>4</td>
</tr>
<tr>
<td>Paramedics/Emergency Medical Assisting</td>
<td>4</td>
</tr>
<tr>
<td>Massage Therapy</td>
<td>3</td>
</tr>
<tr>
<td>Registered Psychiatric Nurses</td>
<td>3</td>
</tr>
<tr>
<td>Medical Diagnostic &amp; Therapeutic Technologists</td>
<td>2</td>
</tr>
<tr>
<td>Counselling Therapists/ Psychotherapists</td>
<td>2</td>
</tr>
<tr>
<td>Chiropodists</td>
<td>1</td>
</tr>
<tr>
<td>Homeopathy</td>
<td>1</td>
</tr>
<tr>
<td>Kinesiologists</td>
<td>1</td>
</tr>
</tbody>
</table>
4.2 Legislative Framework: A Comparison of the Provinces

The next area of analysis addressed how the provinces structured the health professions legislation. Appendix C contains a compilation of the legislation in place for the health professions in each province. British Columbia, Alberta, Manitoba, Ontario, Quebec, Nova Scotia and Newfoundland and Labrador all had some type of overarching or umbrella legislation under which a number of professions were regulated. Quebec was unique in that the provincial legislation was the Professional Code, which provided the regulatory framework for 53 professions, from various fields including healthcare. The Code delegated supervision to the professional orders. Orders are the professional associations that regulate a number of various professions in Quebec including health professions (Government of Quebec, 2015). Some of these health professions had specific regulations outlined as chapters within the Code. Under the code 25 professions were provided with protection of title, and regulated by 20 professional orders. A further 25 professional orders were established for profession with reserved titles and exclusive right to practice. Unfortunately additional details of these profession specifics acts could not be found on the government website and the professional orders websites searched did not contain English documentation. As a result Quebec health professions were excluded from the rest of this analysis.

All but three provinces had some type of legislation that covered multiple professions; Saskatchewan, New Brunswick and Prince Edward Island did not have overarching legislation mandating self-regulation for health professions. Saskatchewan did have one Act, the Dental Disciplines Act (Government of Saskatchewan, 1997) which covered the dental health professions of dental assistants, dental technologist, dental hygienists, denturists and dentists. Likewise, both New Brunswick and Prince Edward Island had similar scenarios in which multiple classifications of nursing and dental health professions were each covered under common legislation. None of these provinces were classified to have overarching legislation because none of this legislation extended to non-related health professions. British Columbia, Alberta, Manitoba, Ontario, Nova Scotia and Newfoundland and Labrador all had some type of overarching legislation for the regulation of health professions. Of the provinces that did have overarching legislation, all but Ontario and Manitoba covered only a portion of the health
professions that were delegated self-regulation in that province. Alberta had two pieces of legislation delegating self-regulation; the Health Professions Act, 2000 which laid out the regulatory framework for 29 professions (through 26 regulatory Colleges) and the Health Disciplines Act, which outlined the regulatory framework for three health professions (2000a, 2000b). British Columbia’s legislation delegated self-regulation which covered 25 of the 26 health professions. On the British Columbia government’s website pertaining to self-regulation of health professions it was noted that social workers were self-regulated under a separate piece of legislation, the Social Workers Act, 2008 (n.d). Other provinces also granted social workers self-regulation, but in the cases where overarching legislation existed they were covered under separate legislation with the exception of Alberta and Nova Scotia where social workers were considered in the overarching legislation. Nova Scotia’s legislation, the Regulated Health Professions Network or RHPN (2012) covered 22 professions, and while social workers were included, paramedics were covered under separate profession-specific legislation. In a structure mixing umbrella legislation and profession-specific legislation, the Newfoundland and Labrador Health Professions Act (2010a) covered 7 professions, and had profession-specific legislation for 16 other professions. As a result of these splits between overarching legislation and profession-specific only legislation, only Ontario and Manitoba had overarching legislation that provided a common legislative framework, and definitions of restricted acts that covered all of the self-regulated health professions as defined by these provinces respectively.

4.3 Mandates Legislated to the Colleges by Province

Table 4.3 provided a summary of key features that were examined as part of the analysis of overarching legislation. Specifically, British Columbia, Alberta, Manitoba, Ontario, Nova Scotia and Newfoundland and Labrador all had some type of overarching legislation for delegating self-regulation to the health professions and were subsequently reviewed to determine if there were clear mandates outlined for the College, if the mandates included expectations surrounding addressing professional conduct including establishing a code of ethics, a complaints and investigations process and disciplinary process. In addition, the documents were examined to
determine if there was any protection of title and any controlled or restricted activities defined in
the documentation, which would then in turn be delegated to the appropriate professions. British
Columbia, Alberta, Manitoba, Newfoundland and Labrador and Ontario were most similar in
that the legislation provided for College mandates including processes for professional conduct,
code of ethics and protection of title. British Columbia, Manitoba and Ontario defined controlled
or restricted activities and had a similar number of them although they were classified and
organized in different manners. Alberta did not include the restricted activities in the Alberta
Health Profession Act (HPA), (Government of Alberta, 2000b), but provided for it in another
piece of legislation which covered all the health professions, the Government Organizational
Act, section 7.1 (Government of Alberta, 2000c). Nova Scotia and Newfoundland and Labrador
did not provide for any restricted or controlled acts in the overarching legislation and none could
be found in the searches or in profession-specific documents that were analyzed including the
acts governing physicians and nurses. These two professions were chosen for analysis because
these professions were granted the largest number of controlled acts in other jurisdictions.

The Nova Scotia RPHN (Government of Nova Scotia, 2012) did not provide for title protection
but did provide for directives on collaboration between professions on scope of practice since it
was recognized that there would be overlap across professions. The Nova Scotia RPHN outlined
a collaborative process for investigations and complaint handling that was to be implemented if a
patient submitted a complaint about members from more than one of the regulated professions
groups included in the RPHN. Manitoba and Ontario were the only two provinces that covered
all of the areas analyzed in the overarching legislation so that all of the health professions were
governed by a common framework. The Newfoundland and Labrador Health Professions Act
(Government of Newfoundland and Labrador, 2010a) mandated the establishment of
Newfoundland and Labrador Council of Health Professionals ("Council") and the establishment
of self-regulated health professions Colleges, which covered 7 of the 23 self-regulated health
professions. The Council was responsible for registration of individual health professions,
quality assurance of a professional’s practice, and responding to allegations or complaints about
a health professional’s practice, and associated disciplinary actions. The individual Colleges
were responsible for establishing standards of practice and registration as well as scope of practice and code of ethics (Newfoundland and Labrador Council of Health Professions, 2012).

### Table 4.3 Comparison of Provincial Umbrella Legislation for Self-Regulated Health Professions

<table>
<thead>
<tr>
<th></th>
<th>British Columbia</th>
<th>Alberta</th>
<th>Manitoba</th>
<th>Ontario</th>
<th>Nova Scotia</th>
<th>Newfoundland and Labrador</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Umbrella or Overarching Legislation</strong></td>
<td>Health Professions Act (HPA), Health Professions General Regulation 2008. The professions under this act also have profession specific legislation.</td>
<td>Health Professions Act (HPA), 2000. The professions under this act also have profession specific legislation. Three professions are addressed under the Health Disciplines Act.</td>
<td>The Regulated Health Professions Act (RHPA), 2009. The professions under this act also have profession specific legislation.</td>
<td>The Regulated Health Professions Act, or RHPA, 1991. The professions under this act also have profession specific legislation.</td>
<td>Regulated Health Professions Network (RPHN), 2012 (proclaimed sept 2013) - 23 professions under the act</td>
<td>NF Health Professions Act (HPA) (2010) for 7 professions, which form the Newfoundland and Labrador Council of Health Professionals (NLCHP), Others are covered under own legislation as indicated below</td>
</tr>
<tr>
<td><strong>Controlled or restricted Acts</strong></td>
<td>7 reserved acts covering 22 elements</td>
<td>Listed under a different piece of legislation, the Government Organizational Act, section 7.1 (2000). 16 restricted acts with 36 elements.</td>
<td>21 controlled acts</td>
<td>14 controlled acts covering 20 elements</td>
<td>None listed in the RPHN, 2012</td>
<td>None listed in the HPA, 2010</td>
</tr>
<tr>
<td><strong>Duties &amp; Mandate of the Colleges</strong></td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td><strong>Restricted titles</strong></td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td><strong>Professional Conduct:</strong> registration, complaints, investigations, disciplinary processes</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>Collaborative process for investigations and complaints outlined</td>
<td>Newfoundland and Labrador Council of Health Professionals (NLCHP)</td>
</tr>
<tr>
<td><strong>Mandate for the regulatory body to develop a code of ethics to govern its members</strong></td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>Both at the NLCHP level and the College levels</td>
<td></td>
</tr>
</tbody>
</table>

Note: X = present
4.4 Framework for Addressing Professional Conduct in Ontario: An Overview of the Mandated Role of the College

In Ontario, through the Regulated Health Professions Act (RHPA), 1991, the provincial government granted self-regulation to 27 healthcare professions through 26 regulatory bodies, including transitional Colleges (since at the time of this study not all of the profession-specific legislation has been enacted). The regulatory bodies or Colleges were responsible for ensuring all aspects of the RHPA were upheld. The Health Professions Procedural Code (HPPC) of the RHPA outlined the duty and objects of the Colleges as well as the complaint handling process and the disciplinary process. The RHPA stipulated that in carrying out the objects, the Colleges had a responsibility to "serve and protect the public interest" (Government of Ontario, 1991i, c. 18, Sched. 2, s. 3 (2)). COI was not specifically noted in the objects; however, the fifth object in the RHPA directed the Colleges to "develop, establish and maintain standards of professional ethics for the members" (Government of Ontario, 1991i, c. 18, Sched. 2, s. 3 (1)).

The Health Professions Advisory Council (HPRAC), under the direction of the Minister Health and Long-Term Care provided input and advice to the Minister on healthcare matters. The HPRAC outlined primary and secondary criteria deemed necessary to bestow self-regulation on a health profession. The primary criteria used to determine if self-regulation was warranted were based on the assessment and recognition of the specialized knowledge and skill a profession possesses and the risk of harm that the public may be exposed to in the daily work carried out by the profession if it is not adequately regulated (HPRAC, 2007). As a result of the potential risk of harm associated with the work of a profession, the RHPA defined specific healthcare activities as controlled acts, which became restricted actions or activities done with respect to a person (HPRAC, 2006; Government of Ontario, 1991i). The RHPA specified which professions were authorized to perform each of the controlled acts; this varied considerably across the professions. In addition, the RHPA mandated a defined scope of practice and title for each of the professions governed under the act (1991i). HPRAC noted that four key elements that defined scope of practice under Ontario’s legislation (2007). These elements included a scope of practice statement, which was typically noted in the profession-specific legislation; the inclusion of controlled and authorized acts, which were noted in both the RHPA (1991i), as well as
profession specific legislation; a harm clause; and title protection. Each profession had in addition to the RHPA, profession-specific legislation which is listed in Appendix C. The RHPA (1991i) and the profession-specific legislation in turn specified the regulatory obligations of the profession’s College.

For example, in Ontario the College mandates included setting conduct standards and enforcing the objects outlined by the RHPA and were consistent across all Colleges included in the RHPA. Schedule 2 of the RHPA, also known as the Health Professions Procedural Code (HPPC), required each college to have in place seven statutory committees including the Executive Committee, Registration Committee, Quality Assurance Committee, Inquiries, Complaints and Reports Committee, Discipline Committee, Fitness to Practice Committee and Patient Relations Committees (1991i). The RHPA included the powers and expectations conferred upon the committees, standardized processes the committees were to follow.

The health professions’ regulatory Colleges were mandated to meet a number of objects outlined in the RHPA (1991i). One of these objects mandated the College to develop, establish and maintain standards pertaining to professional ethics for those registered with the College (Government of Ontario, 1991i). In practical terms, professional ethics should address COI situations such that if a professional was faced with a situation in which his or her own self-interest or those of his or her employer may impact patient-related decisions, the needs of the patient should override any self-interested motivation.

The Colleges’ regulatory mandates included setting and enforcing COI regulations to ensure that greater devotion to the public is upheld, and the public is protected and provided with appropriate care and services. Two of the statutory committees required by the RHPA were the Investigations, Complaints and Reports Committee (ICRC) and the Discipline Committee. The ICRC was mandated the responsibility for addressing complaints, investigations and registrars reports such that the Committee, based on the investigations undertaken by a panel of the Committee, had the power to refer the Member for incapacity proceedings, appear before a panel to be cautioned, or take other actions considered appropriate and consistent with the legislation as well as refer a specific matter to the Discipline Committee (1991, c.18, Sched 2, s 24 (1)).
The Discipline Committee had a mandated process through which a disciplinary hearing pertaining to allegations made against a member of the College would be undertaken by a panel of the Discipline Committee.

The Discipline Committee panel had powers to make orders based on the outcome of any Discipline Hearing where findings against a member were made. For example, a member might be referred to the Discipline Committee by the ICRC if the ICRC determined through investigation that allegations of professional misconduct or incompetence warranted such a referral. Colleges were mandated to include as part of the profession-specific legislation a Professional Misconduct Regulation, under which COI should be addressed. For example, the Medicine Act Professional Misconduct Regulation (O.Reg.856/93) specified that having a COI constituted professional misconduct. Subsequent to a referral to the Discipline, a panel of the Discipline Committee would conduct a discipline hearing that would address the specific allegations outlined by the ICRC and specified in the subsequent notice of hearing. If a panel of a Discipline Committee found a member to have committed an act of professional misconduct, as would be the case if a professional was found to have acted on a COI, the orders that would result might include directing the College’s Registrar to revoke the member’s certificate of registration, or any combination of suspending the member’s certificate of registration for a specified period of time, and directing the Registrar to impose specified terms, conditions and limitations on the member’s certificate of registration for a specified or indefinite period of time. In addition, the panel might also require the member to appear before the panel to be reprimanded and may require the member to pay a fine of not more than $35,000 to the Minister of Finance (Government of Ontario, 1991i, c. 18, Sched. 2, s. 51 (2); c 1-5).

4.5 Summary

The provinces differed in the regulatory framework that was put in place to delegate self-regulation to the healthcare professions. The framework utilized in Quebec covered professions outside of healthcare as well as healthcare professions, but was excluded from the full analysis due to difficulties in accessing English versions of profession-specific documentation. Of the
remaining provinces, all but two provinces had some type of overarching/umbrella legislation that covered multiple health professions and disciplines. Manitoba and Ontario were the only provinces that had one health professions act that covered all of the self-regulated health professions. Ontario’s Regulated Health Professions Act (RHPA), 1991, along with the profession-specific legislation or acts, covered 27 health professions, while Manitoba’s Regulated Health Professions Act (RHPA), 2009, covered 23 health professions (Government of Manitoba, 2009a). Both RHPAs for these provinces defined and listed controlled acts, and College mandates, including restriction of titles, professional conduct processes and the requirement to develop a code of ethics to govern the College registrants and allowed for further profession-specific mandates to be outlined in the profession-specific legislation.

The provinces that had overarching legislation were able to provide some common frameworks and mandates for the professional Colleges and thus a standardized approach to the implementation of healthcare policy. British Columbia, Alberta, Manitoba, and Ontario provided the most comprehensive overarching legislation, which included clearly outlined mandates for the Colleges including the mandate to develop a code of ethics to govern the membership, professional conduct mandates including registration, complaint handling processes and the provision for restricted use of titles. British Columbia, Manitoba and Ontario all defined controlled acts/restricted activities within the overarching legislation, while Alberta also had a defined list provided for in a separate piece of legislation. Newfoundland and Labrador had overarching legislation which covered 7 of 23 self-regulated health professions, and had as part of this legislation a Council that consisted of members from all of the 7 profession which addressed complaints and disciplinary issues.

In reviewing the legislation in place and the implementation timelines it appeared that the provinces were moving towards an overarching legislative framework with Ontario having the oldest legislation (1991), followed by Alberta (2000), British Columbia (2008) and Manitoba (2009). More recently, Newfoundland and Labrador and Nova Scotia legislation was passed with Newfoundland and Labrador’s HPA (2010a) and Nova Scotia’s RHPN (2012). In the provinces where the overarching legislation did not cover all health professions the document
analysis did not reveal the rationale behind the legislative framework and was deemed beyond the scope of this analysis.
Chapter 5
Results: Part II

Multiple-Case Study Results

The second part of the study incorporated a multiple-case study in which the questions focused on understanding how the Colleges addressed financial COI. The answers to the research questions will be addressed in the next sections.

5.1 College Definitions of COI Including the Incorporation of Specific Scenarios or Situations

A summary of the published documentation related to and defining COI can be found in Table E1, Appendix E. All four Colleges had in place the mandated profession-specific professional misconduct regulations in which COI was addressed. The CASLPO, CNO and CPO all contained the same wording when including COI in the professional misconduct regulations, “Practising the profession while the member is in a COI” (Government of Ontario, 1991b, O.Reg. 7419/93, section 11, proposed regulation, s. 17; Government of Ontario, 1991f, O. Reg 799/93, s. 26; Government of Ontario, 1991h, O. Reg 388/08, s. 5), while the wording in place in the CPSO professional misconduct regulation was bit broader, “Having a COI” (Government of Ontario, 1991d, O. Reg. 856/93, s. 5). The CPSO also had a COI Regulation in which specific conditions were listed that constituted a COI (Government of Ontario, 1991c). The regulation also included details of what might be included as a ‘benefit,’ which was the term used to describe any direct or indirect advantage, or personal benefit that might be derived by the member (Government of Ontario, 1991c. O. Reg. 114/94, s15). The CASLPO had in place a Proposed Regulation for COI (1996), in which an explicit definition of COI was provided as well as a detailed definition for benefit. Neither CNO nor CPO had a COI regulation in place, but did provide explicit definitions in their published practice standards or reference documents. The CNO defined COI in the Independent Practice Standard (CNO, 2013b) and the Professional Conduct Professional Misconduct reference document (CNO, 2013c) and referred to a
forthcoming proposed COI regulation that was not available at the time of this study. The CPO’s practice standard entitled, “Standard for Professional Practice – Conflict of Interest” (n.d.a.) provided an explicit definition which was also published in the guide to the standards for professional practice, “Advertising: Fees & Billing, and Conflict of Interest, 2009” (2009).

The definition and elements included in defining COI for each of these four Colleges, along with the document sources are outlined in Table E1 (Appendix E). All four Colleges had similar definitions, which included self-interest being placed ahead of patient care along with the appearance or perception of a COI as in the case of the CPO’s definition, “A COI arises when a registrant puts him or herself into a position where reasonable people, including patients, could conclude that his or her professional judgment is influenced by financial or personal benefit. In fact, even if a registrant’s judgment is not actually compromised, there may be concerns over COI. If circumstances cause a reasonable person to suspect that the registrant’s judgment is affected, this constitutes a potential COI” (CPO, n.d.a, p.1, para. 2). The elements included by the Colleges when defining COI will be discussed for each College in the next sections.

5.1.1 Defining COI: CASLPO

In the proposed regulation for COI, the CASLPO defined benefit to include monetary payments, gifts, receipt of goods and services at no cost or at pricing below market value, discounts and rebates, consultation fees, reduction of debt or financial indebtedness, credit related to patient referrals and any loan received without proper evidence of indebtedness, repayment terms, including market-based interest rates (CASLPO, 1996). The elements defining COI included relationships with industry in which benefit was conferred based on business volumes; improper solicitation to provide services privately during the course of working for an employer in a setting in which health-related services were provided to the public; possible conflicts related to prescribing/recommending and selling the prescribed/recommended products; offering or receiving benefit in return for referrals; and failing to follow disclosure and transparency guidelines in the conduct of research. The proposed COI guidelines also required that the registrant provides alternative options for his/her patients in terms of purchasing
recommended/prescribed products and that assurances be made that quality of care was not contingent upon purchases made with the registrant. Key informants provided additional insight into how the College operationalized the definition of COI. CASLPO key informants referenced the proposed regulation. One key informant stated that because the registrants were professionals and self-regulated that they would have a working knowledge of what COI was and that it was a common phrase. It was felt that COI was very scenario-based and nuanced such that time was spent communicating with the registrants to assist them in sorting out where there might be a perceived or real COI, being wary of those scenarios and how to avoid such situations. It was also noted that the proposed COI regulation was undergoing review as consideration was being given to having it subsumed under the professional misconduct regulation as this was a trend that one of the key respondents noted to be occurring in other Colleges.

5.1.2 Defining COI: CNO

In the CNO reference document Professional Conduct Professional Misconduct benefits or personal interests were noted to include anything of monetary value, including cash, or gifts or anything else that might be considered a personal benefit (CNO, 2013c). Areas included in the CNO standard were: soliciting business to provide services; promoting personal interests including side businesses that may or may not be related to health care; using credentials to endorse products for personal gain; lending or borrowing money from a client or influencing them in decisions regarding their estate; making care decisions for the patient which might include admission to healthcare facilities or treatment on behalf of clients, unless appointed by court as the client’s legal guardian; and delaying urgent care for one client over another client for non-health reasons (CNO, 2013c). The CNO key informants referred to the reference document, and the concept of the power imbalance in the therapeutic professional relationship was brought forward as a key area of focus for the College. Key informants indicated that the notion of avoiding COI through maintaining professional boundaries, along with the potential risk of harm to clients if these boundaries were not maintained. This theme of maintaining profession boundaries was noted throughout the nursing standards. COI was noted to involve personal
relationships and could extend beyond financial interests. It was felt that COI primarily related to clients, and might involve undue influence on the client in terms of when professional boundaries were not maintained. Boundary violations were seen to be linked to COI because it was felt that these boundary violations occurred when the professional was looking after his/her own needs instead of their clients resulting in the COI.

