The Slippery Slope of Nursing Regulation: Challenging Issues for Contemporary Nursing Practice in Canada

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Abstract
This paper provides readers with an overview of some contemporary issues associated with nursing regulation and scope of practice in Canada. Issues with the current organizational structure of nursing regulation and its impact on nursing advocacy in Canada are explored. An argument is presented that nursing regulation needs more consistency and collaboration in Canada. Several examples are used to illustrate this. Fragmentation of regulation is explored and regulatory disciplinary processes are examined in relation to some countries with similar professional structures. The impact of changes in the regulatory status of complementary and alternative health practitioners on nursing is also critiqued. We provide recommendations for future policy and practice to better pave the way for nursing scope and regulatory clarity.

Introduction
Nursing regulation is a complex issue, and some recent developments in healthcare regulation in Canada are likely to significantly impact the future development and status of the nursing profession within the healthcare system. Under the Canadian Constitution, healthcare primarily falls under the authority of the provincial/territorial governments, and they retain the power to pass laws governing the financing and delivery of health services to their citizens. Provincial/territorial governments exercise considerable authority over the delivery of services, and there are widely differing regional variations (Duncan et al. 2010; Health
This means that instead of a national centrally administered system that is uniform across the country, Canada has a number of provincial/territorial healthcare systems that differ both in structure and operation. The regulation of nurses includes licensing, the creation of professional standards, enforcement of those standards, disciplinary measures and nursing education approval. It also involves the regulatory positioning of nursing within a multidisciplinary health professional team. The goal of Canadian nursing regulatory bodies is to protect the public by ensuring uniform, high-quality regulatory practices (Canadian Nurses Association 2007). However, the standardization of nursing regulatory practices (to ensure consistency across provinces and territories) is challenged by ongoing fragmentation, and healthcare systems’ workforce redesigns, where legal boundaries and scope clarity are blurred (MacPhee 2014). This diversity of regulatory systems and recent changes creates an environment for nursing that may well represent the start of an erosion of nursing services and public well-being within Canadian healthcare. There is a need for regulation that is more consistent and collaborative and clearly demarcates professional nurses’ unique contributions to safe, quality care delivery, while recognizing the pressing needs of today’s healthcare systems.

**Background**

The Registered Nurses (RNs) receive their legal authority to use the title “Registered Nurse” or RN through individual provincial/territorial legislation and through regulation by the various provincial/territorial colleges and associations in each province or territory. A typical example is British Columbia (BC), where the highest level of statutory nursing regulation is identified under the BC Health Professions Act. This Act sets out the legal framework for 26 named health professional bodies to regulate their own professions. In addition to nursing, other professions include physicians, midwives, pharmacists, physiotherapists and some complementary and alternative medicine (CAM) practitioners (e.g., naturopaths). To legally practice, healthcare professionals must register and meet the conditions of registration imposed by their specific regulatory body (usually a college). Records are maintained through these individual institutions, whose primary function is to ensure that their members are qualified, competent and following clearly defined standards of practice and ethics.

Overall, the key principles that underpin the statutory professional regulation of healthcare may be considered as: (a) maintaining the safety and quality of the care that patients receive from health professionals; (b) sustaining, improving and ensuring the professional standards of health professionals and identifying and addressing poor practice or bad behaviour; (c) providing systems and legislation that sustain the confidence of both the public and the healthcare professions through demonstrable impartiality; and (d) ensuring that the integrity of health
professionals is sufficiently flexible to effectively meet the different health needs of the public and healthcare approaches can adapt to future changes and demands (Hewitt 2007; ICN 2014; Walsh 2012; WHO 2002).

To ensure that regulatory standards are effective, the regulatory process itself needs to be seen as impartial and independent from the government, the professionals themselves, employers, educators and all the other interest groups involved in healthcare (Hewitt 2007).