5.1.3 Defining COI: CPO

The CPO’s practice standard and guides pertaining to COI defined benefit to include rebates, credits or discounts on, or reimbursement of the cost of goods or services; receipt or distribution of goods or services at no charge or a cost below market value, debt reduction or payment; receipt of consultation fees; receipt of loans where repayment terms or interest did not reflect market rates; monetary payments beyond market value for services provided (CPO, n.d.a; n.d.b; CPO, 2009). The CPO’s standard for professional practice on COI (n.d.a) also listed performance expectations that addressed a number of areas where the potential for COI existed including: product endorsements or recommendations in which there was the potential for the member to benefit; recommending a clinic or services in which there was a personal interest in the product/service/clinic being recommended; ensuring the patient that care from the member was not contingent upon purchasing recommended products from them, entering into agreements where benefits were tied to volume-based agreements, payment or benefits tied into referrals; and the treatment of family members. The standard also noted expectations regarding transparency with the patient with respect to providing alternative suppliers, and documenting discussions as well as disclosure to the College upon request details of any activities or arrangements in which there might be concerns regarding potential COI. The CPO key informants noted that COI was defined in the College COI standard for professional practice and accompanying guide. It was noted by one key informant that a descriptive definition was provided as to what benefit might look like, but when registrants called in for practice advice a common scenario was related to referrals for profit, both to and from other health providers. The key informants also noted that a COI might be actual, potential or perceived and that even if the professional did not feel they were in a COI they needed to be cognizant of how an outside
party would perceive the scenario and act accordingly. The key informants also noted that they often spent time going over a scenario brought forward by the registrant, assisting them in the decision-making process to determine whether there was a COI. It was noted that in cases where the standard was very explicit, it was very easy to provide an answer; however not every case was explicit.

5.1.4 Defining COI: CPSO

The COI regulation outlined in the Medicine Act (Government of Ontario, 1991c) defined benefit to include reimbursement of the cost of services from any person; reduction in any payment or debt owing; consultation fees received without the appropriate documentation (contract, records) or outside of the members normal scope of practice; loans without appropriate documentation which included evidence of indebtedness, fixed term and market-set interest rates; and any kind of credit for referrals. COI scenarios noted in the regulation specifically mentioned the following areas: benefiting from relationships with industry; receiving or providing benefit associated with referrals; rent arrangements that related back to volume of business or referrals; selling or otherwise supplying any drug, medical appliance, medical product or biological preparation to a patient at a profit, (except, in the case of an emergency and resulting lack of availability) or in the case of allergy preparations if specified conditions were not met; or ordering services where there is personal benefit. The CPSO key informant perspective indicated the focus was on the professional misconduct regulation and in addition to the CPSO’s document, “The Practice Guide: Medical Professionalism and College Policies”, which was designed to set out the medical professionalism principles and values for all CPSO policies (CPSO, 2008). The values noted in the interview were professionalism, service and altruism. It was also noted that altruism touched on COI because the professional’s primary duty was to his/her patient, not self-interests regardless of the nature of these interests, which might extend beyond financial. The CPSO key informant made clear that the regulation extended to all types of COI.
The CPSO had additional policy documents in place that addressed COI (CPSO, 2006a, 2006b). The policy statement entitled, “COI: Recruitment of Subjects for Research Studies” (CPSO, 2006a) provided a definition of COI along with expectations surrounding compensation, research ethics, including ensuring research was approved by a research ethics board and that patients included in the study provided informed consent to the release of any patient information. The CPSO also adopted the Canadian Medical Association (CMA) Guidelines on relationships with pharmaceutical companies (CPSO, 2014). This policy provided guidelines regarding compensation in research, surveillance studies continuing education, clinical evaluation packages, peer selling and other areas where the potential where there was a potential for COI to occur.

5.1.5 Defining COI: Cross-College Comparisons and Analysis

Definitions of COI were fairly consistent across the Colleges. The definition of benefits and the elements included in the definition of what constituted COI documented by each College in their regulation or standard and mentioned by the key informants had some expected similarities and notable differences. The CPSO was the only College to have a regulation in place for COI, although the CASLPO had a proposed COI regulation. Both the CPSO regulation and the CASLPO proposed regulation had similar definitions of benefit. CASLPO included in the definition rebates and discounts on goods or services and the receipt of goods or services at no charge or below prevailing market rates as well as reduction of debt or financial obligation and benefit tied into referrals. The CPSO included in its regulation the notion of reduction of debt or financial obligation as well as benefit being tied into rental agreements. Both CNO and CPO had in place standards that addressed COI and defined benefit (CNO, 2013b, 2013c; CPO, n.d.a, 2009). The CPO’s definition of benefit covered the same areas as the CASLPO. The CNO’s was the least detailed and did not specifically mention rebates or discounts, loans (other than that with clients), consulting fees, or credit for referrals although it did address product endorsements. Key informants for each of the four Colleges noted that COI was very scenario based. The CASLPO and CPO key informants indicated a lot of communication time with members was
used to help them work through their practice scenario and determine if there was a potential COI.

These similarities and differences between the Colleges can be related back to the practice variables under consideration in this study, which were: nature of work or decision making authority; work environment or culture; and remuneration. These variables helped to explain where the Colleges were similar and where and why they might have differed. In the subsequent sections of this cross-College comparison specific areas that were noted in the College documentation on COI, will be discussed as they related to the practice specific variables. These specific areas include referrals and solicitation of business, the recommendation and or sale of products and industry relationships, and loans and financial interests.

5.1.5.1 Referrals and Solicitation of Business

COI relating to referrals and solicitation of business could be related back to both work environment and nature of work/decision making authority. The CASLPO, CPSO, and CPO all noted either in their documents or in the key informant interviews that benefit ensuing from either making or receiving referrals constituted a COI. All three of these Colleges had members practicing in work environments in which patients scheduled appointments for services. Some of these scheduled appointments would be made at the discretion of the patient resulting from either seeking out services independently, or relying on recommendations of a family member, friends or other healthcare providers. Other appointments might require a professional’s referral, as in the case of a physician practicing a specialty, where a physician-based referral would be required in order to obtain publicly insured services. In contrast, the CNO members typically worked in hospitals, long term care or community-based care (CNO, 2012a; 2013a) such that they would not be generating work from referrals, but more likely have worked scheduled by their employer. According to the key informants and the 2012 annual report a smaller percentage of CNO members (8.2%) worked in settings other than hospital, community or long-term care (CNO, 2013d). In other settings, such as a self-employment scenario, the member might very well be in a position they would make referrals and receive referrals. One key informant indicated that
referral to one’s own independent service was not allowed. The CNO Professional Conduct – Professional Misconduct reference document indicated that, “recommending that a client be treated in a particular facility or by a particular professional because of personal considerations” constituted a conflict of interest (p. 13, CNO 2013c).

The CPSO regulation explicitly included scenarios involving rental agreements in its documentation on COI. The CPSO COI regulation specifically included referral-related benefit scenarios in which the amount of rent paid to or by the physician was tied in to referrals (Government of Ontario, 1991c). The CPO also provided an example in the “Guide to Advertising, Fees, Billing and Conflict of Interest” in which the amount of rent paid by the member was set as a percentage of profits. This type of scenario was deemed to be a referral, volume-base agreement and one to be avoided (CPO, 2009). The notion of rental agreements where the member would work in an independent practice and have a leased or rented workspace and had payment tied into referrals related both to type of work done/scope of practice and to work environment since how patients accessed their services and the type of work environment were both factors in such arrangements.

Solicitation of business could also be related to the practice variables work environment and nature of work. The CASLPO, CNO and CPO documents all included solicitation of business in defining COI; the CASLPO, CPSO, CNO and CPO referenced directing, recommending or referring patients to a clinic, product or service in which there was a personal interest as a COI (CASLPO, 1996; CNO, 2013c; CPO, n.d.a; Government of Ontario, 1991c). The concept of solicitation tied back to the type of work environment and the nature of work done by the professional, such as selling products as a side business to supplement the services provided, (which will be discussed further in the next section), although this might not always be the case. For example, in situations where the solicitation of business was for services or products outside of healthcare (e.g. referring a patient to a family member’s house cleaning services), the type of work performed, work environment or remuneration might not have any relation or link to the solicitation of business (CNO, 2013c).
5.1.5.2 Recommending or Selling Products, Product Costs and Industry Relationships

The sale of products to patients in the course of providing services might also constitute part of the professional’s remuneration structure as well as constitute a core part of the nature of work performed such that both remuneration and nature of work performed might be practice variables explaining how the Colleges compared in this area. For example, a CPO member might sell neck pillows and back supports as part of the offerings in the provision of services relating to treating back and neck injuries (CPO, 2009), while a CASLPO member might sell hearing aids in the course of providing hearing care services (CASLPO, 1996). The CPO standard for professional practice on COI and the CASLPO proposed COI regulation both noted in the definition of benefit discounts, rebates, or pricing below market value on goods or services (CPO, n.d.a; CASLPO, 1996). Given that members of both of these Colleges might sell products to patients as part of the services they provided or the nature of work performed, it would make sense that a focus would be in these areas. The College documentation regarding relationships with suppliers and industry went beyond selling products. Each of the CASLPO, CPO and CPSO noted relationships with industry and where there was the potential for a COI. With the CPO and the CASLPO possible COI areas noted included receiving benefit from recommending or prescribing (in the case of CASLPO), selling or promoting a product and included volume-base agreements (CASLPO, 1996; CPO, n.d.a). The CNO reference documents indicated that using one’s registration status to promote or endorse commercial products or services was not acceptable (CNO, 2011a; 2013c). CASLPO, CPO and CPSO all noted the requirements for transparency and full disclosure of personal gains or business interests to be made to patients along with providing alternate solutions or options CASLPO, CPO and CPSO (CASLPO, 1996; CPO, n.d.a; Government of Ontario, 1991c). The CPSO’s conflict of interest regulation included registrant’s relationship with industry and covered receiving benefits from suppliers and included ordering therapies or services (Government of Ontario1991c). The regulation also noted that unless there was an emergency or reasonable access drugs, products or biological preparations could not be sold to patients for a profit (Government of Ontario, 1991c, O.Reg.114/94, s.16d).
The CPSO and the CASLPO also noted conditions that needed to be met for consulting arrangements or industry employment to be acceptable. For example, the CPSO required that the area of consultation fall within the member’s normal scope of practice, a contract be available to provide to the College upon request, and adequate records be maintained for any consultation services provided (Government of Ontario, 1991c). Additional documentation was also found in the CPSO policy document, “COI: recruitment of subjects in research studies” (CPSO, 2006a). The CASLPO’s proposed COI regulations indicated that a member receiving benefit from a manufacturer should not sell or prescribe that manufacturer’s products and that alternative purchasing options should be provided when the member was both prescribing and selling devices (CASLPO, 1996). The CPO’s professional practice standard on COI focused on ensuring the patient was provided with alternative sources to purchase products as well as ensuring a reasonable mark up (CPO, n.d.a). The CNO’s reference document Professional Conduct – Professional Misconduct (2013c) and the CNO’s Nurse Practitioner Standard (2011a) did not provide a lot of detail on industry relationships or pricing of products to the profession, but noted that promoting commercial products and endorsing them without providing information on alternative products might constitute a COI. The CNO’s nurse practitioner practice standard also indicated that profiting from selling medications was not allowed as it noted that the registrant should not charge more than the cost of the medication when selling medication to patients (2011a).

The differences in the degree of documentation the four Colleges had in identifying potential areas where COI with industry relationships and product pricing might arise was aligned with the nature of work and decision making authority of the various professions. The CASLPO key informants noted that the membership had shifted more towards independent practice environments in which the members would be charging fees and services and selling products. Key informants indicated that the audiology members of CASLPO both prescribed and sold hearing aids so the focus on industry relationships could be explained by the nature of the professions’ work done, their decision making authority as well as remuneration. For the CPO selling products that were related to the services provided was also seen as being related to
nature of work being done as well as being related to remuneration. For CPSO members, the
industry relationship guidelines outlined in the regulation were more tied to remuneration aspects
where the member entered into a consulting relationship (Government of Ontario, 1991c). This
type of industry consultant role would be directly tied to the type of work done by CPSO
members, and the resulting remuneration agreement because the emphasis was on documenting
the nature of the consulting work, with the requirement to be consistent with the members
established nature of work and for the remuneration to be in line with work done. For CNO,
there was limited focus on industry and selling products which was more related to product
endorsement and offering alternatives, although it was noted that selling products for profit was
to be avoided (CNO, 2013b; 2013c).

5.1.5.3 Loans and Other Financial Interests

The CASLPO, CPSO and CPO all outlined conditions that needed to be met for loans to be
considered appropriate and not constitute a COI. Interest free loans or loans that were not in line
with market-level interest rates as well as any reduction in debt of any financial obligation, any
debt reduction or loan repayment related to referrals were identified as concerns and potential
COI areas (CASLPO, 1996; Government of Ontario, 1991c; CPO, n.d.a). These types of loans
could be related back to the workplace environment, the nature of work performed and decision
making authority variables because they would either be related to industry relationships or
referrals, and these scenarios would be more likely to occur when the professional was in a
workplace environment where a business loan might occur such as an independent practice
setting where there were loans related to equipment, or indebtedness related to purchase and sale
of products.

The CNO was the only College in this study to explicitly document that lending or borrowing
money from patients, making decisions about personal care on behalf of patients, influencing a
patient’s decision in his or her estate constituted a COI (CNO, 2013c). The CNO also noted that
knowingly delaying care of a patient for non-health considerations was a COI (CNO, 2013c).
The key informants for the CNO indicated that the nursing work environment and the nature or
the work often resulted in a scenario in which a nurse might be working for long durations of
time, providing intimate care, often at a patient’s home. It was felt that due to the nature of the
work maintaining professional boundaries was very important to reduce the risk of a COI
occurring. The focus of the CNO College documents on COI related to failing to maintain
professional boundaries could be explained by the nature of the work and work environment in
which the majority of the CNO College members provide services relative to the other three
Colleges’ registrants.

5.1.5.4 Other Areas

The CPO was the only College participating in this study to include the treatment of related
persons (including spouses and family members) in its COI documentation although the CNO
included this in the documentation pertaining to maintain therapeutic patient-client relationships
(CNO, 2006a) and the CASLPO, CPO and CPSO had separate documents pertaining to treating
related persons and maintaining professional boundaries (CASLPO, 2013c; CPO, 2005; CPSO,
2007). The CASLPO addressed COI as it pertained to research in it proposed regulation
(CASLPO, 1996); while the CPSO identified requirements for consulting arrangements in the
regulation (Government of Ontario, 1991c) and also had a separate policy document pertaining
to conducting research and requirements to avoid COI (CPSO, 2006a). The CPSO was the only
College in this study that had mandatory reporting requirements for its membership if, “a
member or a family member had a proprietary interest in a facility where diagnostic or
therapeutic services are performed shall inform the College of the details of the interest”
(Government of Ontario, 1991c, O. Reg. 241/94, s. 17.2.).

5.1.6 Summary of Cross-College Comparison

All four of the Colleges in this study noted in their professional misconduct regulation that
practicing in a COI constituted professional misconduct. All four of the Colleges in this study
provided to their registrants an explicit definition of COI. These definitions varied in the types
of documents in which they were contained as well as the areas that the College focused on in
providing a definition and/or directives. The CPSO had a COI regulation and the CASLPO had
a proposed COI regulation. In contrast, the CPO had a standard for professional practice specific to COI and the CNO included COI in its Nurse Practitioner practice standard as well as reference documents pertaining to professional misconduct. The areas covered in the four Colleges’ documentation varied in a manner that could be explained the following practice specific variables: nature of work or decision making authority; work environment or culture; and remuneration. For example, the solicitation of referrals either from patients or other professionals was addressed explicitly by the CASLPO, CPSO, and the CPO and to a lesser extent by the CNO. The CASLPO, CPO and CPSO focused on benefits conferred in return for referrals, while the CNO along with the CASLPO and CPO focused on soliciting a patient to provide private services outside of the service model under which the professional was providing them services. Recommending/prescribing products and also selling these products was covered by the Colleges in which the members’ nature of work tended to allow for this to occur and aligned with their remuneration structure. Of the four Colleges in included in this study the CNO focused more on COI resulting from crossing professional boundaries; this is consistent with the nature of the work done by nurses and the environment under which most of its members provided services. The next question examines further the guidance that the four Colleges provided to the registrants pertaining to the financial COI.

5.2 How the College Provided Registrants with Education and Guidance Pertaining to Financial COI

The information analyzed from the document analysis and key informant interviews pertaining to education and guidance with respect to financial COI was summarized for each College prior to comparing across the Colleges. Table E1 (Appendix E) provides a summary of the documentation each College published. This was supplemented by the information provided by key informants about the role the College took in providing education or guidance to its membership. Each case was summarized in the next section, followed by a cross case comparison.
5.2.1 Registrant Education and Guidance: CASLPO

The CASLPO used a variety of methods to provide education and guidance to the membership on COI. Methods included one-way communications such as the publication of various documents, and interactive communication in which the College engaged the membership or responded to membership inquiries. Published documents that the key informants referenced included the by-law outlining the College’s code of ethics (CASLPO, 2010), the proposed regulation for COI, (1996), articles in CASLPO Today the College’s quarterly publication to the membership, position statements for various workplace environments, and the interprofessional collaboration tool kit (CASLPO, 2012b).

By-law 2011-08, the Code of Ethics stated in section 4.2.6, members “shall avoid activities that could be construed as involving a COI”. In addition, in the proposed COI Regulation (1996), COI was defined, along with directives to the registrants including the criteria for COI, “It is a COI for a member to participate in any professional activity where the member’s personal or financial considerations compromise or may compromise the member’s judgment in that professional activity, or where such involvement may appear to provide the potential for the member’s professional judgment to be compromised.” The current Professional Misconduct Regulation (Government of Ontario, 1991a) indicated that practicing while in a COI constituted professional misconduct.

Articles published in CASLPO Today provided guidance to the registrants. One article, “Opening a Private Practice” (Carling-Rowland & Bock, 2012), addressed COI potentially arising from working in public and private sectors simultaneously, as well as fees and advertising. The CASLPO had also posted a social media e-learning module that was developed in co-operation with six of the Ontario regulated health professions Colleges (CASLPO, n.d.a). The tool provided some COI scenarios including online product endorsement scenarios, and using a work-related patient database to contact and solicit patients related to personal business interests. The module also incorporated a question and answer section to provide the registrant
with the opportunity to test their knowledge and determine appropriate approaches in addressing potential COI scenarios.

The online interprofessional collaboration tool kit was also cited by key informants as material provided to the CASLPO membership. The tool kit, which was developed by the Federation of Health Regulatory Colleges of Ontario (FHRCO) was accessible through a link on the CASLPO website to the FHRC site (FHRCO, n.d). Although the tool kit did not specifically address COI, it did provide access to guidelines for accountability of each profession in an interprofessional team and dealing with conflicts within the team. CASLPO key informants indicated members were directed to this tool if they were dealing with team-related issues and it would be useful in addressing potential COI scenarios.

CASLPO key informants also brought forward a number of interactive approaches that were used including regional seminars for registrants, the Quality Assurance program, and the Practice Advice Program. Five regional seminars were scheduled in 2013 in various locations across the province, with the information posted on the website as well for those who were not able to attend (CASLPO, 2013b). The seminars covered the proposed records regulation, consent, support personnel and the Interprofessional Collaboration Tool Kit, and associated website. During the webinars, attendees were able to send in questions/or comments throughout the webinar in order to clarify questions. The past webinars did not specifically table COI as a topic; however, a College key informant indicated it is a planned topic for upcoming regional seminars based on input and questions from the membership.

The CASLPO’s Practice Advice Program was described by a key informant as an interactive approach that was used to address concerns that the membership or the public brought forward to the College. The CASLPO had practice advisors for both professions that fielded calls from the membership and/or public about concerns or questions pertaining to the practice of either speech-language pathology or audiology in Ontario. The key informants indicated that there were a number of scenarios brought forward by registrants in which the CASLPO registrant was faced with either an ethical dilemma or was concerned about a potential COI. Key informants
indicated that because most of the calls were scenario-specific, the approach to addressing the practice advice calls typically involved problem solving to assist members in providing their own answers and solutions to complex issues. The typical scenarios were summarized in a subsequent section of the results.

Discipline hearings and findings were posted on the website (CASLPO, n.d.b). No cases for 2012 cited COI as a finding. One key informant noted however, that if an allegation of professional misconduct was examined further and one tried to understand the motives behind actions, it would not be surprising if there were a financial self-interest behind the allegations. There were no examples that could be brought forward because at the time of the interview there was a pending case that had yet to be heard and until the discipline hearing was completed the specifics could not be discussed. The informant indicated that outcomes for any disciplinary hearings would be posted on the College website as well so this information was accessible to the public.

5.2.2 Registrant Education and Guidance: CNO

The CNO used a variety of methods for providing education and guidance to the membership on COI. Methods included passive or one way communications such as the publication of various documents, online learning modules and interactive communication in which the College engaged the membership or responded to membership inquiries.

The CNO key informants referenced a number of publications, which included practice guides and standards materials. The Therapeutic Nurse-Client Relationship Practice Standard (CNO, 2006a) and the Practice Guideline: Independent Practice, Revised 2013 (CNO, 2013b) both provided guidelines related to COI. The Nurse Practitioner Standard (CNO, 2011a) and Professional Misconduct reference document (CNO, 2013c), also addressed COI.