Historically, controlling the quality of healthcare practices and interventions was one of the key original motivators behind the establishment of regulation and licensing for physicians, nurses, dentists and other health professionals at the turn of the past century. Orthodoxy in North American healthcare only appeared during the late 19th century through new processes of regulation linked with structured education (Bivins 2007). Prior to this, there was a plethora of dubious and harmful health interventions being promoted by many different unlicensed practitioners. These ranged from doctors and nurses to phrenologists and mesmerists, prescribing such interventions as radium toothpaste, morphine baby soothing syrup, asthma cigarettes and magnetic therapies: all with practically no government oversight (Offit 2013).

Therefore, to maintain the quality of healthcare and public safety, regulation is not simply a question of colleges supervising the professional character of its members. There is also a need to monitor the quality of healthcare practices and interventions, and to ensure the educational preparation and scope of practice of practitioners is appropriate to maintain public confidence and safety, and demonstrate impartiality in this process. The following sections highlight the many considerations and implications related to the roles and responsibilities of Canadian nursing regulation.

**Nursing Regulation and Professional Representation**

Today the distinction between professional regulation and professional advocacy, support and promotional activities has become somewhat fragmented within nursing and other health disciplines (Spenceley et al. 2006). The ICN (2014) identifies three pillars of the nursing profession: regulation, association and union. This separation of roles does seem logically appropriate, given the need for the regulatory body to be seen as impartial (Hewitt 2007). However, there does appear some differentiation on how these different elements are managed across Canada. Recognition of these distinct pillars of governance has led to a separation of regulatory responsibilities and professional activities, such as public relations, policy work and advocacy in many provinces. In 2010, in BC, the College of Registered Nurses of British Columbia (CRNBC) withdrew its membership from the national
nursing professional association (the Canadian Nurses Association [CNA]), citing a conflict of interest (CRNBC 2010). The CRNBC identified its only functions as regulatory in nature, overseeing program approval, public protection, standards of practice, disciplinary procedures and maintaining registration records. The Association of Registered Nurses of British Columbia (ARNBC) was then formed to take on the professional association role with support from the CNA.

However, not all nursing professional bodies in Canada have made this functional division so distinctly. In Alberta, the College and Association of Registered Nurses of Alberta (CARNA) identify that “providing leadership in promoting and celebrating excellent nursing practice” is a part of their mandate, suggesting this body retains some aspects of a nursing advocacy function (CARNA 2014). Some provinces may not have sufficient membership to justify separating these functions. However, where separation has occurred, collaboration between these bodies and with the government is essential to promote cohesive healthcare governance. A good example of this interface between professional representation and public protection is that of nurses and substance abuse. Ineffective policies on this issue have been associated with punitive actions that have impeded impaired nurses’ applications for assistance with their addictions, while early intervention is associated with full recovery from addictive disorder and successful return to practice (Monroe and Kenaga 2010). In BC, confidential, non-punitive support for nurses has been made possible by a collaborative arrangement between the nurse, the CRNBC, the employer and the BC Nurses’ Union (BCNU). The Licensing, Education, Advocacy and Practice (LEAP) program has been a collaborative success since 1988 (BCNU 2014). There may be clear distinctions, therefore, between professional representation and public protection, but because of the complexities of today’s healthcare systems, collaboration across these key stakeholder groups is required. Also, without clear communication and a role in influencing policy with regard to professional status, there is a risk that regulatory bodies may become little more than policemen enacting provincial government policy to discipline criminal or incompetent behaviours, rather than protecting the public by improving professional standards and challenging poorly designed policy.

**Disciplinary Practices**

As the primary role of regulatory bodies is public protection, there are established regulatory arrangements to deal with complaints and disciplinary procedures for nurses across Canada. A reasonable assumption is that these processes operate similarly across the provinces and territories and, in general, outcomes should be comparable, and also comparable to countries with similar professional structures (Kenward 2008). Nevertheless, these assumptions are challenged when we look at reports of disciplinary actions. In (approximately 56,000 RNs), for example, of the
35 disciplinary actions reported in 2012, no RNs were permanently removed from the register, and only two were temporarily suspended (OIIQ 2013). In Ontario, in 2012, out of about 60,000 RNs there, 35 reprimands/suspensions occurred, six RNs had their licenses permanently revoked and two resigned following investigations (CNO 2013). In BC (approximately 36,000 RNs), about 37 nurses a year are suspended from the CRNBC professional register, but only one person has been permanently removed in the past decade. The CRNBC states that “the majority of complaints are resolved through a consensual resolution process” and prefers this approach to formal disciplinary hearings (CRNBC 2009). Suspension means these practitioners are eligible to regain their registration at some point (although conditions may apply). Collaborative support programs, such as the BC LEAP program (BCNU 2014), may decrease reported violations and license removals, but do not necessarily explain the variability seen among Canadian nursing regulatory bodies, or the number differences between the CRNBC, for instance, and the UK and California in the USA. Reasons for suspension in several provinces include actions involving criminal offences (such as theft or violence), which often result in permanent removal from the register in many countries to minimize risk to the public, and maintain public credibility with the disciplinary process. For example, if we compare to California, there were 26 RNs’ licenses permanently revoked in June 2013 alone (CBRN 2013). Very similar numbers to those in the USA are found in the UK (NMC 2013) and equate to about 0.1% of the RN population.

In broad statistical terms, differences in numbers of RN disciplinary actions seen across the country give rise to concerns of face-value credibility of the complaints and disciplinary procedures across provinces and territories. Overall, considering the comparative populations, we should at least be concerned with whether or not dissimilar disciplinary practices exist. Diverse disciplinary outcomes across Canada may not promote national confidence in the profession’s ability to regulate itself.

**Disjointed Nursing Regulation**

Unlike many other health professional disciplines such as physicians, nursing in Canada is divided up between a variety of regulators. There are three regulated groups of nurses in Canada: RNs, licensed practical nurses (LPNs or registered practical nurses [RPNs] in Ontario) and registered psychiatric nurses. We also have two categories of advanced practice nurses, nurse practitioners (NPs) and clinical nurse specialists, who are also RNs. Registered psychiatric nurses represent the largest group of mental health professionals, but are only found in the provinces of BC, Alberta, Saskatchewan, Manitoba and Yukon Territory (CIHI 2012). These professional categories of nurses are separately identified with individual provincial legislation. For example, under the BC Health Professions Act,
these nursing groups are separately licensed and regulated with completely different educational preparation programs and educational requirements for each of them.

In BC, RNs and NPs are regulated by the CRNBC, while registered psychiatric nurses are regulated by the College of Registered Psychiatric Nurses of British Columbia, and LPNs are regulated by the College of Licensed Practical Nurses of British Columbia. Conversely, in Ontario, RNs and RPNs are regulated by the College of Nurses of Ontario (CNO). In Saskatchewan, there is the Saskatchewan Registered Nurses Association, the Registered Psychiatric Nurse's Association of Saskatchewan and the Saskatchewan Association of Licensed Practical Nurses. This alphabet soup of nursing professional regulation continues throughout Canada with over 26 different governing bodies regulating professional nursing practice. The end result is that these many regulatory bodies represent relatively small numbers of nurses (i.e., RNs, LPNs/RPNs, registered psychiatric nurses) who are siloed from each other. The CARNA, for example, has just over 30,000 RNs on its register, while CRNBC has approximately 36,000 RNs. This compares to 670,000 RNs and midwives in the UK, all licensed under a single Nursing and Midwifery Council (NMC) or 300,000 RNs registered in California under the Board of Registered Nursing – State of California. As professional nurses (in all their forms) make up the majority of healthcare practitioners in Canada by far, the current system confounds a systematic unified voice of nursing, weakens nurses’ political influence in the healthcare delivery and regulation and results in an inefficient use of resources. In recognition of this issue, the CNA has been working with provincial/territorial regulatory bodies to develop a national regulatory policy that “ensures a coordinated regulatory approach that enhances accountability to the public and promotes the mobility of nurses (RNs) within Canada” (CNA 2007: 2). Also, the Canadian Council of RN Regulators (CCRNR) was formed in 2011 to bring RN regulators together and focus on excellence in regulation (CCRNR, 2011).