In addition to the published practice guides and standards the CNO also posted on the website a question and answer scenario section, in which a potential COI scenario was addressed (CNO, 2012d), an on-line learning module on the therapeutic nurse/client relationship standard (CNO,
2006b), and a video, “One is One Too Many” which was available by a link on the website or by DVD (CNO, 2012b). “One is One Too Many” addressed a number of elements of the Therapeutic Nurse/Client Relationship Standard and included a section pertaining to COI. This video also had an accompanying workbook. The question and answer section of the website, entitled “Ask Practice”, addressed a potential COI scenario involving the selling of products (CNO, 2012d).

The Practice Standard: Nurse Practitioner (2011a) clearly defined and provided directives about COI. The standard indicated that the Nurse Practitioner should not benefit from the prescribing, dispensing or compounding any medication. The standard also provided guidance on advertising and product endorsements. The Practice Guideline: Independent Practice Standard (CNO, 2013b) also provided guidelines for the membership regarding advertising, using, recommending, providing, or selling client-care products and setting fees where it was noted that the nurse was to avoid benefiting from selling products as well as refrain from advertising about selling products.

The therapeutic nurse/client relationship standard document addressed accepting gifts as well as engaging in activities which would put the nurse’s own self-interest ahead of the patients, as stated on page 9, “not engaging in activities that could result in monetary, personal or other material benefit, gain or profit for the nurse” (CNO, 2006a). The learning module Therapeutic Nurse-Client Relationship addressed maintaining boundaries, which in turn impacted the risk of COI to occur (CNO, 2006b). The learning module also included questions to verify learning. The “One is One Too Many Video” addressed abuse prevention with a module related to financial abuse of a patient and also included a multiple-choice quiz with accompanying answers, as a method for ensuring learning of the materials (CNO, 2012b).

The CNO key informants also indicated that the CNO posted a webcast on maintaining professional boundaries (2011b). The webcast featured the training module on the Therapeutic-Nurse Client Relationship. In addition, during the first quarter of 2014, new videos on professional accountability and practice reflection were scheduled to be released. These new
_videos were to be focused on key issues that might arise in nursing, including practicing nursing in someone else’s home. At the time of data collection the video on professional accountability was not posted on the website.

Discipline hearings and findings were posted on the website (CNO, 2012c). In the “Facts, Figures and Tidbits” section of the website, COI occurring during the use of social media was noted. The CNO had a version of the social media e-learning module, “Reflect Before You Post” on the website (CNO, 2013d). Five scenarios were presented along with one in which maintaining professional boundaries, was addressed covered along with some scenarios in which a professional using social media might be seen to be in a COI, although financial COI was not specifically discussed.

The key informants also indicated that the CNO had in place Outreach Consultants. These consultants provided practice advice for registrants or the public calling or writing in. Upon request, the Outreach Consultants also followed up with organizations to discuss a particular practice issue and the applicable standard and would provide information or education to groups.

5.2.3 Registrant Education and Guidance: CPO

The CPO used a variety of methods for providing education and guidance to the membership on COI. Methods included passive or one way communications such as the publication of various documents, online learning modules and interactive communication in which the College engaged the membership or responded to membership inquiries. The CPO had a number of documents that were published on the website that provided information or guidance on COI. These documents included “The Guide to Advertising, Fees and Billing and Conflict of Interest” (CPO, 2009)” which covered a number of areas where COI might occur including advertising, fees and billing. The document provided details on the professional misconduct regulation, and outlined what might constitute professional misconduct. “Practicing in a situation of COI” was included in this listing. The standards for advertising and fees and billing both addressed areas where the registrant was reminded of the requirement to put the patient needs first. For example
in the case of advertising, if an advertisement offered incentives to attract new patients, the registrant was required to ensure that appropriate steps were taken to ensure that his/her recommendations related to services and/or selling of goods were not based on self-interest instead of patient needs. The standard also recommended disclosure of underlying business motives if the possibility of COI was present. The standard also set forward requirements for billing, including ensuring fees charged were reasonable, billing represented accurately the services provided and that the registrant should not increase billing based solely on the knowledge that the patient was able to pay for more services or had additional coverage. A number of scenarios were outlined for both advertising and fees and billing sections, along with checklists for the professional to use as a guide. The final section of the standard covered COI. This section included a definition, and two tools for the registrants to use. These tools were described as principle-based. The first tool outlined a series of key questions for the registrant to answer when facing a potential COI situation. The questions required the professional to determine if they were in a COI, the impact of the scenario and how they might defend their actions. The second tool outlined steps that the registrant was directed to take when a COI was deemed unavoidable. These steps were designed to ensure full disclosure or transparency to the patient. These tools were followed by a section in which scenarios were provided along with how COI might be perceived to occur; this included detailed explanations. Examples covered in this section included payment for referrals, self-referrals, giving and receiving gifts, treating relatives and friends, and selling products. The final section of the standard was a self-reflection exercise in which a number of scenarios were outlined for the registrant to work through using the tools and checklists.

The CPO also published “Standard for Professional Practice – Conflict of Interest” (CPO, n.d.a) which provided a definition of the COI and performance expectations related to recommending products or services, volume related agreements, referrals and providing services to family members.
Other documents on the website that provided some information/guidance on COI included: The Practice Standard and the Guide to Therapeutic Relationships and Professional Boundaries (CPO, 2013b, 2013c), in which the power imbalance and inherent risks of crossing the boundaries were clearly outlined. The CPO also had two COI scenarios posted in the “Practice Scenarios” section of the website. The first scenario focused on the sale of products and the second scenario addressed personal/professional boundaries impacting decision making (CPO, n.d.d, n.d.e). Referral arrangements and the potential for COI were addressed in chapter 3 of the ethics e-learning module, posted on the CPO website (n.d.b). A practice scenario was presented in which other professionals expected some type of benefit to ensue based on referrals. The module explained the ethical and legal implications of such an arrangement to assist in the decision making process. The code of ethics was further elaborated in the CPO documented standard for code of ethics (2013e).

The CPO website also offered online learning modules on ethics which covered advertising and selling products. There were videos available online as well with one entitled, “Top Practice Advisor Questions” published in 2013 which included a section on professional boundaries and COI (CPO, 2013d). The video directed the viewer to both the Therapeutic Relationships and Professional Boundaries standard as well as the COI Standard. The CPO also posted all upcoming disciplinary hearings as well as disciplinary hearing outcomes on the CPO website and provided a summary of the cases that went to disciplinary hearings in the reporting year in its annual report (CPO, n.d.f; CPO, 2012; 2013a).

One key informant explained that members of the CPO were also required to complete a jurisprudence module after initial registration, then every 5 years thereafter. Within this module there were questions on COI. Jurisprudence Module 1, which was the module utilized in 2006, was posted on the website (CPO, 2006). Some of the case questions dealt specifically with COI. Particular scenarios covered including selling devices/products and paying for referrals. Other areas considered under the general domain of ethics or practice management also had elements related to the potential for COI to occur.
One key informant indicated that the CPO also offered outreach to the physiotherapy university programs where part of the presentation to students included professional boundaries and COI.

Other forms of education for the members included the Practice Advice Program, in which CPO members and the public were able to call in or e-mail with questions. The key informant indicated that during a practice advice call related to COI, the member would be walked through the decision making process, unless it was an issue that was explicitly outlined in the standard that could be answered very directly. The Practice Advisor also developed “frequently asked questions” for the College website, of which one included an item on COI that dealt with treating family members.

The quality management program was also in place to provide the members guidance. As part of the program the informant referred to a chart stimulated recall review in which the practice assessor (a peer) reviewed a number of patient files and then discussed the treatment, approach and rationale behind the member’s actions. One key informant indicated that, although the results of the quality management audit were confidential, if there were significant concerns they might alert the registrar to investigate further in a particular area such as billing.

5.2.4 Registrant Education and Guidance: CPSO

The CPSO key informant indicated that the CPSO did not provide education or training on COI because it was already provided by the medical schools. However, the CPSO did provide directives to the membership on COI. In addition to the COI regulation outlined in the Medicine Act, (Government of Ontario, 1991c), the College provided guidance through the College’s “The Practice Guide” which was published and available on the CPSO website (CPSO, 2008). The key informant noted that the guide was designed to set out the values of medical professionalism, service and altruism and that all regulations and College policies were based on these values. The CPSO also posted on the website a reprint from the College monthly publication, Dialogue (2006b) the reporting obligations for unavoidable COI along with the mandatory declaration form (2011).
The CPSO had a Practice Advice Program. It was also noted that through its Practice Advice Program the College provided guidance when members or the public contacted the CPSO with concerns or questions. The key informant indicated that COI might be brought forward in a more generic way with questions about member activities.

Discipline hearings and findings were posted on the website. It was noted that some of the cases in which the allegation against the member was that of professional misconduct might contain elements of COI even though this was not specifically stated, since an allegation of COI would be considered an act of professional misconduct. This is reviewed further in the scenario analysis section below.

5.2.5 Registrant Education and Guidance: Cross-College Comparison and Analysis

All four Colleges provided guidance, education or direction to their registrants regarding COI. All of the Colleges engaged in both one-way and two-way communications pertaining to COI. While all Colleges provided one-way or passive communication, with Colleges posting or publishing by-laws, standards, policies, reference and guidance materials on their websites, they varied in terms of the amount of information provided and the approach to providing this information. The Colleges in this study all had some two-way or interactive communication with the membership in which registrants interacted with the College for guidance on COI. A comparison between the Colleges indicated that there were consistencies across Colleges, particularly where required by regulations, but there were also some differences. The similarities and differences will be discussed followed by an analysis of how these might relate related back to the practice variables under consideration in this study (nature of work, decision making authority, work environment and remuneration).

The CPSO had an approach to registrant guidance that varied the most relative to the other three Colleges. In addition to posting the regulations and policies, the CPSO relied on the Practice Guide, which was noted to contain overarching principles of medical professionalism. The CPSO was the only College in the study that provided its registrants with a declaration form for
mandatory reporting of unavoidable COI. An example of an unavoidable COI included a scenario in which the member or his/her family member had a proprietary interest in a diagnostic therapy or service that the physician was recommending or providing. Unlike the other three Colleges, the CPSO key informant noted that the CPSO’s role was not to educate the registrants because they had received training and guidance on COI during their training and education to become physicians. In terms of an interactive approach to providing guidance on COI, the CPSO did provide guidance through the practice advice calls in which registrants could call in looking for guidance. The CPSO key informant noted that the calls they received from patients were more related to patient care; however COI issues could be identified through calls or complaints. The key informant indicated that this might arise as a result of an inquiry related to patient files or retention of records in the event that a group practice was separating, but could also arise regarding business arrangements (e.g. ownership) or charges for particular items.

The CASLPO, CNO, CPO all provided both passive and interactive guidance to their membership. CASLPO’s proposed COI regulation (1996) provided a specific definition of benefit, which was very similar to that outlined in the CPSO COI regulation. The CASLPO also provided very specific COI guidance to its registrants involved in prescribing or selling products (e.g. hearing aids) as well as providing professional services to a patient independent from his/her employer, which was either also provided by the member’s employer or subsequent to the discontinuation of the these services. Neither the CNO nor the CPO had a COI regulation, but instead had published practice standards and reference documents. Both the CNO and the CPO provided detailed definitions of COI and addressed common scenarios, which will be analyzed in detail in a later section. The CNO and the CPO provided detailed information in their standards and included the sale of products even though the CNO informants had noted that selling products was not a common scenario for its registrants. CASLPO had posted an article on private practice, which did cover some potential COI scenarios, but did not have the detailed guidance or scenarios that CPO provided. CPO’s guidance included a tool for assisting registrants in working through his/her practice scenario. Key informants from each of the four
Colleges noted that practice advice calls occurred in which interactive communications about COI between the Colleges and either its registrants or the public occurred.

Web-based learning modules were also available from the CNO and the CPO. These modules included various checklists or follow up questions to assist registrants. CASLPO indicated that webinars were held with the membership and one to address COI was planned for the coming year. The CASLPO and CNO had posted the social media e-learning module. The CASLPO version explicitly addressed COI, provided some guidelines along with a follow up quiz in which included COI. This social media e-learning module was something that was created by a subset of the Ontario regulated health professions Colleges and both the CASLPO and the CNO had a version of “Pause/Reflect Before You Post” on their website. Of the Colleges included in this study, only CNO had an Outreach Consultant group that actively fielded requests to talk to groups of professionals about issues including maintaining boundaries that would potentially involve COI issues.

5.2.6 Summary of Cross-College Comparison

In summary the CASLPO, CNO, CPO and CPSO all provided guidance to their registrants on COI pertaining to scenarios they might encounter. The CPSO provided the regulations and reporting requirements, but did not view educating the membership as part of its role. The CASLPO, CNO and CPO provided additional education on COI. Although all four Colleges had some type of documentation on their websites, the CNO and CPO provided extensive documented guidance that covered various practice scenarios in the form of learning modules, practice standards and guides. The CNO was the only College that had an official Outreach Consultant group that would field requests to go speak to groups about practice advice. All Colleges had a dedicated “Practice Advice Program” which provided the opportunity to understand the challenges and scenarios the registrants faced and provide guidance.

In order to analyze how the guidance provided by the Colleges related to the practice variables further examination of the scenarios the College registrants encountered was done. The next
section provides the analysis of the types of COI scenarios that the College key informants indicated their registrants reported or had the potential to experience and how this related to the educational guidance.

5.3 Potential Financial COI Scenarios

All of the Colleges in this study had a general statement pertaining to COI in their professional misconduct regulation or practice standards. The statements ranged from stating that practicing while in a COI was constituted professional misconduct to defining the benefits that might be associated with a COI. In various documents or publications specific scenarios were brought forward that the College membership might encounter. During the course of the key informant interviews these scenarios along with other ones from practice advice calls were brought forward. The summary of these types of scenarios are outlined in Table E2 (Appendix E) and will be summarized in the next sections for each College and then compared across Colleges.

5.3.1 Potential COI Scenarios: CASLPO

The CASLPO key informants indicated that during interactive communications with members a lot of time was spent discussing a scenario and sorting out with the member where a potential COI might arise, where and when to be wary and how to avoid COI. The change in practice environments, and more people entering into private practice, was felt to impact the interest and questions from the membership. COI was described by key informants as very scenario-based, such that the College may be able to identify common areas of concern based on input from membership and the public, but it was acknowledged they may not have covered all areas. The COI scenarios that were brought forward included the selling of devices, fees charged for services, proper administration or implementation of various third party funding models, and self-referrals.
The audiology membership of CASLPO had the act of prescribing hearing aids in their scope of practice. In addition to prescribing devices for patients, audiologists also might practice in a scenario where they also sold hearing aids and other associated devices. The CASLPO had a number of guidelines in place to address potential areas of COI, which included requiring the professional to ensure that the devices prescribed for a patient were most appropriate for their needs. The audiologist was required to inform the patient of alternatives in terms of purchasing options so that the patient was aware they were not obligated to purchase prescribed products where they received the prescription. As noted in the proposed COI regulation, “The member gives the patient or client the option of selecting an alternative service provider or alternative product by, wherever possible, providing the patient or client with the name of at least one other comparable supplier, facility or service in the same geographic area, and the member assures the patient or client that the choosing of an alternative supplier, facility or service will not affect the quality of health services provided by the member, or having explored all other potential service providers or products, the member concludes that access to a comparable service, facility or product cannot reasonably be arranged for the patient or client; and the patient or client then expresses a preference for the service provided or the product sold or dispensed by the member.” (CASLPO, 1996, s. 7.2(c)).

A key informant also noted that the Ontario Assistive Devices Program (ADP), a funding program accessible to most Ontarians and one that provided funding for a significant number of hearing aids in Ontario, also provided similar guidelines as a condition of funding. It was noted by a key informant that because the consumer may be skeptical and view the audiologist as being in an inherent COI (recommending and selling a product) that the audiologist needed to be able to justify very clearly his/her recommendations about products and how it matched the results of any assessments with an emphasis on improving patient care.

Working in a commercial environment where fees were charged for services was noted by CASLPO key informants as providing more opportunity for COI for both professions. The professional misconduct regulation (Government of Ontario, 1991b) noted that charging
excessive fees for professional services was deemed an act of professional misconduct, but it was noted by a key informant that the College did not actively set or regulate fees, which made it difficult to define what was appropriate. The professional associations provided a recommended fee structure to its members, but not all CASLPO registrants were members of the professional association so there was no mandated fee schedule in place. The key informant stated that fees were likely addressed by the market, such that marketplace pressures would have an impact on fees and the pricing of products sold, meaning if a registrant set the pricing for either their products or services too high then the marketplace would force adjustments on them.

Key informants indicated that COI was also seen to have the potential to occur in scenarios where third party funding impacted the length and duration of services. The first of these funding scenarios was described as occurring when the professional was in a position to benefit from what might be deemed self-referral from a publicly funded service being moved to their own privately provided service. This was described to potentially occur when a publicly funded treatment program had a limit to the number of treatments available to a patient, but the needs of the patient exceeded the publicly funded allocation. Speech Language Pathologists (SLPs) that provided services under this type of publicly funded model might also practice in a situation that they would be able to provide these services privately as an independent practitioner. When this might be deemed a COI was if the professional actively solicited to provide private services. If the patient approached the professional to have the services provided privately the SLP was required to outline for the patient their options, which also included where else they might obtain services.

Another funding-related scenario brought forward by key informants pertained to the reimbursement structure of third party agencies, such as an insurance company, when the reimbursement amounts varied according to who was providing the services. COI scenarios were identified where an SLP might submit billings to a third party, but not be the person actually providing the services. This potential scenario has been brought forward to the College by SLPs who have been approached by other service providers requesting they bill on their
behalf in order to increase the amount that was funded. A variation to this scenario might involve an SLP who employed supportive personnel to perform certain clinical services, but then billed for them as if he or she performed the services themselves.

The scenario where an employer was billing the third parties was cited by a key informant as an area where the member may not be aware of inappropriate billing practices. It was stressed that the CASLPO did not regulate companies, but the professional was required to be transparent in his/her actions and take the necessary steps to verify the accuracy of the billing of their services and bring forward any concerns.

Another scenario related to billing for services involved changing the dates when services were provided in order for the services to fall within funding restrictions. For example if only a certain number of treatments were allowed in a block of time, and the number of treatments exceeded what was covered in that block, if the documented date in which some of the services were provided was changed such that it occurred within the next funding period it would be construed as a COI. This was a scenario that SLP members indicated was often requested by the patient or the patient’s family in order to get extended coverage. Similarly, SLPs have called the CASLPO requesting advice when patients had requested SLPs to split the billings across patients and caregivers/family members who were not provided any services in order to increase coverage if third party programs offer family member coverage of some sort. Although falsifying records and services might constitute fraudulent behavior, these types of billing scenarios would only be considered a COI if the amount covered by a third party would be greater than if billed for privately, or if there was no provision for private billing such that the professional would not be receiving any remuneration for the services such that the professional had a personal gain in changing the billing dates.

Possible COI scenarios that dealt with work environments brought forward by one key informant included providing services in a work environment the member was not comfortable working in, but due to financial pressures was continuing to practice in. Providing services outside of knowledge, skills, was also noted by this key informant as a potential COI because self-interests
might be placed ahead of patient interests. In a similar vein, practicing when perhaps no longer fit to practice might also be viewed as a financial COI since personal interests would be superseding patient interests and these may or may not be financially driven. Other scenarios cited in which COI must be at risk of occurring included deciding what types of patients to take on as a caseload so as to maximize financial position. Whether this would constitute a COI might be scenario-based or possibly be related to accessibility to alternate services.

5.3.2 Potential COI Scenarios: CNO

The CNO key informants indicated that maintaining professional boundaries in the therapeutic relationship was paramount in avoiding COI. COI scenarios typically involved situations in which these boundaries were crossed, including any use of the power imbalance in the relationship to result in personal gain. Scenarios that might result from crossing the boundary that were noted included accepting of money, property, power of attorney, influencing a will, purchasing clothes, or accepting gifts. Entering into a personal relationship during a professional relationship created the potential for a COI.

Other scenarios where COI might arise included what was referred to by one key informant as “double-dipping” in which a nurse might get paid for providing services at two different locations on the same day, but only actually work at one of the locations. Additionally, not responding or taking the time to assess a patient might also be related to COI. The sale of products by a member of the College was allowed, but the published directives indicated that it should not be for profit (CNO, 2013c).

5.3.3 Potential COI Scenarios: CPO

The CPO key informants indicated that areas where COI had the potential to occur included fees and billings; referral-related issues; and working in an employee in a setting that provided publicly-funded or third party-funded services while also offering services independently in the private sector. Payment for referrals was a COI issue brought forward by the College key informants and cited in the Professional Misconduct Regulation (Government of Ontario,
The expectation for payment could be made by a number of health professionals, who were being asked to refer patients to physiotherapy clinics.

Other scenarios brought forward included those in which the member provided services funded by a third party in addition to offering either privately billed services or selling associated products as part of a private business. For example, one scenario brought forward was one in which a physiotherapist (PT) was providing services under a third party funding model and once the services covered by the model ended, the member entered into an arrangement in which the services were provided privately. It would only be considered a COI if entered into without full disclosure and providing alternative options as outlined in the standard, or if the services were unrelated to patient need. Another COI scenario for PTs might occur if a member worked in a publicly funded setting and sold private items as a side business. The key informant also noted that this may also include offering recommendations outside of the scope of practice. The CPO had specific guidelines to address both issues so that profit was not placed ahead of patient need and any potential conflict was disclosed to the patient.

Billing issues related to COI included block treatments or services. Under block treatments a third party program would allow for a certain level of services. Where the risk of COI was deemed to occur was if the member billed for the maximum allowed by the block without necessarily considering the needs or treatment plan the patient required. A final billing issue scenario involved billing for services to maximize what was covered under the patient’s plan often involving treating a group of people and using the block treatment to bill for each, which depending on the circumstances might be construed as a COI. Block treatments will be discussed further in subsequent sections.