**Multiplicity in Nursing Education, Standards, Competency and Scope of Practice**

All regulated nursing groups in Canada are required to meet the basic professional standards and competency requirements of their respective regulatory bodies. Nurse competencies refer to professional knowledge, skills and judgment. The three regulated nursing groups within Canada learn from the same body of nursing knowledge, but distinctions are made between the different groups in terms of the depth, breadth and focus of their educational preparation. Scope of practice directives specifies the entry-level competencies and level of education required for each regulated group (Black et al. 2008; CNA 2007). See Table 1 for a summary. The majority of provinces and territories require a bachelor’s degree for RN and registered psychiatric nurse entry-to-practice (CNA 2014). In Quebec, the
Quebec Order of Nurses (OIIQ) recently moved to require all nurse education to be baccalaureate-level by 2014, allowing for a five-year grace period for nurses to advance from their current diploma requirement (OIIQ 2012). This trend towards higher educational preparation in professional nursing is well-established and mainly driven by the increasing complexity of technical healthcare and care delivery management for an aging population with more multifaceted care needs. It is also a common trend outside of Canada. For example, in the UK, nurse education moved to a national degree level entry in 2011 (NMC 2010) following the guidance of the European Tuning project (EU 2009). Clinical and academic hours in programs across Europe are also now standardized at a minimum of 4,600 hours of training including 2,300 hours of clinical experience as specified in European Union (EU) Directive 2005/36/EC. Higher educational preparation is argued to provide the critical thinking skills necessary to make independent patient care decisions and manage complex care scenarios (Boblin et al. 2008; Tanner 2006). However, RN program length and number of clinical hours required to qualify remain very diverse across Canada (and in many provinces, minimum clinical hours are not mandated by the regulator). For example, in Manitoba, a minimum of 1000 clinical practice hours are mandated in all provincial programs (CRNM 2013). While in Ontario, the York University/Seneca College BScN program requires 1,700 hours of practice (Seneca College 2014). Also, the degree of simulated experience permitted to be considered as clinical practice also has no current national standard. This makes the level of preparatory experience across Canada quite diverse. Furthermore, many Canadian qualified RNs are now ineligible to work in a European country as an RN without undertaking another initial preparatory program, as they do not meet the latest minimum EU pre-registration experience criteria (EU 2009).