5.3.4 Potential COI Scenarios: CPSO

The CPSO key informant indicated that discipline-related items, or cases that went to a disciplinary hearing, tended to be focused on what was considered more serious professional misconduct issues including sexual abuse, and gross clinical incompetence. There were potential
COI scenarios that were brought forward by the key informants which included offering insured services which were contingent upon purchasing uninsured services, referral arrangements involving benefits, accepting gifts or incentives, retention of records (with the dissolution of a group practice) and areas pertaining to fees and inappropriately billing for services or products. The CPSO key informant indicated that most services provided by physicians were publicly funded by the Ontario Health Insurance Plan (OHIP). However, some services were not insured so that a member might be working in a scenario in which he or she provided both insured and uninsured services. Where a potential COI might occur was that if the provision of insured services was predicated on the patient receiving and paying for the uninsured services. Where there was not a clear distinction between uninsured and insured services there was seen to be the risk for potential COI issues. For example, the influence of the physician over the patient in complementary or uninsured medicine might be a COI if the physician was recommending products or services for sale in which the physician had an interest. One example brought forward was when a physician was billing patients who had terminal illnesses for uninsured services and products that were of limited value. These billings had a negative impact financially on the patients and their families, provided no health benefit to the patients, but benefited the doctor.

Referral arrangements were seen as another area for the potential for COI. The scenarios described were not just ones in which there was a direct payment for referrals, but also instances where the benefit was less obvious. For example, referral arrangements might also be tied into other business interests. A possible scenario might involve physicians receiving a reduced rental rate in exchange for directing patients to the pharmacy in the building. Another scenario brought forward involved sending referrals to another professional because in turn the referring professional would get more business or referrals themselves. Even without an actual exchange of money, there could be a conflict because benefits conferred or received. However, part of the issue cited with this scenario was that this type of arrangement was not necessarily done without acting on the patients’ best interests. The CPSO key informant indicated that reasons for referring may be based on what was deemed as, “very good arguments” in their patient’s best
interest. It was recognized that even exchange of money did not mean that the referrals were not in the patient’s best interest. It was further noted that this was part of the rationale behind the guidance to avoid COI wherever possible, and to manage them by disclosure when they did arise. The goal at all times was to ensure that the physician puts the patient’s interests first and that the patient believes that their interests were being put first.

Advertising was mentioned as an area that was not a huge focus, but one covered in an ethics or professionalism course; however the key informant did not know to what extent it was covered. The CPSO professional misconduct regulation noted that charging excessive fees constituted an act of professional misconduct. Profit was addressed in the COI regulation, but the key informant noted fees and pricing may be difficult to determine, including the distinction between appropriate mark-up to cover reasonable costs and profit. The key informant indicated that there had been conversations within the College trying to differentiate between mark-up and profit and what level would be considered reasonable and appropriate.

Physicians accepting gifts or incentives from pharmaceutical companies including certain types of educational activities were identified as opening up the potential for COI to occur as well, so the CPSO had policy in place to address this area (CPSO, 2006b; 2014). Research in which physician influence was garnered through these types of activities was described as part of the rationale behind the policy. The issue of industry supporting educational events event if the education was not directly linked to the event was brought forward as a current area of discussion within the College in addition to being noted in the CPSO policy (2014).

Change in practice environments was brought forward as an area where members had questions and might introduce potential COI. For example, if physicians in joint practice decided that they no longer wanted to work together, and entered into a dispute over who owned the patient medical records. If this dispute interfered with access to care for the patient (i.e. personal interests were place ahead of patient interests) it might be considered a COI.
The final scenario brought forward in the interview involved physicians providing independent medical examinations for an organization or company, such as an insurance agency. It was felt that there might be either the appearance of or the potential for a COI if outcomes were based on employer mandates and goals and associated incentives.

5.3.5 Potential COI Scenarios: Cross-College Analysis

All four Colleges had identified common COI scenarios to which they provided their members guidance. These scenarios included situations in which publicly funded services crossed over into privately funded services, and billing concerns. Sales of products were more of a focus for only two of the Colleges as were referrals. In terms of identifying common scenarios, maintaining professional boundaries was mentioned by only one College. The similarities and differences for these areas will be summarized in the next sections as these scenarios will be summarized as they related to the practice specific variables.

5.3.5.1 Remuneration: Billing-Related Scenarios

The scenarios in which services might be funded through different streams, including public funding, third party funding or private funding, presented potential issues for all four Colleges in this study, but in slightly different manners and to different degrees. For the CASLPO, CNO and CPO one of the main COI scenarios brought forward was when the professional solicited to provide private services either once the public or third party service funding reached its funding limits or in addition to the funded services. The concern arose in how and if the privately funded services were solicited and the transparency and options explained to the patient in the process. For the CPSO, most services provided by its members were publicly funded, so a potential issue arose when a professional provided uninsured services in addition to publicly funded ones. The concern for CPSO was whether patient care was contingent upon the procurement of the uninsured services or how these services impacted the insured services. For all four Colleges, key informants noted how the services were funded and the potential for the member to inappropriately gain benefit from additional private remuneration were identified as the key issues.
Billing-related COI scenarios had some similarities and slight differences across Colleges as well. The CASLPO and CPO key informants brought forward issues that might arise in terms of providing appropriate billing to third parties. The CASLPO key informants brought forward concerns about the possible scenarios in which members billed for services that they did not actually provide, but other healthcare providers delivered, or for services that support personnel provided. The CPO key informant indicated concerns about block treatments and maximizing billings in questionable manners, which was reflected in the guidance regarding billing scenarios in their documentation. Neither CPSO nor CNO key informants brought third party billing-related concerns forward as a common concern with or from its membership.

Billing appropriate fees for private services was brought forward by both the CPSO and the CASLPO key informants, although key informants from both Colleges indicated that defining an appropriate mark up or profit was problematic because setting fees was not within the scope of the College and was also very difficult to determine. The CPSO key informant also indicated that the College no longer verified appropriateness of OHIP billing practices. It was noted that OHIP, the provincial single payer for insured physician services, conducted billing audits, although complaints might be received by the CPSO. The CNO was also the only College in the study to bring forward the concept of being paid for work not done based on payment of two salaries for allegedly working in two places at the same time.

5.3.5.2 Remuneration: Industry Relationships

The CALSPO, CPO and CPSO all noted requirements for industry relationships and benefits associated with industry in their documentation. The CPSO went further and provided its membership with a policy pertaining to consulting relationships with industry in which expectations for physician relationships with drug companies was outlined (CPSO, 2006a; 2014). The policy included consulting arrangements, accepting gifts and continuing education. Industry relationships were noted in the CASLPO proposed COI regulation, but the key informants did not bring forward any potential COI scenarios pertaining to this area. The CPO addressed
industry relationships in its COI standard, noting that a member should not enter into a volume-based agreement, but the key informants did not bring this forward as a common scenario.

5.3.5.3 Nature of Work: Sale of Products

The sale of products was brought forward as a potential source of COI for all four Colleges. CNO indicated that there should be no profit associated with the sale of any product by its members. The CASLPO and CPO had members involved in similar scenarios in which the members both recommended and sold devices or products to their patients. For the CASLPO audiology members prescribing and selling hearing aids or other assistive devices might constitute a significant portion of their services so the proposed COI regulation included a section in which the member was required to provide alternate suppliers for the prescribed device and inform the patient of their options. The CPO membership were also required to be transparent and make sure that the patient was aware that services would not be compromised if the products they recommended were not purchased from them. The CNO key informants did not bring forward the sale of products as an area of concern, although the college had guidelines and directives in place to address this area. The CPSO key informant mentioned the importing and selling of unapproved products as a potential source of COI along with billing for uninsured services as was noted earlier.

5.3.5.4 Nature of Work: Referrals

The scenario where benefit was conferred in exchange for referrals was noted by both the CPO and the CPSO key informants. Although the CASLPO has this noted in the proposed COI regulation it was not brought forward as a scenario for the membership. The CNO did not address this area at all, although self-referral was touched upon. Given the nature of work done by members of the CPO, CPSO and CASLPO were more likely to be based on referrals and the CNO members less likely it made sense that this was not a significant focus for the CNO relative to the other Colleges.
5.3.5.5 Nature of Work: Maintaining Professional Boundaries

The CNO key informants were unique in bringing forward maintaining professional boundaries as a common scenario in which financial COI might occur. When professional boundaries were not maintained the risk of the member taking advantage of his or her client might occur; examples provided in the documentation or interviews included accepting gifts, influencing decisions regarding wills, power of attorney, borrowing money and misappropriating property. It is worth noting that although maintaining professional boundaries was not brought forward by the other College key informants, it was addressed in documentation. The CASLPO did not bring this forward as an area of concern, however, the positions statement, “Professional Relationships and Boundaries”, stated that accepting or receiving gifts, and loaning or borrowing money from patients were signs that professional boundaries were not being maintained, although it was not stated that they constituted a COI (2013c). Although professional boundary scenarios were not brought forward by the CPO key informants, the CPO also had documentation in the Practice Standard, “Therapeutic Relationships and Professional Boundaries”, where it was noted that treating a partner or family member was a COI (2005a). The CPSO did not bring forward this as a potential COI scenario and the College’s, “Practice Guide: Medical Professionalism and College Policies” addressed COI in broader terms, including placing patient interests ahead of secondary interests (2008).

5.3.6 Summary of Cross-College Comparison of Potential COI Scenarios

In summary, issues that were common to all Colleges included scenarios in which services that were funded either publicly or through a third party might also be provided privately by a member once the third-party funding coverage reached its limit. If this crossover in service delivery was to occur, whether the services were solicited inappropriately for personal benefit or whether the provision of these services was transparent to all involved were key issues. Issues related to appropriate billing practices were brought forward by the three Colleges that had members who worked in remuneration scenarios where they would bill third parties for services.
The CNO, which typically had members employed in settings where they would not bill for services, did not bring forward these types of scenarios but did bring forward the concept of being paid for working at multiple sites when in fact only one job was being done.

Relating more to type of work done, the sales of products in addition to the provision of services was identified as key issues for two of the Colleges (CASLPO and CPO), briefly mentioned as a possibility for one College (CPSO) and not mentioned by CNO key informants as a common issue although written guidance was provided by the College. Industry relationships were noted in the College documentation, but not brought forward by key informants. Benefit conferred with referrals was brought forward by CPO and CPSO key informants. The CNO scenarios tended to focus on the risks involved in failing to maintain professional boundaries with clients, which was not brought forward by the other College key informants as a common area of concern.

5.4 College Process to Address Allegations of Professional Misconduct Related to Financial COI

The RHPA, 1991, outlined the mandatory process required of all Colleges when addressing allegations of professional misconduct. Each College’s Investigations, Complaints and Reports Committee (ICRC) were responsible for addressing complaints or issues which the Registrar reported to the Committee. As noted earlier, the ICRC had the authority to make findings and directives as well as refer a member to the Discipline Committee. The ICRC findings and actions taken might include a letter of concern or caution to the member, an oral reprimand, the directive to complete a remediation program, or a referral to the Discipline Committee (CNO, 2013a). Any of these actions might be taken in addressing member-specific issues related to financial COI; however, specific details on issues referred to the ICRC were not part of the public record and considered confidential. Cases where the ICRC considered member actions to constitute professional misconduct that warranted a referral to the Discipline Committee did
become part of the public domain. Given that only cases that were referred to the Discipline Committee for a discipline hearing became part of the public domain, for illustrative purposes, document analysis was done to review discipline hearings that occurred during the most recent year for which College annual reports were also available. The annual report, College press releases and disciplinary hearing summaries of the College websites were reviewed to determine if there were any reported discipline hearings pertaining to financially-based COI matters.

During the key informant interviews participants were asked how the College enforced and addressed COI issues and if there were any COI situations that they knew of that had alleged to have occurred or occurred that they could provide some insight on with the attempt to determine whether the processes in place had been utilized. Participants were also asked to comment on whether they felt that self-regulation and the College processes were effective in addressing COI.

The Colleges shared the same responsibilities under the RHPA in relation to duties and objects and addressing professional misconduct. Each College conducted mandatory investigations when necessary and had an ICRC and a Discipline Committee. Results for the College’s most recently published annual reports summarized each College’s ICRC decisions and included the number of referrals to the Discipline Committee. Cases referred to the Discipline Committee would include any cases where allegations of COI that constituted professional conduct might exist. The Discipline outcomes for hearings conducted in 2012 (or in the case of CPO 2012-13) are summarized in Appendix D.

5.4.1 Addressing COI: CASLPO

CASLPO’s 2012 annual report stated that three of the 25 matters decided by the ICRC in 2012 were referred to the Discipline Committee. All three referrals were for the same member. However, hearings pertaining to these referrals did not occur in 2012, nor were any disciplinary hearings held in 2012 (CASLPO, 2013a). One key informant did reference a pending disciplinary hearing in which they felt the case involved underlying motives that might relate to COI. Details could not be provided because the hearing had not yet occurred. Subsequently, the
author participated as a panel member or chair in a number of discipline hearings, including the case referenced by the key informant so the results were excluded from this study.

5.4.2 Addressing COI: CNO

The CNO reported that for 2012 the ICRC rendered decisions on 317 complaints, 4 of which were referred to the Discipline Committee (CNO, 2013a). The CNO annual report indicated there were 45 discipline outcomes, with 6 registration revocations, and 35 reprimands, suspensions and terms, conditions or limitations ordered (CNO, 2013a). Matters referred to the Discipline Committee may not necessarily have the hearing completed in the same year; the annual reports included number of cases referred as well as those that had outcomes. The nature of the allegations and findings were not detailed in the annual report, but were posted by member names on the CNO website. A review of the discipline decisions posted for 2012 indicated that 5 involved at least one element that would be construed to involve COI, although the allegations made were of professional misconduct, not specifically COI. One case involved the member accepting gifts from a patient, two other cases involved members taking money, gift/credit cards from the patients or their families, while another case involved the member borrowing a patient’s credit card to pay registration dues and also suggesting to a patient that they move back to their house and the member move in with them. The final case involved the member borrowing money from a patient. In all of these cases findings were made. In the final case described, the member resigned from the profession and in the remaining cases each member was ordered a public reprimand, a temporary suspension of registration and terms, conditions and limitations placed on the registration.

5.4.3 Addressing COI: CPO

The CPO’s annual report for 2012-2013 indicated that 69 decisions were rendered by the ICRC and of these 4 were referred to the Discipline Committee (CPO, 2013a). Three Discipline Hearings were completed during this reporting period and the summaries were noted in the report. One of the three cases involved a member who submitted false claims to and was reimbursed by insurance companies for various types of healthcare services and products.
supposedly provided by her although these products and services were never actually provided. This might be considered a COI due to the failure to put responsibilities as a healthcare professional ahead of personal interests, although the term COI was not used in the summary or agreed upon statement of facts (CPO, 2013a). The member was ordered a penalty that included a reprimand, a six month suspension which could be shortened to three months upon completion of an ethics program and practice monitoring for three years (CPO, 2013a).

5.4.4 Addressing COI: CPSO

The CPSO 2012 annual report noted 67 of the 2,676 ICRC decisions were referred to the Discipline Committee. This resulted in a total of 38 members being referred to the Discipline Committee as some had multiple ICRC referrals (CPSO, 2013). Of the 37 hearings conducted in 2012, 13 involved allegations of disgraceful, dishonorable or unprofessional conduct, but did not report on the nature of the allegations or the details of the facts. A review of the website postings on discipline decisions for 2012 indicated that up to four of them related to COI, although it should be noted that the allegations made did not specifically state COI, instead stating allegations of professional misconduct. One case involved a member borrowing money from patients, another case involved a member requiring patients to pay for a membership fee to the member’s private business in order to receive publicly funded services and two cases involved members being reimbursed for authorizing prescription medications based on reviewing information for patients submitted online. For all of these cases findings were made and the members’ orders included public reprimands; temporary suspension of registration; and terms, conditions and limitations placed on the registration. The two cases involving of authorization prescriptions included fines from other jurisdictions.

5.4.5 Addressing COI: Cross-College Comparison

As part of the process, the Colleges published discipline matters and outcomes and included the names of the registrants involved as part of the public record. The CNO, CPSO and CPO had discipline outcomes summarized on their websites from the last available annual reporting period, and the CASLPO had evidence of more recent discipline hearings posted on its website
although none had occurred during the time frame examined. The public register of members which, each College is required by the HPPC to have posted for the public, noted for each of the members the reprimands, suspensions and terms, conditions or limitations ordered through any hearings.

The four Colleges participating in this study had varying numbers of discipline referrals and hearings. CASLPO had the least with 3/25 (12%) of the ICRC cases being referred to discipline and no hearings for the reporting period that was analyzed. For the CPSO, 67 of the 2,676 (25%) of the ICRC cases were referred to discipline and of the 38 hearings that occurred during the reporting year, 4 cases (10.5%) related to financial COI. In contrast the CNO’s ICRC rendered decisions on 317 complaints, of which 4 or (1.3%) were referred to discipline. During the same reporting period the CNO had 41 discipline outcomes rendered and 5 (12%) of these cases involved financial COI. For the CPO 4 of the 69 (5.7%) cases that were considered were referred to discipline by the ICRC. Of the three hearings that occurring during the reporting period, one case had an element of financial COI.

These cases can be related to the practice variables as follows: providing prescribing services for a fee without actually seeing the patient (CPSO), and requiring the patient to purchase private services in order to receive publicly insured services (CPSO) can both be related to the nature of work performed/decision making authority because in first case the COI is only possible because of the restricted act of prescribing a product and the selling of privates services is also related to nature of work done. Both may be tied in to work environment as well since observability of both scenarios might impact the potential for COI and since both are directly tied into remuneration this is a factor as well. The cases which involved borrowing money from a patient (CNO, CPSO), accepting or taking money or other gifts from a patient (CNO) could be tied back in to nature of work and work environment because as the CNO key informants indicated the nature of work performed may result in a patient being more vulnerable. Work environment would also be seen as a factor because the more isolated the environment the less observable and the few support structures in place. The last case involving falsifying billings for gain (CPO)
could be seen as relating strictly to the remuneration model, which was abused, but might also tie into the work environment (i.e. observability) and also the nature of work as it related to whether individual involved had the decision making authority and took advantage of it in an inappropriate manner. Given that all of the Colleges followed the disciplinary process as mandated by the RHPA, all four were consistent in outlining the findings, terms, conditions, limitations and any penalties ordered to the members.

5.5 The Extent COI was an Issue for Each Practice Specific Variable

The key informants were asked specifically about how each of the practice specific variables impacted potential for COI. For each practice variable a summary for each College is provided followed by a cross College comparison. A summary of the practice specific variables and the potential COI scenarios are outlined and summarized in Table E2, Appendix E.

5.5.1 Nature of Work Performed

5.5.1.1 Nature of Work Performed: CASLPO

Key informants indicated that scope of practice impacted the profession in terms of defining how the professions earned a living, how it might restrict activities or services provided, and it was also felt to impact how the public might view the profession. One informant felt that the act of defining a scope of practice might introduce a potential COI because defining a scope of practice for any profession could be used solely for financial gain, “is it defined in order to gain financial territory? …There are multiple motivations when any profession describes their scope of practice and they may not be completely without self-interest”.

It was felt that if College registrants stepped outside of their scope of practice it may not necessarily be due to a COI. For example, College members were not authorized to perform the controlled act of communicating a diagnosis, which key informants indicated posed challenges in
recommending services. The risk of COI was felt to be greatest for someone who had a limited scope of practice because he or she may maximize the services provided in this limited scope in a manner not always taking into account the best interests of the patient. Further, it was stated as an example, that if all you do can do is prescribe to make earn a living then you may be more tempted to enter into a COI than someone who had a broader scope and more options open to them, “You can’t make money off of doing something else so you are going to make money off of the thing you can do.” One key informant had noted that from the public’s perspective they might already view the CASLPO audiology members as being in an inherent COI because their work might involve both prescribing and selling hearing aids.

The final factor indirectly related to nature of work and scope of practice was retirement. It was suggested by one key informant that a member might choose to work beyond a point at which they should retire or longer than perhaps they should from a competency standpoint in order to maximize income or because they cannot afford to retire. This was potentially more of a competency issue than a COI issue, but if an individual undertook to provide services that they knew were beyond their knowledge, skills and judgement solely for personal gain, than these actions would meet the criteria for COI.

5.5.1.2 Nature of Work: CNO

Key informants at the CNO indicated where the scope of practice had been extended to prescribing and dispensing there may be an increase in the opportunity for a COI to occur. It was felt that practice tied in to self-referral, which was potentially an issue. In addition, due to the nature of the nursing therapeutic relationship the risks of COI occurred when the boundaries were not maintained.

The CNO informants noted that the nature of work that nurses did put them at potential risk for COI because they worked for long periods of time, often at a person’s home, often with family members and often having physical contact with their patients. Nursing work was described to potentially entail long duration patient care scenarios that, because of the duration of care, and
the professional intimacy of the care, could put a nurse at a greater risk for crossing professional boundaries of the therapeutic nurse client relationship and result in the potential for COI to occur. Much of nursing was described as being at someone’s bedside, including physical care and potentially being emotional in nature. The duration of care, which was described to span in some cases “8 hours every day for 5 years”, was seen as a factor that might result in both the patient and the nurse becoming vulnerable. For nurses, recognizing the professional expectations and ensuring patient needs were not displaced by personal needs was noted as crucial. Many nursing COI risks were characterized to occur when the relationship boundaries were crossed. Examples of this included direct exchange of money, accepting gifts, and influencing the patient’s financial decisions such as changing their will. One excerpt from a key informant interview summarized the impact of nature work done by the membership, “COI is the bedrock of all and really stands out for nursing because it’s so emotionally and physically intimate. So professionally understanding what your needs are, how to meet them so that they don’t impact your ability. They don’t displace the client’s needs”.