Table 1. Nursing governance organizations in Canada

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<thead>
<tr>
<th>Province/Territory</th>
<th>Nursing Categories</th>
<th>Regulatory Bodies</th>
<th>Independent Professional Association*</th>
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<tbody>
<tr>
<td>Alberta</td>
<td>Registered nurse</td>
<td>College and Association of Registered Nurses of Alberta</td>
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<td></td>
<td>Nurse practitioners</td>
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<td></td>
<td>Registered psychiatric nurses</td>
<td>College of Registered Psychiatric Nurses of Alberta</td>
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<td></td>
<td>Licensed practical nurse</td>
<td>College of Licensed Practical Nurses of Alberta</td>
<td>-</td>
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<tr>
<td>Province/Territory</td>
<td>Nursing Categories</td>
<td>Regulatory Bodies</td>
<td>Independent Professional Association*</td>
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<tr>
<td>British Columbia</td>
<td>Registered nurse</td>
<td>College of Registered Nurses of BC</td>
<td>Association of Registered Nurses of BC (ARNBC)</td>
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<td></td>
<td>Nurse practitioner</td>
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<tr>
<td>Registered psychiatric nurse</td>
<td>College of Registered Psychiatric Nurses of BC</td>
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<tr>
<td>Licensed practical nurse</td>
<td>College of Licensed Practical Nurses of BC</td>
<td>Licensed Practical Nurses Association of BC</td>
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<tr>
<td>Manitoba</td>
<td>Registered nurse</td>
<td>College of Registered Nurses of Manitoba</td>
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<td></td>
<td>Nurse practitioner</td>
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<tr>
<td>Registered psychiatric nurse</td>
<td>College of Registered Psychiatric Nurses of Manitoba</td>
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<tr>
<td>Licensed practical nurse</td>
<td>College of Licensed Practical Nurses of Manitoba</td>
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<tr>
<td>Newfoundland &amp; Labrador</td>
<td>Registered nurse</td>
<td>Association of Registered Nurses of Newfoundland and Labrador</td>
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<tr>
<td></td>
<td>Nurse practitioner</td>
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<tr>
<td>Licensed practical nurse</td>
<td>College of Licensed Practical Nurses of Newfoundland and Labrador</td>
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<tr>
<td>New Brunswick</td>
<td>Registered nurse</td>
<td>Nurses Association of New Brunswick</td>
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<td></td>
<td>Nurse practitioner</td>
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<tr>
<td>Licensed practical nurse</td>
<td>Association of New Brunswick Licensed Practical Nurses</td>
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<tr>
<td>Northwest Territories &amp; Nunavut</td>
<td>Registered nurse</td>
<td>Registered Nurses Association of the Northwest Territories and Nunavut</td>
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<td></td>
<td>Nurse practitioner</td>
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<tr>
<td>Licensed practical nurse</td>
<td>Northwest Territories Department of Health &amp; Social Services</td>
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<tr>
<td>Nova Scotia</td>
<td>Registered nurse</td>
<td>College of Registered Nurses of Nova Scotia</td>
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<td></td>
<td>Nurse practitioner</td>
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<tr>
<td>Licensed practical nurse</td>
<td>College of Licensed Practical Nurses of Nova Scotia</td>
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<tr>
<td>Ontario</td>
<td>Registered nurse</td>
<td>College of Nurses of Ontario</td>
<td>Registered Nurses Association of Ontario (RNs &amp; NPs) Registered Practical Nurses Association of Ontario (RPNs)</td>
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<td></td>
<td>Nurse practitioner</td>
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<tr>
<td>Registered practical nurse</td>
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LPNs/RPNs receive their theoretical and clinical education through diploma programs of one to two years, typically offered through community colleges (Health Canada 2006). Research in Alberta, Saskatchewan (Besner et al. 2005) and Ontario (Oelke et al. 2008; White et al. 2008) has noted that separation (or siloing) of nurse education programs (i.e., RNs, LPNs/RPNs) and lack of intra-professional training between groups have resulted in the different nursing groups lacking appreciation for each other’s scopes of practice. In many instances, rather than an appreciation of different educational preparation, nursing legislation and

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<tbody>
<tr>
<td>Prince Edward Island</td>
<td>Registered nurse Nurse practitioners</td>
<td>Association of Registered Nurses of Prince Edward Island</td>
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<td></td>
<td>Licensed practical nurse</td>
<td>Licensed Practical Nurses Association of PEI</td>
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<tr>
<td>Quebec</td>
<td>Registered nurse Nurse practitioners</td>
<td>Ordre des Infirmières et Infirmiers du Québec</td>
<td>Association des Infirmières Praticiennes Spécialisées du Québec (NPs)</td>
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<td></td>
<td>Licensed practical nurse</td>
<td>Ordre des Infirmiers Auxiliaries du Québec</td>
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<tr>
<td>Saskatchewan</td>
<td>Registered nurse Nurse practitioners</td>
<td>Saskatchewan Registered Nurses Association</td>
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<td></td>
<td>Registered psychiatric nurse</td>
<td>The Registered Psychiatric Nurses Association of Saskatchewan</td>
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<td></td>
<td>Licensed practical nurse</td>
<td>Saskatchewan Association of Licensed Practical Nurses</td>
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<tr>
<td>Yukon</td>
<td>Registered nurse Nurse practitioners</td>
<td>Yukon Registered Nurses Association</td>
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<tr>
<td></td>
<td>Registered psychiatric nurse Licensed practical nurse</td>
<td>Yukon Department of Community Services</td>
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National Associations
• Canadian Council of Registered Nurse Regulators (CCRNR)
• Canadian Council for Practical Nurse Regulators (CCPNR)
• Registered Psychiatric Nurses of Canada (RPNC)
• Canadian Federation of Mental Health Nurses (CFMHN)
• Canadian Nurses Association (CNA)
• Canadian Association of Schools of Nursing (CASN)

Note: *Excluding unions.
regulation have become focused on differentiation through functionality and identifying tasks performed (Baranek 2005; Basford and Orr 2005). The systematic use of the nursing process, including higher-order assessment, critical thinking, planning and evaluation skills, is argued to better distinguish between these different groups of nurses (Boblin et al. 2008, Tanner 2006). However, there is typically significant overlap in nursing tasks or functions performed by the different nursing groups.