5.5.1.3 Nature of work: CPO

A CPO key informant speculated that it could be possible for a broader scope of practice to introduce more opportunities for COI since there were more opportunities for self-interest. It was noted that standards of performance were developed for authorized activities in order to provide guidance to the membership. Referrals and any expectation of reciprocal benefit were brought up as a possible source of COI. It was felt in general it was hard to draw a connection between scope of practice and COI, but that it was more related to intrinsic factors, such as the desire for someone to line their own pocketbook at the expense of others.

5.5.1.4 Nature of Work: CPSO

The CPSO key informant indicated that just because physicians had the broadest scope of practice it didn’t mean that they were entitled to perform any of the controlled acts under their jurisdiction. The CPSO’s position was that the members needed to practice within their own scope and experience. It was felt that some may be tempted to practice beyond scope of
knowledge for monetary gains. The example was given of physicians trained in an area such as surgery, opting to discontinue surgical practice and work in a walk-in clinic, which their scope of practice would entitle them to do; however without additional training they may not have the knowledge, skill and judgment to do so and hence be in a potential COI. Other areas where COI might enter into play might be surgeons self-referring or ordering of excessive tests if the scope of practice allowed for this to occur. It was felt that scope could go in many directions and that a larger or smaller scope of practice would not impact the risk of COI.

5.5.1.5 Nature of Work: Cross-College Comparison

Scope of practice was not an area that the Colleges focused on in terms of potential for COI. It was recognized by CASLPO and CPSO that practicing beyond one’s knowledge, skill and judgement for personal gain might occur. A CASLPO key informant noted that a restricted scope of practice might increase the risk of a COI occurring since there were limited options to earn a living. It was further noted that both prescribing and selling the prescribed product could result in COI and may be viewed by the public as an inherent COI.

The CPSO felt that an increased scope of practice might either increase or decrease the potential for COI depending on the scenario, but that not all scenarios tied back to COI. A CPO key informant also noted that an expanded scope might give individual more opportunities, but also noted that it was difficult to draw a connection between scope of practice and COI and the risk was more likely related to the individual’s motivation. The CNO viewed nature of work as important because it was inherent in the nurse-client relationship and noted that the nature of work performed by nurses in general involved longer periods of sustained contact and hence put them at greater risk of crossing professional boundaries and at risk for COI.

5.5.2 Work Environment

5.5.2.1 Work Environment: CASLPO

Work environment was felt to have an impact on the risk of COI opportunities occurring. It was reported that when a member worked in a private practice environment, had a side business or
was involved in selling products, more potential issues or concerns were brought forward by registrants. It was recognized that there was a diversity of workplaces including private/retail, remote communities, publicly funded environments including schools, hospitals, educational settings, rehabilitation centres, and community care and access centres (CCACs). The CASLPO key informants also noted that members working in team environments had tools such as the interprofessional collaboration tool to assist in dealing with overlaps in scope of practice, or disagreements or barriers (e.g. record keeping).

Key informants noted that both professions that comprised CASLPO membership had the opportunity to work in a private or retail environment. It was felt that when a member was selling a product, such as a hearing aid, to the patient, that suspicion might arise from the public if the professional was both providing the service and selling the product. This would result in the professional needing to demonstrate to the patient that their decisions were based solely in the patient’s best interest.

One CASPO key informant noted that in an employer-employee relationship such as an agency or private company, the billing was conducted through an employer, so the professional may not have been directly involved in the billing. However, the professional may have concerns about the billings. “Whether it is their professional misconduct, it’s doubtful because they work for a company but when they have a very strong suspicion ….. We can’t regulate the company”. The risk of the professional billing inappropriately though might arise. It was also felt that in a publicly funded system there was more support and on the job training. In private setting it was noted that there was nothing in terms of training or reporting mandated unless a complaint is received.

For the CASLPO members work environments were transitioning more towards private or retail environments and retail was considered by one CASLPO key informant to be somewhat unique in the healthcare world. It was noted that working for a non-member could potentially impact decision making as there may be different priorities and perspective. It was felt that the member was required to balance pressures of retail and still provide health services. The work
environment was characterized by one key informant as a changing approach to care; it was described as a business. The informant noted that was not necessarily a bad thing, but it was changing how people approached the concept of that profession. It was also noted that CASLPO registrants were probably impacted more in terms of work environment changes than some other health professions due to changes in funding which precipitated the move to private practices as publicly funded work place settings had been reduced. One CASLPO key informant noted that along with the change in environment a change in accountability occurred because members might be dealing with those who pay for services directly or work for those that provide the funding directly (e.g. a private employer or the patient instead of reporting in to a department head).

CASLPO key informants had also noted the scenario where a member might offer services both privately and under an employment agreement, introducing the potential for a COI to occur. For example a member might provide services in a setting in which they were employed and the services were covered under a funding program. The member might also have a private side business in which they could potentially provide services to his/her patients once the publicly funded services were concluded. The solicitation of these private services and whether the member followed the disclosure steps outlined in the proposed COI document was a key factor in determining if there was a COI.

The final area related to work environment pertained to where the professional worked. Due to financial pressures a professional may work in place or for someone whose practices they question. For example, they might be working in a setting where they did not agree with the employer’s philosophy but still worked there because of limited employment options. The professional might also be selective about the clients or patients they provide services to in order to maximize their financial situation.
5.5.2.2 Work Environment: CNO

Practice environment was seen to be an important factor that impacted risk of COI occurring for nursing professionals. Typical practice environments for nursing included hospitals, palliative care, corrections facilities, nursing homes or long term care facilities, in an individual’s home through working for an agency and also in independent practice.

The informants compared the setting of a hospital relative to someone’s home. Hospitals were described as team-based care environments with many people in a team interacting with the patient, so that others would be more likely to hear or see what is happening. In addition hospitals were described to have systems for tracking and gathering data, which were noted to include documents, and tracking incidents and documenting facility accreditation. Hospitals and multi-team settings were seen to offer fewer opportunities for COI to occur and to offer more structural support for health professionals; this might include not only supporting professionals to do the right thing, but also protecting clients from having bad things happen to them. It was also noted that in environments where there was interprofessional collaboration there were also mechanisms such as the interprofessional collaboration tool for dealing with disagreements regarding plan of care for a patient.

The CNO also noted that nurses may also be employed in multiple environments, which might include settings where services were publicly funded (e.g. hospital) as well as environments in which services were paid for privately (e.g. private home care). If a nurse worked in a publicly funded place (e.g. hospital) providing patient care, and contracted to provide services privately once the publicly funded services were discontinued this could constitute a COI if improper solicitation of business occurred. In addition, independently practicing nurses might also have a retail component to their work environment, as was previously noted.

Independent nursing was contrasted to home care, whether through an agency or independently provided, in which even if a team was involved the care is often provided in isolation of the team. Lack of observability was noted as a risk factor. Independent nursing was noted to have
no data collection systems that would exist in a hospital setting. Independent practicing was also seen as an opportunity for COI with respect to determining the number of treatments/appointments necessary such that determining when services might end and the resulting remuneration were tied together.

5.5.2.3 Work Environment: CPO

The CPO noted that College registrants practiced in a number of different workplace environments in both publicly funded and private settings. As with the CNO registrants, it was not uncommon for patients to seek privately funded services after coverage for publicly-funded or third-party funded services reached the funding limits. The manner in which the privately accessed services were arranged and whether there was inappropriate solicitation of services introduced the potential for COI. This was an issue that members brought forward to the College to ensure there was no COI.

Some environments, such as hospitals, were described as entailing multi-disciplinary teams providing healthcare services. The CPO referenced its practice standard on concurrent services to ensure services weren’t duplicated where standards of practice overlap (CPO, 2005). Overlapping of services provided by different professions such as PTs, chiropractors, massage therapists were noted to have the potential to occur in any environment, including private practice. The practice standards were principle-based, not environmentally based, so the expectation was that the professional applied them in any environment. The work environment was generally characterized as competitive with concern about business being stolen when in private pay environments.

It was also generally felt that there was more risk of COI in environments where there was a lack of audits or oversight and there were vulnerable populations. The area of bulk services was characterized as the area with the potential for greatest mischief. Bulk services were explained as scenarios in which a particular group were all receiving maximum services regardless of actual need. For example, an entire family receiving the maximum number of services that a
benefit plan would pay, or every member of a union receiving services from a particular provider would be considered bulked services.

Intrinsic factors were felt to be more important in terms of risk of COI, “Environment will play big role in terms of your mentors are and what the culture of the environment that you work in.”

5.5.2.4 Work Environment: CPSO

Work environment was considered a risk factor for COI in that in a collaborative environment where there were policies as well as multiple professions or healthcare personnel present more checks and balances were in place for a variety of things. However, it was pointed out that although independent practice resulted in fewer checks and balances, it should not be concluded that an independent practitioner was more likely to act on a potential COI. It was felt that the occurrence of an actual COI was the interaction of the environment with the individual, other circumstances along with an individual’s own understanding of COI. It was stated that not all members might see their actions as a COI and having others around might offer a safeguard.

Other work environment-related items that were brought forward included the concept of self-referral. For example, some surgeons worked in an environment in which they evaluated and determined whether a patient requires surgery. This determination would be considered a self-referral and inherent in this was the risk for a COI to occur. It was noted that no one would ever get surgery if the definition of COI was taken in its strictest sense.

Another work environment-based situation involved practice environments in which a physician was hired to perform specific exams for purposes other than care (i.e. insurance evaluation). It was felt by some that this type of work environment exacerbated the inherent risk of COI given there may be a desire for a particular outcome from the hiring party. For example, insurance companies paid for policy holder physical evaluations or medical rulings based on health information and there was the question as whether the medical decisions or outcomes were biased if such an employment arrangement was an individual’s sole source of income or if there were incentives related to company targets.
Additional work arrangements included scenarios like in vitro fertilization (IVF) where there is an exchange of money in both procuring donor eggs and providing them to the recipient. Benefiting from both the procurement of eggs and making the decisions regarding providing them to the recipient could place a member in a potential COI.

Work environments in which referrals might be expected based on business arrangements was also noted as an area in COI might occur. These arrangements included rental agreements and direction of prescriptions, or somehow related to the volume of referrals generated. For example, a rental agreement might have the rent contingent on the level of referrals business that was provided the lower the rent.

5.5.2.5  Work Environment: Cross-College Comparison

All four Colleges noted that practice environments which either had multi-disciplinary teams or some degree of direct oversight might either reduce the opportunity for COI; or provide additional support and guidance to its members. Private businesses or work environments that did not have direct oversight, observability and/or reporting mechanisms were seen to increase the potential for conflict of interest to occur; however, it was stressed by one key informant that this lack of oversight did not mean COI was occurring. CASLPO and CPSO key informants brought forward employer-employee relationships and the competing interests of a for-profit business and the risk that business objectives might impact a member’s decision making and introduce a potential COI. The CPSO key informant brought forward concerns regarding work environments which allowed for self-referral. All four Colleges brought forward possible issues when the provision of services that were either initially accessed in a publicly funded setting or only partially accessed through public funding and were continued in a privately funded work setting and how the facilitation of this transfer of services might be precipitated in an inappropriate manner. The CPO brought forward the notion that the work environment would play a significant role from the standpoint of mentorship and the culture fostered in the work environment.
5.5.3 Remuneration

5.5.3.1 Remuneration: CASLPO

Key informants indicated that risk of COI related to remuneration issues might occur in a number of ways including fees charged for services, and sale of products, and billing scenarios in addition to charging for services privately after the funding allocations allowed for under public or third party funding reached their maximum funding allowance.

The first issue relating to private practice was that professionals working for an employer or in a setting where services were covered through either public funding or third party funding, might also have a side business in which their remuneration was based on a private fee for service model. The risk of COI related to the solicitation to provide the services privately to patients that were receiving these services from the same professional under a publicly or third-party insured model. This issue might be seen as being related to work environment as well since working in two different environments increased the opportunity for COI to occur (e.g. a professional would likely only solicit to provide private services if they had a private business). It might also be seen as remuneration based, because the patient would seek private services only if the public or third party-funded services ceased to exist and the opportunity to get additional remuneration is presented to the professional. The issue again was related to transparency of the professional and options provided to the patient.

One CASLPO key informant felt that the risk of billing-related COI was low for its registrants, but as more professionals enter into private practice and direct billing of insurance companies the insurance companies may report fraudulent billing. Examples were provided where massage therapists had their registered numbers stolen and used by non-members to fraudulently bill for services.

The CASLPO key informants noted it provided guidelines for its members selling products, in the proposed COI guidelines (CASLPO, 1996). Financial dealings were considered by the College only from the perspective of whether they biased the judgement of the professional in
their decision making. The College did not take a role in determining what entailed appropriate fees or profit levels. It was noted by a CASLPO key informant that the public’s perception of professionals’ approaches to selling products was a factor since the professional was providing healthcare services in addition to selling products. Pharmacy was used as an example of how brands being sold should not be based on coercion. In terms of products being sold by audiologists, it was stated that the professional was required to ensure that the patient understood his/her options in terms of where they could purchase the product from and that the recommendations were based on the grounds of patient care and not on anything external to that.

The other financially based area the College dealt with pertained to fees charged by professionals for services. The issues that were brought forward pertained to privately funded, publicly funded as well as mixed funding models, in which a portion of the product or services might be publicly funded. One key informant stated that fees were not supposed to be exorbitant such that they impacted access to care. However, the key informant noted that the College did not set fee levels and it was felt that the market pressures would regulate these fees to some extent. In terms of remuneration by a third party for services the issue that was brought forward stemmed from a cap or limit set to the services covered in some models. For example, speech language pathology services funded through an insurance company might have a dollar limit or limit to the number of sessions. The reported reality was that often times the third party funding ended before patient’s requirements for services ended. In order to work around the service limitation the professional might falsify billing records. For example, members indicated to the CASLPO that patients have asked them to change the actual date services were provided on the records in order to fit within the billing requirements (either billing into the next period or before the billing window ended). This would be construed as a COI in that the professional might also stand to gain in this scenario if they were to otherwise not be able to charge for the services or charge less for the services. The other issue related to billing was the falsification of services provided. The key informants indicated that this could be done in a number of ways. One way would be to use family coverage of services such as counseling for SLP and bill under each family member’s allowance (e.g. father, mother and child) when only the child and one parent received services.
Another way in which billing might occur fraudulently was if an SLP billed for services that they did not provide, but a non-member provided. These services might be done by another worker in the same company or through an arrangement made with another individual working in a different field. Finally, fraudulent billing was also reported to be possible if an SLP billed for services that were outside of their scope of practice. A final issue brought forward related to billing was that if a professional worked for a small company and the company billed on behalf of the professional, sometimes there was concern about the company’s billing practices if the professional did not ensure oversight of the billings.

CASLPO key informants indicated that for members working in a scenario where they were providing uninsured services, the potential for financial COI became more of an issue. One key informant stated that processes or tools that professionals used prior to the delisting of services were no longer applicable under a privatized model. It was felt that the patient was more vulnerable because under the OHIP model the patient would receive the services that they needed and under an uninsured model there was uncertainty and a different kind of consideration. Further, the feeling was that CASLPO members had gone through more of a transition to privatized (uninsured) services than other health professions such as nurses or doctors. Cuts to third party funding were also viewed as a catalyst for ensuring accountability and transparency to the funding agencies.

5.5.3.2 Remuneration: CNO

Remuneration was seen as a factor that might increase COI when nurses were involved in selling products, self-referrals, and/or accepting remuneration from either multiple sources or other sources in addition to their current employer. In the sales of products, College members were supposed to offer choice, follow advertising regulations and avoid personal gain.

Independently practicing members might work in multiple settings such that they were also employed and worked in a setting that provided services through public or third-party funding scenarios. In this type of scenario where a professional was employed by an organization and
was also self-employed, self-referral was seen as a potential for COI. Fees charged in independent practice and the assurance that acceptable payment methods were utilized were other areas noted. It was further noted that if reimbursement was based on the number of visits/services required that could introduce the potential for COI to occur. This COI might arise through providing unnecessary services or increasing treatments beyond what was required. COI could also be related to billing for services that were not provided. Scenarios where unnecessary services were offered were considered to be a breach of the therapeutic nurse client relationship, as was not fulfilling work obligations in a fixed remuneration structure.

Other instances in which COI were noted to potentially arise was through a member advocating for the third party coverage to augment the insurance coverage. Another example was cited in which a member accepted research funds from a company to conduct research in a setting where he or she was employed (e.g. a hospital), but instead ran an independent nursing practice. A final scenario provided was being paid directly for nursing services that in fact were not being provided because the professional was working elsewhere at the time the services were billed to the employer.

In general remuneration wasn’t considered a significant issue by the key informants for the CNO. One informant stated, “Nurses and clients for the most part don’t ever talk about money or what’s being paid for. It’s a public thing. That is a big difference because it’s from both sides.”

5.5.3.3 Remuneration: CPO

Remuneration scenarios in which the risk of COI might occur for CPO registrants included selling products, soliciting private business while working in a setting that provided services under a public or third party funding model, third party billings, and FFS models.

The first scenario brought forward was one in which a member worked in a setting in which services were provided through public or third party funding and was asked to provide additional services privately once the funding reached its limitation. Solicitation for services, contractual
obligations all impacted the likelihood of risk of COI. Given many of the publicly and third party-funded models may not provide all of the services that a patient requires the patient or his/her family might be willing pay for additional services. Key informants indicated this scenario had been reported by members as an issue when families were looking for or requesting services. The concern was not whether services were provided privately but whether they were inappropriately solicited or violated any contractual agreements.

PTs selling products also presented an opportunity for COI. Depending on the products being sold, and the context under which they were being presented, there was felt to be the potential for an ethical issue and a COI. Members were expected not to pressure their patients into purchases, and to ensure that patients understand that should they opt not to purchase something that there would be no impact on quality of care.

It was felt that benefits or insurance that the patient was eligible to receive could influence the potential for COI. Unlimited benefits could increase the risk of COI. It was also noted that the patient might expect or feel entitled to unnecessary services based solely on benefit eligibility and that it was obligation of the member to set and manage expectations and treatment options, which were to be needs based.

In terms of publicly-funded services in private clinics, in the FFS model of publicly-funded reimbursement, the opportunity for COI might be seen through the attempt to maximize billings through group services such as group treatment or exercises. Under the FFS system there might be additional public reimbursement billed through assessment and reassessment fees but some clinics also found ways to insert other fees. Under the public funding model based on episodes of care, additional fees can’t be billed. If additional services were warranted a new referral was required. “A set amount of money was allocated to institutions and it would be up to the administrators to distribute the episodes of care to ensure physiotherapy could be delivered over the year without running out of funding.”
The physiotherapy field was characterized as being highly competitive and often payment or other benefits for referrals was asked of members from referral sources. Competitive pressures were felt to increase the risk of COI.

Not doing the work when one was being paid anyhow under a flat reimbursement system was considered to be an employment or work standards issue, not a COI.

5.5.3.4 Remuneration: CPSO

The CPSO key informant felt that in general COI was complicated because under the OHIP model of insured services COI was in theory less of an issue because there were fewer opportunities provided. However, it was recognized that some changes in the profession have introduced some COI risks. One issue brought forward related to the changing of the profession into one which offered uninsured services such as cosmetic procedures or selling certain products. It was felt that if a physician offered both insured and uninsured services there was often not a clear division in their practice between the two, which complicated the issue. An example that was brought forward was cataract surgery and ophthalmology. Some of the associated tests and procedures may not be covered, while others were covered. The question that was raised related to what was appropriate for the physician to recommend as a result of his/her consultation and whether some of the uninsured services were required prior for the physician to provide the insured services.

Another situation previously noted involved rental agreements in which physicians might receive rental rates in exchange for directing patients to a pharmacy in the same building. These types of mutually beneficial arrangements were thought to be less obvious that direct payment for referrals. Arrangements where a professional was sending patients to another professional in order to increase his or her own business (through reciprocal referrals) were cited as a potential COI in which there was no direct exchange of money. However, it was also noted that this kind of arrangement might be defendable and also be in the best interests of the patients. It was noted
that exchange of money does not necessarily mean the actions were not in the patient’s best interest.

Under the insured services scenarios in Ontario, a physician may be compensated on a fee-for-service (FFS) mechanism, through a capitation model, a blended model or through a hospital (Deber, at al., 2008). Given the key informant felt insured health services reduced the risk of COI; the question was posed as to whether there was a difference in risk across the different payment mechanisms that existed in the publicly-funded services. It was felt that there was no difference and that the only difference might occur if an individual was dissatisfied with their rate of pay and wished to “build their practice into something else”. For an individual this might mean providing uninsured services or selling products such as hearing aids, custom creams and some other services related to tests.

It was noted that in the past the College had a division that acted on behalf of the government in dealing with auditing of OHIP billing, the Medical Review Committee (MRC). However, the function now existed within the government. As a result the College did not have access to billings of physicians except in relation to an investigation, nor did it monitor the billing of physicians because this was not the College’s role. It was felt that issues relating to not providing appropriate care would be addressed through other aspects of professional conduct and upholding standards of the profession, not through COI regulations.

It was noted that some remuneration scenarios that were related to outcomes or goals might appear to have the potential for COI issues. One example provided was when physicians provided independent medical examinations for private companies (e.g. insurance companies). In the patient’s view these exams may not be seen as objective. If the physician’s only compensation was tied to these types of examinations, of which the results might impact a company’s profit margin there might be the potential for actual or perceived COI if the goals of the company and any associated incentives took priority over patient care. The employment arrangement of the physician with the company would be not be the issue because this relationship would be fully disclosed. However, the public might conclude that the insurance
company had goals regarding outcome targets or reducing expenditures, so while there might not be an actual COI there could be the perception of one.

5.5.3.5 Remuneration: Cross-College Comparison

There were a number of areas pertaining to remuneration that were brought forward by the four Colleges in this study including solicitation of business, recommending and selling products, and reimbursement mechanisms including third party billing concerns. Each will be compared across the Colleges to identify similarities and differences.

5.5.3.5.1 Selling of Products and the Solicitation of Business

All four Colleges indicated that the sale of products could introduce the potential for COI. CASLPO and the CPO focused in this area. CASLPO indicated that both recommending or prescribing products and then selling these products put the member in an inherent COI. As a result the CASLPO elaborated on steps that members ought to take to ensure full transparency to the public. These steps included disclosure of options including providing alternative providers and ensuring that the patient was informed prior to pursuing any purchases. The CPO also addressed its members recommending and selling products. The College required that alternatives be provided to patients and that the CPO registrant was to assure the patient that treatment services would not be negatively impacted if the patient chose to purchase elsewhere.

The CPSO documentation, Conflict of Interest Regulation (Government of Ontario, 1991c) provided specific directives, which included circumstances for selling medications and that there should be no mark up. The CPSO key informant indicated that the procuring of private services or products was not to be a requirement or condition for receiving publicly funded services and that the College would investigate complaints brought forward related to selling products. The CNO documents had indicated selling of products should only be done if they were sold without any mark-up. Both the CPSO and CASLPO key informants noted that they were not involved in setting fees or determining pricing. One CASLPO key informant felt that market pressure would address pricing to some degree.
The billing of third parties for services provided was seen as a potential area for COI by CASLPO, CPO and to a much lesser extent by one CNO key informant. Ensuring that the member provided the services as billed and that the fees were charged in an appropriate manner was an area of focus for both the CASLPO and CPO. This was also an area that one CNO key informant noted that although was not a main focus for members, might impact those who worked in independent practice. The CNO key informant brought forward what was described as an old case of a member advocating for third party coverage to augment insurance coverage and another case where a member was accepting research funding but using it for other means (both of these cases went to discipline hearings where findings of professional misconduct were made). The CPSO was unique in that its policy documentation did not specifically cover third party billings. Given CPSO members were more likely involved in remuneration scenarios in which services were insured by OHIP, the CPSO key informant did note that the responsibility for addressing appropriateness of OHIP billings was directly under the Ontario government.

All four Colleges’ key informants were consistent in their view that publicly insured services lowered the opportunity for COI. The key informants did not view the risk of COI to be as much of a concern under a public funding scenario. Oversight of billing for insured services was not within the College’s responsibility. The CPSO and CASLPO key informants noted that the Colleges did not set or recommend fees. The notion that it was very difficult to determine how to define a fair fee was commented upon by key informants from both CASLPO and CPSO. When asked about the risk of COI under a publicly funded scenario, key informants from each of the Colleges in this study took the stance that if a member failed to provide the appropriate standard of care, which could have been done through either overbilling or providing minimal or sub-standard care under fixed funding model that the mechanism to address this was through looking at professional misconduct in terms maintaining the standards of practice. A CASLPO key informant further noted that the public was vulnerable and under an uninsured services model there was the potential for uncertainty about receiving necessary care. A CNO key informant noted that because the membership worked primarily in publicly-funded models COI
related to remuneration was not a large concern for members or typically talked about by either patients or members.

Key informants from each of the four Colleges provided scenarios that indicated that when their members practiced in scenarios where there was the potential to provide services under a funding model and also provide private services outside of this model that there was the potential for COI to occur. For CNO, CASLPO and CPO members these scenarios mostly focused around the member soliciting their patients to provide private services upon completion of the services being provided in a third part insured model (including both public and other third party funding models). The COI issues in these scenarios were focused on whether the private services were inappropriately solicited or if the member provided full disclosure regarding treatment options. For CPO there was also the issue of taking advantage of the third party billing models in private clinics in providing services that were covered but not necessarily required. The CASLPO also brought forward concerns related to billing for third party services that were not provided by the professional, but by another provider. For the CPSO members the concerns arose when the member was provided publicly insured services, but also offering private services. The issue for CPSO members was based on how the private services related to the publicly funded services and whether providing patient care in the publicly funded areas was contingent upon the patient committing to the private services.

5.5.3.6 Summary of Cross College Comparison

In summary, the differences in remuneration models were reflected in the types of COI that these four Colleges addressed and defined. The Colleges, CASLPO and CPO, which had members that frequently prescribed/recommended and sold the recommended products, had specific expectations outlined for their members, while the CNO had less detailed guidelines to address the less frequent occurrences of these situations and the CPSO referred to the conflict of interest regulation in place for its membership. Billing third parties was not a focus for the CPSO which tended to have its membership remunerated under a publicly insured services model, while it was a greater focus in terms of providing guidance for the CPO, CASLPO and CNO to a lesser
extent. The CNO key informants indicated that COI related to remuneration did not result in a large number of concerns because their members were generally remunerated in a manner that was tied to publicly-funded services or standardized fees. Where members had the potential to offer private services in addition to those offered through various funding models all four Colleges had areas of concern. The CASLPO, CPO and CNO all tended to focus on how the private services were solicited. The CPO was also sensitive to how services were provided under a third party funding model. The CPSO was the only one of the Colleges examined where the focus of COI related to whether the patient accessing publicly funded services was contingent upon them accessing the private services the member might offer.

5.6 Importance of Financial COI and Effectiveness of College in Addressing COI from the Key Informant Perspective

The final area of inquiry involved asking the key informants how important financial COI was to the College and whether the College’s approach to addressing COI was effective. The responses were summarized below by College.

5.6.1 Importance of COI and Overall College Effectiveness: CASLPO

The CASLPO key informants indicated that COI was important overall, but was not ranked as a top concern. It was noted that the College’s role was to, “make sure members were accountable for their level of professionalism and were accountable for their behavior and conduct”. One informant noted that there were few complaints that would fall into the category of COI. It was noted that for some members, including those in private practice, those providing non-insured services or those in retail environments it may be more of concern than others because of the nature of work and reimbursement structure. It was further noted that members called in proactively to discuss various practice scenarios to ensure they were not in a COI. One key informant noted that the CASLPO group was relatively low at risk for COI issues to arise, but
that there was still the potential noting, “Where there is money, there is going to be certain individuals that are going to push the boundaries, and that’s a problem.”

The CASLPO key informants also indicated that overall what was in place was effective. It was stated that the College had a lot of formal documentation in place to address potential COI. It was noted that the culture of professionalism helped and that one of the biggest roles of the College was to make sure that members were accountable. The informant noted that the College was getting better at emphasizing accountability to the membership and helping them to realize that accountability was part of the care that they delivered. One key informant summarized that, “self-regulation is effective as long as those under the regime of self-regulation understand that it is a privilege and not a right, understand that they need to participate in their self-regulation”.

5.6.2 Importance of COI and Overall College Effectiveness: CNO

The CNO key informants indicated that due to the nature of nursing the risk of COI was always present and as a result guidance and directives were given to nurses in various documents and practice standards. COI was felt to be important in nursing because nursing involved, “constant, very intimate care and obviously very vulnerable clients in their homes, clearly physically and emotionally, socially vulnerable”.

In terms of effectiveness one of the CNO key informants indicated that it was hard to measure how well the area was addressed because there was no way of knowing everything that was prevented. The CNO focus was on providing comprehensive information regarding expectations of the membership and to incorporate practice reflection and input from the membership to understand underlying issues and provide guidance.

5.6.3 Importance of COI and Overall College Effectiveness: CPO

The CPO key informants indicated that COI was important and important to the membership but there were also other significant concerns for the College. It was noted by one key informant that COI was important because a COI might prevent patient’s needs from being put first. It was
noted that the mandate was to protect the public, but that financial COI and its importance would depend on the scenario and the risk to the public. One key informant noted that all concerns would be taken seriously as breaches of the rules by the College.

The CPO informants indicated the practice standards in place were very clear and the tools in place to assist the members in assessing their situations and deal with unavoidable COI scenarios were very helpful. It was noted that members contacted the College to discuss scenarios which were of concern. In terms of the top ten issues brought forward by the members and tracked by the College, COI was combined with ethics and was sometimes in the top ten list, but not in the top five. Overall, the conclusion was the CPO was doing a good job addressing COI.

5.6.4 Importance of COI and Overall College Effectiveness: CPSO

The key informant for CPSO noted that in general COI was a concern because, “it strikes at the heart of professionalism”. The informant went on to explain that the College’s primary concern was ensuring that the public interest was protected. Its main focus was in ensuring patient safety through registration, investigation and assessment processes. Ensuring safe and professional clinical care was the priority for public interest and public trust. Issues related to professionalism, including COI were also important given the potential impact on trust in the profession.

The CPSO key informant indicated that overall what the College had in place was quite effective. The College was obligated to investigate every complaint it received. The outcome of that complaint would depend on the seriousness of the issue, whether it was about COI or anything else. An example of a potentially smaller COI was ongoing business arrangements (e.g. rental agreements, etc.). It was also stated that regulators needed to be vigilant to both, but the emphasis was on public safety and good patient care. The informant indicated that there was always the possibility to do more, and one mechanism might be a stronger regulation relating to COI. As an example, it was pointed out that there were grey areas in terms of pricing and mark-up for profit, but it was recognized that it was difficult to define an appropriate pricing structure.
5.6.5 Cross-College Comparison: Importance of Financial COI and Overall Effectiveness of College in Addressing COI

The key informants for all four Colleges in this study indicated that COI was important and that they had a comprehensive approach to addressing COI. Key informants indicated that protecting the public was a primary role of the College. Key informants from both CASLPO and CPSO referenced the concept of professionalism as a guiding principle behind expectations on the membership following the directives provided. One CASLPO key informant noted self-regulation only worked with the active participation and buy-in from the membership. The CPSO key informant indicated that COI could undermine the concept of professionalism, which was the foundation for self-regulation.

The key informants for all four Colleges also responded in a similar manner regarding how much of a concern COI was for the College. The scenarios presented by key informants were noted to be based largely on preventing COI from occurring and providing registrants/College membership with appropriate guidance. Further, members were noted to proactively contact the college, indicating an understanding and interest in complying with the regulations and practice standards/guidelines set forward by the College in this area. Overall the College informants noted it was important, as were other concerns related to protecting the public but key informants for CASLPO, CNO and CPO noted, it was not the top concern for their College. Comments from CASLPO key informants supported the notion that some members might be more concerned about it than others and it was felt this was related to the nature of work performed (e.g. a commercial environment where products were sold), how services were paid (e.g. private pay instead of third party funding) and the work environment (e.g. a retail setting instead of a publicly-funded setting). CNO key informants noted it was a concern for nursing because of the nature of nursing such that comprehensive materials were provided to guide the registrants. One CPO key informant noted that the COI was an area that members were mindful of and took advantage of the tools the College provided to guide their practice. It was also noted that although members brought forward concerns about COI it was not in the top five concerns tracked. The CPSO key informant noted that all COI issues were a concern to the College, but
each issue brought forward needed to be investigated and evaluated by a committee pursuant to the legislative processes to determine the seriousness.

In terms of addressing COI key informants for four Colleges felt that their College had comprehensive documentation or directives and support materials in place for their members. One CNO key informant noted it was hard to measure how effective the materials were because there were no measurable outcomes and it hard to know what behaviors were prevented. The same informant also noted that the College pro-actively took input from the membership in order to provide educational information and to support and guide their practice. The CASLPO and CPO informants referenced the few complaints related to COI as supporting evidence that the approach in place was effective. The CPSO key informant indicated that there was always the opportunity to put more regulations or tougher regulations in place, but also acknowledged that some of the grey areas such as pricing or fees were very difficult to quantify. The key informant also noted that the emphasis of the College was on ensuring its members had the proper skills and that the right people were registered with the College such that good patient care resulted. The key informant indicated that any change in regulation or approach needed to be informed by an evaluation of risk to the public.
Chapter 6
Summary and Conclusions

Summary of Key Findings and Conclusions

6.1 Part I: Summary of Key Findings and Conclusions

Part I of this study focused on a descriptive analysis of the regulatory framework under which healthcare professions provided services across the Canadian provinces. Specifically, the goal was to provide an overview of which health professions were delegated self-regulation and then to gain an understanding of the extent to which the legislation in place was overarching to provide a common structure or set of mandates for all the health professions that were granted self-regulation or varied by profession. The regulatory frameworks were complex and differed across the provinces such that only general comparisons were made. Quebec was not included in the review of the legislative content due to the lack of availability of the professional regulatory bodies’ documentation in English.

Fourteen of the thirty-seven health professions that were delegated self-regulation in at least one province were granted self-regulation in all provinces. Some professions, such as paramedics, were only granted self-regulation in a few provinces, or were regulated under different legislation. For example, in the case of Alberta, paramedics were granted self-regulation, but were excluded from the overarching health professions legislation, the Health Professions Act (2000). Social workers were also treated differently across the provinces with some provinces (Alberta and Nova Scotia) including them in the overarching legislation, while others (e.g. British Columbia) were granting the profession self-regulation under its own legislation.

Overarching legislation which contained a common regulatory mandate, protection of title, and professional conduct mandates were present to varying degrees. British Columbia, Alberta, Manitoba, Ontario, Nova Scotia and Newfoundland and Labrador all had some type of overarching legislation addressing these areas, although not all of the professions that were
included under one province’s umbrella legislation were necessarily included in the other provinces’ umbrella legislation. The legislation for Manitoba and Ontario covered all the regulated health professions, while the umbrella legislation in Newfoundland and Labrador covered 7 of the 23 self-regulated professions, with the others being covered by profession-specific legislation. Only British Columbia, Alberta, Manitoba and Ontario defined a common set of restricted or controlled activities, although it should be noted that Alberta’s controlled acts were not listed in the umbrella legislation, the Health Professions Act (2000), but in the Government Organization Act (2000). This separate listing only further supported the finding that each province had its own complexities and unique legislative framework.

Provinces in which there was some type of umbrella legislation had a common regulatory framework and associated College mandates, which provided a certain degree of consistency and expectations regarding how the Colleges that fell within this framework would regulate their respective registrants. For example, in Ontario, the College mandates included setting conduct standards and enforcing the objects which were outlined by the RHPA (1991). Seven statutory committees were outlined along with standardized processes, powers conferred upon the committees and/or College. From a policy implementation standpoint this would appear to be an efficient manner in which to have regulatory bodies implementing policy, since the more aligned the Colleges were in processes and approaches the more efficient it is for government and/or the public to understand how healthcare regulation is implemented and the public safety and interest is maintained.

However, in the case of Ontario, each College was still independent and the regulatory activities that were addressed in this study were self-contained within each College. By contrast, Newfoundland and Labrador’s overarching legislation also included a Council comprised of members from each of the seven professions designated under this legislation. This Council was responsible for the disciplinary process for all health professions included in the legislation. This framework allowed for a common disciplinary process across the seven professions. In addition to improving process efficiencies and consistency across professions, objectivity might be
enhanced by having other professions involved when dealing with allegations of professional misconduct or incompetence, while at the same time ensuring that subject matter experts would be able to provide profession specific input as required. This interdisciplinary structure might provide economies of scale both in terms of effort and cost, particularly for smaller professions where the cost to uphold some of the statutory requirements of a College, such as disciplinary hearings, may become onerous on the membership who must bear the costs of maintaining the College.

A closer examination of the Ontario regulatory framework was completed based on the premise that understanding the basic format of this framework would be helpful in undertaking Part II of this study, which was to look at four specific health professions regulatory Colleges in Ontario. The Ontario model, included umbrella legislation, with common mandates and processes to address professional standards of conduct. This common framework enabled a direct comparison of how the Colleges addressed COI for each practice variable outlined in figure 2.1 (The Conceptual Framework for Managing Financial Conflict of Interest), that is, scope of practice, work environment and remuneration and how the Colleges manage financial COI. This comparison may have been more difficult or confounded by the framework differences if the legislative framework under which each College operated varied. Assessing self-regulated health professions in other provinces that lacked an overarching legislation might introduce other complexities that might make comparisons difficult, but it may also provide further insight regarding how self-regulation and the concept of professionalism has been internalized and put in practice when the legislation is less explicitly mandated. The model used in this study might provide a template under which other Colleges operating under different legislation frameworks could be examined and contrasted to those with common regulatory frameworks.
6.2 Part II: Summary of Key Findings and Final Conclusions

In the second part of the study a multiple-case study design was incorporated to understand how four different Ontario-based health professions’ Colleges addressed financial COI with its membership. The Conceptual Framework for Managing Financial Conflict of Interest (Figure 2.1) was used to guide the examination of the three specific practice variables, nature of work, work environment and remuneration structure and to determine how these variables impacted how financial COI was addressed by looking at how these Colleges utilized self-regulation mechanisms. The theoretical framework incorporated hypothesized that how the Colleges managed financial COI would by impacted by the differences between Colleges for these practice variables. The results indicated that the Colleges had in place the self-regulatory mechanisms to address COI and financial COI, with a focus on the areas of greater risk to their membership as determined by these practice specific variables in order to meet the expectations that professions will maintain high standards of competency and moral responsibility (Sullivan, 2000). The findings indicated that the Colleges had commonalities in their definition of COI and financial COI, as well as directives to their registrants. The differences between the Colleges in where they focused their directives and guidance/education could be explained by the practice variables in the model.

There were a number of key findings about how the potential for financial COI was viewed by the four health professions regulatory Colleges that are summarized in Table E2 (Appendix E). COI in general, was described as very nuanced and scenario-based, and often multiple practice variables impacted the potential for financial COI such that there was overlap in the results for the three practice variables. Given the differences inherent in the cases or Colleges selected, the theoretical proposition that guided that analysis was that there might be differences between the Colleges that could be related to these practice specific variables. Given that the Colleges all had similar regulatory frameworks under the RHPA, as discussed in Part I of the study, the cross-College comparisons were relatively straightforward, which may not have been the case if each College had different regulatory frameworks and mechanisms in place.
The first area of examination was the approach each College took in defining COI and subsequent to that providing further directives and or education to the registrants. Even though it was noted that COI was very scenario based, all four Colleges had similar definitions of COI and had documentation in place to address COI, which ranged from the most binding, in the form of a regulation on COI in the case of CPSO, to less binding documentation including a proposed regulation on COI in the case of CASLPO, and practice standards and reference documents as with CPO and CNO. In terms of directives, guidelines and materials provided to College membership, the focus or study was directed towards examining what was in place pertaining to financial COI.

In addition to defining COI and providing COI-related directives, all four Colleges had in place Practice Advice services in which they could provide support and assist a member in assessing their own practice situation. The CPO, CASLPO and CNO all took active steps to provide education to their membership using various means including articles, on-line education videos and learning modules and in the case of the CNO, an Outreach Consultant service which was available upon request to meet with membership and go over practice concerns as they related to the standards. The types of materials and focus of the Colleges tended to be directed towards areas viewed as potential sources for financial COI for the membership.

The focus of the CNO differed from the other three Colleges in this study in that most of the education and guidance was directed towards the therapeutic patient-client relationship and the risk of COI and financial COI occurring if professional boundaries were crossed. The CNO had extensive educational materials in various formats for its registrants providing guidance in this area and, as noted above, also offered face-to-face guidance with the Outreach Consultant services offered by the College. This Outreach Consultants service was not offered by the other three Colleges studied; it appeared to offer a tailored approach to providing guidance and two-dialogue on practice standards to registrants that might further enhance the educational tools in place and also help to ensure that the College understood the challenges its members
encountered. This type of Outreach Consultancy group might be a concept that other Colleges would find beneficial.

In addition, the CNO had extensive educational materials related to maintaining professional boundaries of which the general concepts that might beneficial for other Colleges to leverage as a best practice sharing. The CPO and the CASLPO had common areas of focus pertaining to charging for services while also selling products related to the services. This guidance could be related back to both the type of work the registrants did and how they were remunerated. The CPO and CASLPO both focused on non-public third party billing concerns and where the risk of financial COI might arise. While the CASLPO had a proposed COI regulation, it was developed in 1996, and had not gone beyond the proposal stage, although key informants noted that the expectation on members was that they take direction from this posted document. The proposed regulation was supplemented by a couple of more recent educational pieces. In contrast, the CPO had extensive guidelines for financial COI in various formats and tools for its registrants to use in understanding and identifying practice concerns. A number of scenarios in which financial COI might occur were covered, and the self-directed decision tools that were available enabled the user to self-assess their practice situation. Some of these CPO materials might also serve as guides or best practice tools for other Colleges to consider adopting, in situations where registrants have similar practice-related variables.

The CPSO differed from the other three Colleges in that education was not seen as part of the College’s mandate and as a result there were no educational materials pertaining to financial COI posted on the website. The CPSO did post the regulatory directives (i.e. the professional misconduct legislation) and was the only College in this study that posted a mandatory reporting form to be used when COI was deemed unavoidable. The form was evidence that the College was aware that circumstances might arise when COI might unavoidable and as a result allowed for transparency and full disclosure. This type of disclosure might be of benefit for other Colleges to consider in their management of financial COI.
As noted, the areas the Colleges focused with their membership could be related back to the practice variables in this study. These practice variables included nature of work and decision making authority, work environment and the support or culture of that environment and remuneration-based issues, including selling products and payment for referrals. Areas in which there were opportunities for further policy development tended to be impacted by all three practice variables to varying degrees as will be discussed below.

6.2.1 Nature of Work

Nature of work included the type of work done and the decision making authority the profession had in the work. The CNO was the only College of the four in this study that indicated that the nature of the work done by its membership—which included longer term, close physical and often emotional contact, put the membership at risk for crossing professional boundaries which may result in the potential for financial COI to occur.

The other area included under nature of work was decision making authority—which might be considered part of a profession’s scope of practice and might include the authorization to perform controlled acts. Decision making also included determining the number of treatments or appointments necessary and soliciting referrals or self-referral for treatments, procedures, or prescribing and/or recommending and selling products as well as industry/other relationships. All four Colleges were impacted to some degree by this practice variable. For example, the solicitation of referrals either from patients or other professionals was addressed explicitly by the CPSO, the CPO and to a lesser extent by the CASLPO and CNO. The CPSO and CPO focused on benefits conferred in return for referrals, while the CASLPO and CNO along with the CPO focused more on soliciting a patient regarding the provision of private services outside of third party-funded service model under which the professional was already providing these services.

Selling products also fell under type of work done as well as remuneration. The CPSO had a conflict of interest regulation, which touched upon conditions for selling products, and the CASLPO, CPO and CNO had materials and guidance that focused on recommending (or in the
case of CASLPO prescribing) and selling products. The CPSO was also the only College in this study that had in place a document for declaring when the physician was in an unavoidable COI and may be a useful tool for other Colleges to consider. The selling of products will be discussed further in the remuneration section.

Another area related to decision making authority in the nature of work done by a profession pertained to industry/other relationships. The four Colleges in this study all addressed this, but to varying degrees. The CPSO’s COI regulation covered a number of areas that were related to industry relationships including pricing arrangements, loans, rental agreements, consulting arrangements and other forms of benefit. The CPSO also had a policy on relationships with pharmaceutical industry and a policy regarding COI and research. The CASLPO proposed COI regulation covered similar areas relating to pricing, loans and research. The CPO’s standard for professional practice on COI also covered areas related to pricing and referrals. The CNO documentation touched briefly upon selling products with a limited focus on industry relationships. The difference in amount of focus in these areas by the Colleges could be explained by the nature of the type of work done by and the decision making authority of the registrants of the four Colleges.

6.2.2 Work Environment

The work environment was seen as a variable that impacted all four Colleges’ registrants. Key informants from all four Colleges indicated that team environments tended to provide more support and tools to assist professionals in dealing with issues and barriers to treatment. It was noted by the CPSO, CNO and CPO informants that independent practices tended to have less checks and balances in place. For example, a professional’s behavior may not be directly observable by another professional. This lack of observability was cited as a risk factor, although it was strongly stated that just because there might be a lack of observability, or checks and balances in place in a work environment, one should not conclude a COI exists. The CNO also noted that providing care in home environments also resulted in less visibility and a greater chance of vulnerability of both parties.
The change towards a retail or private environment was cited by a CASLPO key informant as increasing the risk of COI. It was pointed out that because for profit companies were becoming involved with the provision of services, healthcare was seen as a business and the objectives of a non-health professional manager/owner may be different than the health professional. Further to this comment, the CASLPO and CPO participants indicated that the employee-employer relationship may impact the culture and risk of COI. A CASLPO key informant noted the negative impact of working in an environment where questionable practices might occur. Conversely, a CPO informant noted that work culture can also positively influence and shape the development of a professional. How work environment also tied into nature of work and remuneration with respect to environments in which there is the selling of goods as well as providing services will be discussed further in the next sections.

6.2.3 Remuneration

Remuneration was examined, from the perspective of how College COI directives took into account the various manners in which a professional was compensated. The results indicated that the Colleges did not focus on all aspects of professional remuneration. Areas that were brought forward included billing third party providers, the transfer from third party insured services to privately covered services, block services, benefit conferred with referrals and the selling of products in addition to services.

Billing third party providers appropriately was an area brought forward by the CASLPO and CPO informants and it was noted by a CASLPO key informant that changes in funding mechanisms inevitably resulted in changes in locus of accountability, particularly when services were not publicly funded. With respect to how and who paid for services, the manner in which third party insured services might be transferred to privately covered services was an area of focus brought forward by the CASLPO, CPO and CNO. These types of scenarios might occur when either a non-government third party was paying for services, or when publicly insured services somehow intersected with privately paid for services (i.e. the conditions under which a transition from publicly insured/third party insured services to privately paid for services
occurred, and the role of the professional in this transition), which resulted in the patient paying directly for services. The CPSO, whose members practiced mostly through a public reimbursement model, had a potential concern related to privately funded services interacting with publicly funded services if a member made receipt of publicly funded services contingent upon the patient paying for private services. The CPO further brought forward the concept of bulk services and the potential for COI. Benefits associated with referrals including payment, rental agreements and other arrangements were brought forward by the CPO and the CPSO informants as areas of concern.

Noteworthy was that one area that was not brought forward from the College informants was COI associated with publicly-funded services. Participants from all four Colleges indicated that publicly funded services minimized the issue of COI. When asked, it was felt either overtreating or undertreating under a publicly funded model was more an issue that was related to maintaining the standards of the profession or a job function issue that would be handled through other regulatory means. It was also important to note that the Colleges were not responsible for overseeing the billing of publicly-insured services. These results indicated that when public funds were utilized in the provision of healthcare, the Colleges did not provide oversight in terms of whether the funds were used appropriately or whether there was financial COI associated with the use of these funds in providing the services. In essence, the Colleges had mechanisms in place that dealt with individual patient safety and welfare, but it wasn’t really clear how a more systemic abuse of funds related to publicly-funded healthcare might be identified and addressed.

How remuneration was impacted by work environment and nature of work resulted in some question regarding the comprehensiveness of mechanisms the Colleges had in place to address potential COI. Specifically, selling products, particularly when recommending and/or prescribing them, occurred for members of the CASLPO, CPO, and to a lesser degree for the CNO and CPSO. This scenario occurred in work environments in which registrants sold goods associated with the services they provided. The Colleges were not responsible for setting fees, or determining what was reasonable with respect to mark-ups, or fair pricing for services provided.
College directives were in place which addressed the professional’s obligation to place patient interests first and to be transparent in the processes when both recommending/prescribing and selling devices as well as for charging appropriate fees for services provided. A CASLPO key informant noted that delivery models had changed and in some cases the registrant might be working for a business or non-professional manager where business objectives might not always be aligned with professional obligations. For example, in the case of hearing care clinics, the industry has undergone consolidation in which many clinics are no longer owned by professionals but by for-profit corporations (Sonova, n.d.). Physiotherapy has also delivery models in which professionals are working at non-physiotherapist owned for-profit corporations (Boyle, 2013) that may provide a variety of health-related services. Scenarios in which self-regulated health professionals provide services under for profit corporations is not unique to the Colleges in this study and similarities can be found in other healthcare fields. For example, vertical integration in eye care has resulted in shops, with an ownership structure tied into the eyeglass manufacturer providing vision testing, prescription services and dispensing the products they manufacture (Baltro, 2014; Luxottica, n.d.).

While professional obligations have been made clear by the Colleges to their registrants, there exists the underlying question of whether primary interests are being impacted by secondary interests. The CSPO was the only College in this study that provided a COI disclosure form for registrants to provide transparency. Although the CASLPO proposed COI regulation indicated transparency and providing alternative options to the patient, and CPO indicated that in the practice standards that service levels should not be tied to product purchases, there was no mandatory reporting or mandatory disclosure of ownership structure for organizations. Even if there was full transparency pertaining to profession-owned versus non-health profession-owned clinics, the question remains as to how this would help protect the public or ensure quality of care. In the case of hearing care, if professional expertise is required to prescribe the appropriate devices how might the public reconcile this with any disclosure of business interests related to a particular clinic given the overwhelming majority of clinics are no longer owned by a self-regulated health professional?
Further, given Colleges are not responsible for determining pricing or fees, the public is relying on the professional to place patient needs first and to some degree on the market pressures that might influence pricing and fees. The public may not be able to judge practice standards or recognize there are differences in training and educational credentials amongst those working in various clinics, and thus is left to judge quality of health services based on areas that are more readily understood, such as pricing and speediness of service, for example. These market-driven metrics may or may not be related to or may even negatively impact good patient care. Colleges clearly do not regulate businesses, but how the public interest might be better met when professions are involved in providing professional services under a non-professional ownership structure is an area that may warrant further study and policy development.

6.2.4 Effectiveness of College Processes

The final part of the analysis looked at how the enforcement mechanisms worked and if the key informants felt they were effective. Even though key informants from the CASLPO, CPO and CNO stated it was not the most important issue facing the membership, they all indicated that any form of COI was considered serious and was treated as such. Key informants also indicated that their membership actively contacted them with questions pertaining to various areas of COI demonstrating both a concern for and understanding of their obligations to meet professional regulatory requirements.

Even though the mechanisms were in place for addressing financial COI, the number of cases that related to financial COI, deemed to constitute professional misconduct and referred to a disciplinary hearing, were very small for the Colleges in this study. This may support the view that financial COI was being addressed by the guidance and directives in place, thus demonstrating the membership is meeting the expectations of high standards and moral conduct that is important to the Colleges. Conversely, it may indicate that the measures in place do not adequately identify and address COI. Conduct concerns addressed by each College were based on ICRC referrals to Discipline. In terms of COI, the ICRC process was reliant mainly on complaints being brought forward to the College from a member or the public, or concerns being
uncovered secondarily, either from a Quality Assurance committee referral for example, or from a registrar’s report to the ICRC regarding a concern brought forward to the registrar. The nature of this process which relies on a complaint or other concern being brought forward to the College, by its nature may miss areas of registrant conduct which fall short of practice standards and regulations. The shortfall of the ICRC process is not limited to COI however, but would apply to many practice standards. It also is a reflection of the underlying principles of self-regulation, which include some important concepts underlying professionalism. These concepts include the assumption that the professional will put the needs of the patient ahead of self-interests, and has the unique knowledge and skills to judge the work of their own, and will ensure members continue to meet the standards set by the profession. It also explains why the College key informants noted they took all matters related to COI seriously, because any breach in conduct not addressed by the College might imply the self-regulatory mechanisms are suspect. In other words, if self-regulation principles underlying the ICRC process fail for COI, then one might question if other areas related to practice competencies, which might have immediate and grave patient safety concerns, were also not being adequately safeguarded. While financial COI has important implications for how public and private funds are spent in healthcare, which arguably affects the healthcare services as whole, other professional conduct issues may have more immediate and life-threatening consequences.

6.2.5 Limitations

The results of this study provided an understanding of how four regulatory Colleges addressed financially based COI. Although the number of key informants from each College was relatively low, the key informants were all knowledgeable in the subject area for their College and the pilot study indicated that saturation on the questions related to College processes was reached after two participants from that College. The CPSO only had one participant, but the questions from the interview guide were obtained in advance in order the information provided was comprehensive. It should be noted that the number of participants may be a limitation in the question pertaining to the key informant’s opinion of how well they felt the College was addressing COI. A larger sample size may have yielded different results, as might a
similar question posed to general members of each College. All efforts were taken to reduce researcher bias although it should be noted that the author was a professional member of the CASLPO Council. The four Colleges were chosen because they varied in nature or work, work environment and remuneration structure. The results are case specific and may not be generalized to other health professions Colleges; however, they do support the Conceptual Framework for Managing Financial Conflict of Interest and offer a framework for comparing other regulatory Colleges’ processes.

6.3 Areas for future study

The results do suggest that further studies may help assess the Conceptual Framework for Managing Financial Conflict of Interest and to understand how other health professions Colleges operating within Ontario’s regulatory framework address COI. This additional research may be useful in developing a common framework for Colleges to use in addressing financial COI as the delivery of healthcare continues to evolve. Further research applying this model examining the same professions operating under a different provincial regulatory framework may also further inform policy development in addressing financial COI.

Accountability and appropriate billing or usage with respect to publicly-funded services was generally seen to be less of a concern with respect to financial COI from the College’s perspective, and, in terms of oversight of billings, outside of the College’s jurisdiction. Further research into how publicly-funded healthcare spending accountability is managed and the effectiveness of other processes in place (including how systemic abuse of funding reflective of professional conduct issues might be detected and provided to the Colleges) is an area that warrants further investigation in terms of transparency in publicly insured health services expenditure and in terms of ensuring the public’s interests are served.

The Colleges also do not have oversight regarding fees charged for privately provided services, or the mark-up associated with selling products. Determining what would be considered
reasonable fees and profit was beyond the scope of the Colleges. While the professional conduct guidelines and COI directives all provide the framework for how the professional should put primary interests ahead of secondary interests, the College’s mandate does not include non-professionally owned/managed businesses and the College guidelines only apply to the College registrants. The role of the College in ensuring the public interest and trust is maintained as profession-controlled markets are moving towards corporately-owned or controlled models is an area that warrants further investigation to inform policy development.

Finally, the enforcement process used by the health professions regulatory Colleges in Ontario is clearly assigned to Discipline Committees within each College. Other models in Canada included those that incorporated multiple College representatives to form a multidisciplinary council to address the disciplinary process. This model warrants further exploration to compare how a complex issue such as COI might be addressed. Interdisciplinary models such as that recently formed in Newfoundland and Labrador may provide benefits in terms of consolidating competencies and costs associated with the disciplinary processes across multiple Colleges which may be of benefit for smaller Colleges that don’t have large membership numbers to cover costs which might be incurred as part of the disciplinary process. In addition, the involvement of multiple professions, in addition to the ‘subject expert’ profession, may help to provide additional objectivity, and consolidated panel experience, both of which might provide additional public confidence in the self-regulatory process.

As the delivery of healthcare continues to evolve, and changes in the expectations of the public continue to evolve as well, it is increasingly important that the health professions and their Colleges adapt to these changes and demonstrate that they are upholding the basic tenets of self-regulation. Further research using the Conceptual Framework for Managing Financial Conflict of Interest under different regulatory frameworks may assist in informing these process-related adaptations. Further research in areas pertaining to accountability and transparency related to publicly-funded healthcare spending, and research directed towards understanding how business interests, which are being more intertwined in the delivery of healthcare, are managed in terms of
protecting the public interest should provide additional insights into addressing COI issues, the self-regulatory process and further enhance policy development.
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Appendix A

Invitation to Participate Letter

Institute of Health Policy, Management & Evaluation
UNIVERSITY OF TORONTO

August 20, 2013

Dear XXXXXXXX,

I am writing to tell you about the study, “How Professionalism Manages Conflict of Interest in the Self-Regulated Health Professions”, being conducted by myself and Raisa Deber, Ph.D., at the University of Toronto’s Institute of Health Policy, Management and Evaluation. This research project is my thesis project and is part of the Accountability in Health Care grant funded by CIHR. In addition to Professor Deber, my thesis committee includes Andrea Baumann, Ph.D., Brenda Gamble, Ph.D., and Audrey Laporte, Ph.D. This CIHR-funded Partnership for Health Systems Improvement (PHSI) research consists of a series of sub-projects within the general theme of accountability in health care. As one of our community partners, I am inviting the College of Nurses of Ontario to participate in this sub-project. A detailed listing of the community partners and more information on the sub-projects can be found on the site:

http://www.approachesstoaccountability.ca.

The purpose of this study is to examine and compare how regulatory colleges address financial conflict of interest. The study will use a nested multiple case study approach. The College of Nurses of Ontario (CNO) was selected as one of the cases. As part of this study I would like to ask you some questions regarding how the college educates, directs and enforces conflict of interest-related issues which its members may encounter.

This project has been approved by the University of Toronto’s Health Sciences Research Ethics Board (REB). The accompanying document provides more details about the study. Please feel free to contact me if you have any questions at xxx-xxx-xxxx. If we do not receive your reply within two weeks a study team member may send you another letter and/or contact you by phone.

Thank you for your time and consideration.

Deb Zelisko, M.C.L.Sc. (Reg. CASLPO)
Ph.D. Candidate

Include enclosure(s) as applicable:
Consent to Participate in Research Information and Form
Appendix A

Consent Form

CONSENT TO PARTICIPATE IN RESEARCH
How Professionalism Manages Conflict of Interest in the Self-Regulated Health Professions

You are asked to participate in a research study conducted by Deb Zelisko and Raisa Deber, from the Institute of Health Policy, Management and Evaluation at the University of Toronto. This research project is the thesis project of D. Zelisko and part of the Accountability in Health Care grant funded by CIHR.

If you have any questions or concerns about the research, please feel free to contact Deb Zelisko at 519-400-6570.

PURPOSE OF THE STUDY

The objective of this research is to investigate how the professional regulatory bodies use professionalism to manage conflict of interest. Specifically, this research will examine which health professions are self-regulated in Ontario. The study will then look at autonomy in the workplace and varying economic incentives impact how the colleges define, provide guidance and regulate conflicts of interest.

PROCEDURES

If you volunteer to participate in this study, we would ask you to do the following things:

You will be asked to participate in a key informant interview of about an hour in duration. The interview will be set up at a time that is convenient for you to participate. Research findings will be made available to participants in the form of a summary report.

POTENTIAL RISKS AND DISCOMFORTS

This study is deemed a low risk study. There are no potential risks or discomforts associated with participation in the study.

POTENTIAL BENEFITS TO PARTICIPANTS AND/OR TO SOCIETY

The intent is to gain a better understanding of how professionalism manages conflicts of interest for self-regulated health professions. The participants may use this information to further inform their regulatory processes.

PAYMENT FOR PARTICIPATION

Participation in this study is voluntary and there is no remuneration associated with participation.

CONFIDENTIALITY

Every effort will be made to ensure confidentiality of any identifying information that is obtained in connection with this study.

Key informants’ privacy will be maintained by ensuring that there is no direct identification of any participant unless expressly permitted in writing or if the data collected is information that is already in the public domain, which may be the case in the document analysis portion of the research.

Transcripts from the interviews and answers to questions will be stored in a locked filing cabinet accessible by only the research team. No information will be used to identify a particular individual unless expressed consent is obtained or the information is already in the public domain. The topics concern policy issues
and practices which are largely a matter of public record.

PARTICIPATION AND WITHDRAWAL
You can choose whether to be in this study or not. If you volunteer to be in this study, you may withdraw at any time without consequences of any kind. You may exercise the option of removing your data from the study. You may also refuse to answer any questions you don’t want to answer and still remain in the study. The investigator may withdraw you from this research if circumstances arise that warrant doing so.

RIGHTS OF RESEARCH PARTICIPANTS
You may withdraw your consent at any time and discontinue participation without penalty. You are not waiving any legal claims, rights or remedies because of your participation in this research study. This study has been reviewed and received ethics clearance through the University of Toronto Research Ethics Board. If you have questions regarding your rights as a research participant, contact:

Research Ethics Coordinator
University of Toronto
12 Queen’s Park Crescent
McMurrich Building, Second Floor
Toronto, ON M5S 1S8
Consent Form

Research Project Title: "How Professionalism Manages Conflict of Interest in the Self-Regulated Health Professions"

Researchers: Deb Zelisko and Raisa Deber, Institute of Health Policy, Management & Evaluation

This consent form, a copy of which will be left with you for your records and reference, is only part of the process of informed consent. It should give you the basic idea of what the research is about and what your participation will involve. Please feel free to ask if you require any additional information about anything mentioned here. Please take the time to read this consent form carefully. You may contact me at any time to discuss the study at dlc_zelisko@rogers.com.

I, ___________________________ understand that this interview is being conducted for a study on "How Professionalism Manages Conflict of Interest in the Self-Regulated Health Professions", conducted by Deb Zelisko and Raisa Deber. I understand that this interview will focus on the regulatory colleges' role in managing conflict of interest.

I understand that I will participate in an interview that will last approximately 45 minutes to 1 hour in length. I understand that with my permission, the interview will be audio-recorded and later transcribed. I am aware that I do not have to answer any questions that I do not feel comfortable answering, and that I can stop the interview at any time. I am aware that the audio-tapes/notes will only be accessed by the research team. I am aware that the answers I provide the researcher with will be kept confidential. I understand the transcripts and audio-tapes will not have my name or any other identifying information on them. A research code number will be used instead. All data will be kept on a secure computer that will be password protected. The completed interview schedules, transcriptions, audiotapes and other research data will be stored in a secure place. No information will be released or printed that would disclose any personal identity, and all such research data will be destroyed upon the completion of the project in February 2014.

Any questions I have asked about the study have been answered to my satisfaction. I have been assured that no information will be released or printed that would disclose my personal identity and that my responses will be completely confidential. Any risks or benefits that might arise out of my participation have also been explained to my satisfaction.

I understand that my participation is completely voluntary and that my decision either to participate or not to participate will be kept completely confidential. I further understand that I can withdraw from the study at any time without explanation and without negative consequences.

I hereby consent to participate in this study.

Date: ________________________________

Signature of Participant: ________________________________
Clarification to Consent form – sent out and electronically approved by participants

I hope this message finds you well.
I am following up on your participation in the sub-project of the Accountability in Health Care study funded by CIHR, “How Professionalism Manages Conflict of Interest in the Self-Regulated Health Professions”. I wish to clarify the consent form which you signed. The form indicated the data collected would be destroyed at the conclusion of the study, expected in February 2014. I would like to clarify that only the audio recordings will be destroyed at the conclusion of the study, which is expected to now extend to December of 2014 upon completion of the project. Please respond to this message confirming you acknowledge the clarification. If you prefer I forward to you a revised consent form please let me know and I will send to you.

Thanks in advance.

With kind regards,
Appendix B

Key Informant Interview Guide

1. What is your role at the College/Where do you work and in what role?

2. How does the College define conflict of interest (COI) for its members?

3. How much of a concern is financial COI for the College?

4. What areas has the College identified where there is the potential for COI to occur?

5. How Does the College address financial COI? [Additional prompts: There are a number of ways a College might address potential Conflict of Interest including regulations, by-laws, training/education and enforcement (which may involve self-reporting, audits, complaint handling, peer reporting/managerial reporting and disciplinary actions).]

6. How does the scope of practice for your College registrants impact the potential for financial COI?

7. Some work environments are more complex than others because of differing scopes of practice, role definition and work environment.
   a. What kind of guidelines the College developed to assist its registrants in dealing with different workplace and interprofessional scenarios?
   b. Are there examples you can provide where a financial COI complaint was levied against a member of your College from a fellow registrant? From another profession?

8. Overall, how well do each of these measures and self-regulation work in practice to ensure accountability/address COI?
Appendix C
Compilation of Legislative Framework for Self-Regulated Health Professions in the Canadian Provinces as of July, 2014

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<thead>
<tr>
<th>Umbrella Legislation</th>
<th>British Columbia</th>
<th>Alberta</th>
<th>Saskatchewan</th>
<th>Manitoba</th>
<th>Ontario</th>
<th>Quebec</th>
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<th>Nova Scotia</th>
<th>Prince Edward Island</th>
<th>Newfoundland &amp; Labrador</th>
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<tr>
<td>Health Professions Act (HPA), Health Professions General Regulation 2008. The Professions Under This Act Also Have A Profession Specific Regulation As Part Of The Act.</td>
<td>Health Professions Act (HPA), 2000. The Professions under this Act also have Profession Specific Regulation As Part Of The Act. Three Professions under The Health Disciplines Act.</td>
<td>None. Self-Regulation Mandated Through Professional Associations For Most Professions.</td>
<td>The Regulated Health Professions Act (RHPA), 2009. Health Professions Regulated under this Act also Have Their Own Act As Outlined Below.</td>
<td>The Regulated Health Professions Act, Or RHPA, 1991. Health Professions Regulated under this Act also Have Their Own Act As Outlined Below.</td>
<td>Professions Are Regulated Under The Professional Code. The Regulatory Bodies For These Groups Are &quot;Orders&quot;.</td>
<td>None. Regulatory Bodies Tend To Be Associations Or Societies</td>
<td>Regulated Health Professions Network (RPHN), 2012 (Proclaine d Sept 2013) - 23 Professions Under The Ac.</td>
<td>None - A Proposal Exists To Have An Umbrella Legislation Under Which The Health Professions Would Have A Common Regulatory Structure</td>
<td>None - Newfoundland and Labrador Health Professions Act (HPA) (2010) For 7 Professions, Others Are Covered Under Own Legislation As Indicated Below</td>
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<td>22 Regulations.</td>
<td>22 Regulations Of which 21 Fall under The RHPA. 1 (Social Workers) falls under separate legislation.</td>
<td>27 Regulations. Of which 26 fall under the RHPA of which 3 were not proclaimed. Social Workers under separate legislation.</td>
<td>Professional Code -26 Provides Regulatory Structure For 26 Professions. Of These 12 Professions Also Had Additional Regulations Cited And Available In English.</td>
<td>23 Regulations, 1 Bill yet to pass (Massage Therapy).</td>
<td>22 Acts, of which 21 falls under the RHPN. Paramedic workers do not fall under RHPN but separate legislation.</td>
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<td>26 Professions Covered (Nurse Practitioner, Licensed Practical Nurses and Registered Nurses Under One College; Audiologists, Speech Language Pathologist And Hearing Aid Practitioners Under 1 College; Dental Assistants and Dentists under 1 College)</td>
<td>28 Self-Regulated; 5 dental health-related professions covered under 1 act; Audiologists and Speech Language Pathologists under 1 College; Nurse Practitioners and Registered Nurses covered under 1 act.</td>
<td>24 Professions Covered (Nurse Practitioner And Registered Nurses Under 1 College; Audiologists and Speech Language Pathologists under 1 College)</td>
<td>29 Professions Covered (Nurse Practitioner And Registered Nurses Under 1 College)</td>
<td>25 Professions Covered (Nurse Practitioner And Registered Nurses Under 1 College; Audiologists and Speech Language Pathologist Under 1 College)</td>
<td>24 Professions Covered (Nurse Practitioner And Registered Nurses Under 1 College; Audiologists, and Speech Language Pathologists grouped together in the HPA framework)</td>
<td>18 Professions Covered (Nurse Practitioner And Registered Nurses Under One College; Dental Hygienists, Dental Assistants and Dentists fall under one regulation)</td>
<td>24 Professions Covered (Nurse Practitioner And Registered Nurses Under 1 College; Audiologists, and Speech Language Pathologist Under 1 College). Of these, 7 profession fall under the HPA (Audiologists and Speech Language Pathologists grouped together in the HPA framework).</td>
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<tr>
<td>Sources</td>
<td>British Columbia</td>
<td>Alberta</td>
<td>Saskatchewan</td>
<td>Manitoba</td>
<td>Ontario</td>
<td>Quebec</td>
<td>New Brunswick</td>
<td>Nova Scotia</td>
<td>Prince Edward Island</td>
<td>Newfoundland &amp; Labrador</td>
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</table>
### Appendix D

**Summary of Discipline Hearings for 2012**

<table>
<thead>
<tr>
<th>College</th>
<th>Discipline Hearings 2012</th>
<th>Cases that had Elements of Financial Conflict of Interest</th>
<th>Orders</th>
<th>Penalty</th>
</tr>
</thead>
<tbody>
<tr>
<td>CASLPO</td>
<td>0</td>
<td>not applicable</td>
<td>not applicable</td>
<td>not applicable</td>
</tr>
<tr>
<td>CNO</td>
<td>45</td>
<td>5 (11%)</td>
<td>Reprimands, Temporary registration suspension or resignation, Terms, conditions, limitations</td>
<td>Yes</td>
</tr>
<tr>
<td>CPSO</td>
<td>37</td>
<td>4 (11%)</td>
<td>Temporary registration suspension, Terms, conditions, limitations</td>
<td>Yes</td>
</tr>
<tr>
<td>CPO*</td>
<td>3</td>
<td>1 (33%)</td>
<td>Reprimands, Temporary registration suspension, Terms, conditions, limitations</td>
<td>Yes</td>
</tr>
</tbody>
</table>

*CPO reporting time period was April 2012- March 31, 2013*
## Appendix E

### Table E1

College Documentation Related to Conflict of Interest

<table>
<thead>
<tr>
<th>College</th>
<th>Code of Ethics</th>
<th>Professional Misconduct Regulation</th>
<th>Conflict of Interest Regulation, Stds or Guidelines</th>
<th>Areas addressed in documentation</th>
<th>Educational Materials/Learning Modules that address Conflict of Interest</th>
</tr>
</thead>
</table>
| CASLPO  | Code of Ethics By-Law 2011-8, section 4.2.6 broadly addresses conflict of interest | ASLPA, 1991, O.Reg. 7419/93 Conflict of interest noted as Noted as, “Practising the profession while the member is in a conflict of interest” (sec. 11, s.17). | Proposed Regulation for Conflict of Interest, posted 1996 | Benefit included gift, advantage or emolument direct or indirect and included: rebate, credit, discount on or reimbursement of cost of goods/services; receipt of goods at less than market rates, payment of debt or reduction of financial obligation; receipt of consultation/other fee for services; receipt of loans that are not properly documented and meeting criteria (including fixed interest rates), receipt of credit related to referrals (s1, CASLPO, 1996)  
“It is a conflict of interest for a member to participate in any professional activity where the member’s personal or financial considerations compromise or may compromise the member’s judgment in that professional activity, or where such involvement may appear to provide the potential for the member’s professional judgment to be compromised.” (s.4, CASLPO, 1996), Industry - receiving any benefit | Practice Guide/Standards Materials - proposed regulation provides specific directives when professional sells products to clients/patients (Proposed Regulation for Conflict of Interest, 1996); Article, "Opening a private practice" (Carling-Rowland & Bock, 2012); Social Media e-learning module, "Pause before you Post" (CASLPO, n.d.b). |
Areas addressed in documentation

- directly/indirectly - related to products that they may prescribe, sell or promote products. Included in definition of benefit were interest free loans. (s.5.1, CASLPO, 1996)
- A member may receive a salary from an equipment manufacturer providing they do not sell directly to patients. (s.5.2, CASLPO, 1996).
- Provision of services independent to those offered to the patient through employer: Where a member is employed by or with a company, institution, agency or other organization that provides health related services to the public providing services directly to a patient independent of their employer without full disclosure, providing alternative options, pricing, etc. (s.6, CASPO, 1996)
- Personal interests: In a situation where the member or a related person to the member or a related corporation to the member receives, or could potentially receive, any direct or indirect benefit from the sale or supply of such product.
<table>
<thead>
<tr>
<th>College</th>
<th>Code of Ethics</th>
<th>Professional Misconduct Regulation</th>
<th>Conflict of Interest Regulation, Stds or Guidelines</th>
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</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td>refers a patient or client to a clinic or other facility in which the member, or a related person to the member, or a related corporation to the member, has any interest, or from which any such person receives, or could potentially receive, any benefit, directly or indirectly (s.7, CASLPO, 1996)</td>
<td>Prescribes &amp; sells a product - needs to provide alternatives to the patient and be transparent during the process. Any personal proprietary interests should also be disclosed to the patient (s.8, s.10, CASLPO, 1996). Referrals - to someone/place/thing where there is a benefit to them or pay (s.10, CASLPO, 1996). Research without full transparency - disclosure to nature of research, informed consent signed, option to opt out and there should be no impact on services based on participation (s.11, CASLPO, 1996).</td>
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<tr>
<td>College</td>
<td>Code of Ethics</td>
<td>Professional Misconduct Regulation</td>
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<tr>
<td>CPSO</td>
<td>None directly by the college (college refer members to Cdn Medical Association 2004 Code of Ethics)</td>
<td>Medicine Act, 1991, O. Reg. 856/93. Noted as &quot;Having a conflict of interest (s.5).&quot;</td>
<td>Medicine Act, 1991, O. Reg 114/94</td>
<td>Benefit included gift, advantage or emolument direct or indirect and included: rebate, credit, discount on or reimbursement of cost of goods/services; receipt of goods at less than market rates, payment of debt or reduction of financial obligation; receipt of consultation/other fee for services; receipt of loans that are not properly documented and meeting criteria (including fixed interest rates), receipt of credit related to referrals (s15, O.Reg.114/94) Referrals - benefit associated (payment, loan reduction) receives any benefit, directly or indirectly, from, (i) a supplier to whom the member refers his or her patients or their specimens, or (ii) a supplier who sells or otherwise supplies any medical goods or services to the patients of the member Rent- where the member rents space to the supplier except where the rent is normal and not related to volume of business - rents from a supplier except where rent is normal</td>
<td>Regulations posted. Practice Guide Materials provide general information, no specific examples. Policy documents: COI: recruitment of subjects in research studies (CPSO, 2006a); policy on relationships with pharmaceutical (CPSO, 2014).</td>
</tr>
<tr>
<td>College</td>
<td>Code of Ethics</td>
<td>Professional Misconduct Regulation</td>
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<td></td>
<td>Educational Materials/Learning Modules that address Conflict of Interest</td>
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</table>

- the amount of the rent is not related to the referral of patients to the landlord;
- Selling or otherwise supplies any drug, medical appliance, medical product or biological preparation to a patient at a profit, except, in the case of an emergency or alter source n/a, of in the case of allergy prep if conditions met (s.16.O Reg/114.94)
- In addition, the total fees charges if a member sells a an allergy preparation do not exceed the cost of the preparation and the fee for the professional component, for the member’s review of the case, for the prescription of the material and for the general supervision of the member’s laboratory in preparing the material d. (s. 16, O. Reg. 114/94)

If a member order a diagnostic or therapeutic service to be performed by a facility in which there are personal interests (either directly or through family interests), the member is in a conflict of interest unless: these personal interests are disclosed to the patient
<table>
<thead>
<tr>
<th>College</th>
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</thead>
<tbody>
<tr>
<td>CNO</td>
<td>“Ethics Practice Standards and Professional Standards (2002)”, &quot;Practice Standard Ethics (2009)”, the &quot;Practice Standard: Professional Standards, revised</td>
<td>Nursing Act, 1991, O. Reg. 799/93 Professional Misconduct Regulation, Includes section 26: &quot;Practising the profession while the member is in a conflict of interest.&quot;</td>
<td>The Reference document Professional Conduct Professional Misconduct (2013a) refers to the proposed Conflict of Interest Regulation under the Nursing Act, but this was</td>
<td>Conflict of interest: &quot;The primary focus of the nurse’s relationship with clients is meeting the clients’ health care needs. A conflict of interest exists when a nurse’s personal interests could improperly influence her/his professional judgment or conflict with her/his duty to act in the best interest of clients.&quot; (p. 13) from reference document Professional Conduct Professional Misconduct (2013a). Personal interests can be monetary, including cash, gifts and rewards; or may provide other personal benefits to the</td>
<td>Reference document Professional Conduct - Professional Misconduct (2013a); Nurse Practitioner's Standard (2011a); The Therapeutic Nurse-Client Relationship Practice Standard (CNO, 2006a) and associated on-line learning module (CNO, 2012d); Online video &quot;One is one too Many&quot; (CNO, 2012b); &quot;Ask Practice“ section of website addressed selling products (CNO, 2012c); The Practice Guideline &quot;Independent Practice, Revised 2013 (CNO, 2013a); CNO webcast on maintaining professional boundaries (CNO, 2011b).</td>
</tr>
</tbody>
</table>

before a service is performed; or the facility is owned by a corporation that is publicly traded and not wholly owned/controlled the member (or family). If a member has a direct (or via family) proprietary interest in a facility where diagnostic or therapeutic services are performed they are to inform the College of the details of the interest. (s.17, O. Reg. 114/94).
<table>
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</thead>
<tbody>
<tr>
<td>2002&quot; (2002), COI not explicitly mentioned. In the Professional Standards under &quot;Relationships&quot; indicators include putting pt needs ahead of personal needs, as well as, ensuring needs of patient remain the focus.</td>
<td>not available at the time of the study.</td>
<td>nurse Soliciting Business: a nurse soliciting business from clients (side business of self or relative) Promoting Personal Interests: Including Commercial products or services. Endorsements - using credentials to lend credibility to a commercial product, product line or service. Knowingly denying or delaying more urgent care to one client in favor of another because of non-health care considerations Lend/Borrow Money: Nurses should never lend money to or borrow money from clients (may create undue influence). Treatment Decisions: nurses cannot make decisions about personal care, admission to health care facilities or treatment on behalf of clients. The exception to this is if the nurse has been appointed by the court as the client’s guardian under the Substitute Decisions Act. Influence the client to do anything with</td>
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<tr>
<td>College</td>
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<tr>
<td>CPO</td>
<td>Standards for the Code of Ethics (2013e) does not include conflict of interest</td>
<td>Physiotherapy Act, 1991, O. Reg. 388/08 Noted as “Practising the profession while the member is in a conflict of interest.” (s. 5).</td>
<td>Practice Standard: “Standard for Practice Standard – Conflict of Interest” (CPO, n.d.a)</td>
<td>&quot;Standard for Practice – Conflict of Interest” provided a specific definition for conflict of interest, “A conflict of interest arises when a registrant puts him or herself into a position where reasonable people, including patients, could conclude that his or her professional judgment is influenced by financial or personal benefit. In fact, even if a registrant’s judgment is not actually compromised, there may be concerns over conflict of interest. If circumstances cause a reasonable person to suspect that the registrant’s judgment is affected, this constitutes a potential conflict of interest”. (CPO, n.d.a). The CPO’s guide to the standards for professional practice – Advertising; Fees &amp; Billing; and Conflict of Interest, 2009 (2009) also defined financial conflict of interest. The registrant’s private or personal interest directly or indirectly conflicts, may conflict, or may reasonably be perceived as conflicting with his or her duties or responsibilities</td>
<td>In addition to the practice standard &quot;Conflict of Interest&quot; (CPO, n.d.a); The Guide to Advertising, Fees and Billing and Conflict of Interest (CPO, 2009); The Practice Standard and Guide to Therapeutic Relationships and Professional Boundaries (CPO, 2005); &quot;Practice Scenarios&quot; section of website (CPO, n.d.d; n.d.e); &quot;Top Practice Questions&quot;, video posted on website (CPO, 2013d); Jurisprudence, Module I (CPO, 2006); Ethics E-learning module, chapter 3 - Referral Arrangements (CPO, n.d.b).</td>
</tr>
<tr>
<td>College</td>
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<td>as a healthcare professional; or the registrant’s private or personal interest directly or indirectly influences, may influence or may reasonably be perceived as influencing the exercise of the registrant’s professional duties or responsibilities. In addition to the elements included in the definition, conflict of interest may also arise in many other circumstances that include research; the employment of a family member; one’s strongly held personal view; the receipt of benefits from suppliers of equipment and supplies; or the referral of a patient seen in one setting to another setting in which the registrant works (CPO, 2009) Product Endorsement/Recommendation - where there is a personal benefit, unless patient is informed and alternatives are provided. They need to assure patient that their level of care won't change if they don’t purchase from them Recommending - to their patients to seek services from another business where the member has a personal interest. Volume-Related Agreements - receives a</td>
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<tr>
<td>College</td>
<td>Code of Ethics</td>
<td>Professional Misconduct Regulation</td>
<td>Conflict of Interest Regulation, Stds or Guidelines</td>
<td>Areas addressed in documentation</td>
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<td>benefit that is related to the volume of the services provided, the number of referrals made, the profit made or the amount of the fee charged</td>
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<td></td>
<td>Referrals - includes paying or providing benefit for referrals or receiving benefit for referrals.</td>
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<td>Treating Related Persons - can only be done if at no charge and relationship is disclosed in any reports sent to other parties</td>
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</tbody>
</table>
### Appendix E

#### Table E2

**Areas of Potential COI by Practice Variable**

<table>
<thead>
<tr>
<th>Practice Variable</th>
<th>Factors contributing to potential COI</th>
<th>Areas noted by College key informants</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Nature of Work</strong></td>
<td>- Intimacy of work – long duration, close contact, often emotional</td>
<td>- CNO</td>
</tr>
<tr>
<td><strong>Decision Making Authority</strong></td>
<td>- Determining number of treatments/appointments necessary</td>
<td>- CASLPO, CPSO, CPO, CNO</td>
</tr>
<tr>
<td></td>
<td>- Self-referral</td>
<td>- CASLPO, CPSO, CPO, CNO</td>
</tr>
<tr>
<td></td>
<td>- diagnostics &amp; treatment</td>
<td>- CPSO</td>
</tr>
<tr>
<td></td>
<td>- Prescribing and selling products</td>
<td>- CASLPO</td>
</tr>
<tr>
<td></td>
<td>- Recommending and selling products</td>
<td>- CPSO, CPO, CNO, CASLPO</td>
</tr>
<tr>
<td></td>
<td>- Industry relationships</td>
<td>- CASLPO, CPO, CPSO</td>
</tr>
<tr>
<td></td>
<td>- Rental Agreements based on business volumes or referral arrangements</td>
<td>- CPSO, CPO</td>
</tr>
<tr>
<td><strong>Work Environment</strong></td>
<td>- Retail/private environment, healthcare seen as a business</td>
<td>- CASLPO, CPO</td>
</tr>
<tr>
<td></td>
<td>- Employer- Employee relationship – different objectives if employer not health related (e.g. hire for exams, strictly focusing on business objectives)</td>
<td>- CASLPO, CPSO, CNO</td>
</tr>
<tr>
<td></td>
<td>- Working in an environment where policies or business goals may differ or impact professional obligations or practice</td>
<td>- CASLPO, CPO</td>
</tr>
<tr>
<td></td>
<td>- Culture of work environment may positively shape and influence the professional</td>
<td>- CASLPO, CPO, CNO</td>
</tr>
<tr>
<td></td>
<td>- Team Environments &amp; Hospital Environments – more collaboration, structural support, more tools to assist in dealing with issues and barriers to treatment.</td>
<td>- CASLPO, CPSO, CNO, CPO</td>
</tr>
<tr>
<td>Practice Variable</td>
<td>Factors contributing to potential COI</td>
<td>Areas noted by College key informants</td>
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<tr>
<td></td>
<td>• Independent practices have less checks and balances – (but one shouldn’t assume that there would be an issue).</td>
<td>• CPSO, CNO, CPO</td>
</tr>
<tr>
<td></td>
<td>• Working in isolation – lack of observability a risk factor, no data collection</td>
<td>• CPSO, CNO, CPO</td>
</tr>
<tr>
<td></td>
<td>• Providing care in home setting vs institution – less visibility, greater chance of vulnerability for both parties</td>
<td>• CNO</td>
</tr>
<tr>
<td>Remuneration</td>
<td>• Fees Charged for Services. Noted that College’s role was not to set or monitor fees charged.</td>
<td>• CASLPO, CPSO</td>
</tr>
<tr>
<td></td>
<td>• Selling products in addition to providing services</td>
<td>• CASLPO, CPO, CPSO, CNO</td>
</tr>
<tr>
<td></td>
<td>• Appropriately Billing for Third Party Services</td>
<td>• CASLPO, CPO, CNO</td>
</tr>
<tr>
<td></td>
<td>• Change in funding, changes locus of accountability</td>
<td>• CASLPO</td>
</tr>
<tr>
<td></td>
<td>• Providing services privately after publicly funded services end (how this is procured, e.g. solicitation)</td>
<td>• CASLPO, CPO, CNO</td>
</tr>
<tr>
<td></td>
<td>• Providing privately-funded and publicly-funded services – with the receipt of publicly-funded services contingent upon the patient committing to the privately-funded services</td>
<td>• CPSO</td>
</tr>
<tr>
<td></td>
<td>• Bulk services</td>
<td>• CPO</td>
</tr>
<tr>
<td></td>
<td>• Benefit related to referrals (e.g. payment for referrals, rental agreements related to referrals, etc.)</td>
<td>• CPSO, CPO</td>
</tr>
<tr>
<td></td>
<td>• Publicly funded services were seen to reduce the issue of COI (unless there was a mix of public and private funding where the crossover or division between the two might introduce complications)</td>
<td>• CPSO, CNO, CPO, CASLPO</td>
</tr>
</tbody>
</table>