An inability to differentiate clearly between the various scopes of practice among professional nursing groups creates anxiety among nurses and often leads to under- or over-utilization of different nurse classifications (Besner et al. 2005, Oelke et al. 2008). Scope confusion has also been reported to be associated with unsafe and compromised care delivery (Baker et al. 2008) and can lead to negative outcomes when care delivery changes are introduced and team members are not aware of their own and others’ distinct and shared roles and accountabilities. Focus on task performance, in particular, increases scope confusion.

The lack of clear understanding of differences in professional roles contributes to considerable overlap in task performance, underutilization of the health professional workforce, tension in the workplace, less than ideal inter-professional relationships, and potentially the establishment of staff mix models that may not always optimize quality of care or patient safety… Optimizing the contribution of all health professionals requires that each provider demonstrate clear areas of expertise that complement rather than compete with the activities of others (Besner et al. 2005: 22).

Scope of practice is clearly linked to level of formal educational preparation. As the determination of entry-level competencies and subsequent educational program accreditation are under the purview of nursing regulatory bodies, there is, perhaps, a stronger case for creating national regulatory frameworks for the three regulated groups. Better standardization across Canadian regulatory bodies (for RNs, LPNs/RPNs and psychiatric nurses) is important with respect to cross-country efforts to establish “equity, objectivity, equivalency, transparency and consistency” for nursing registration and licensure (Yu 2011: 27). These principles should facilitate nurse mobility within Canada and possibly also improve the efficacy of the review and decision process for internationally educated nurses who are seeking entry to practice in Canada (Blythe and Baumann 2009).

Australia serves as a good example for how to tie nursing regulation, licensure and education to a coordinated national initiative. In Australia, as in Canada, there is a concern for lack of sufficient nurses to care for an aging, increasingly complex
population. To address potential/actual workforce shortages, Health Workforce Australia (2014) developed a multi-pronged strategy to meet population healthcare demands. Australia has two regulated groups of nurses, RNs and enrolled nurses (ENs), who are similar to Canadian LPNs/RPNs. ENs originated in the 1980s to assist RNs with managing patients’ activities of daily living. By the 1990s, ENs were formally incorporated into intra-professional teams, performing generalist nursing functions.

Prior to 2010, each Australian state had a separate regulatory board for RNs and ENs. To standardize RN/EN regulations and clearly distinguish between these two groups, one national registration body, the Australian Nursing and Midwifery Council, created national competency standards for RNs and ENs and an accompanying decision-making framework to guide RN/EN staffing assignments in different practice settings (Chaboyer et al. 2008; Jacob et al. 2013). A complementary educational strategy was introduced in 2010; the development and operationalization of a standardized career/education pathway for ENs. Recognizing the complexities of healthcare delivery, a proactive stance of the Australian Nursing and Midwifery Council has been to create a pathway whereby ENs can proceed to university-level education and eventual RN registration and licensure (Jacob et al. 2013).

Where are we at in Canada? A review of Canadian nursing education in 2004 noted a significant lack of collaboration across education programs between the regulated nursing groups (Pringle et al. 2004). The authors recommended creating councils with representatives from each regulated group to enhance intra-professional education and collaborative practice provincially/territorially and nationally. To date, little development has occurred in this respect.

In Canada, we may want to consider a more national, systemic approach to nursing education, competence, standards and scope of practice, similar to Australia’s strategic workforce initiative. Workforce redesign is commonplace in contemporary healthcare settings in Canada. In a country with rapidly increasing healthcare demands, the main drivers for redesign have been considerations of productivity, efficiency, financial constraints and, in some instances, workforce shortages (Tomblin Murphy and MacKenzie 2013). As nurses comprise the largest proportion of the healthcare workforce, many initiatives have focused on nursing care delivery redesign (Kimball et al. 2007). Similar to Australia, Canada has been experimenting with new care delivery approaches, such as collaborative practice or care delivery teams comprising RNs, LPNs/RPNs and unregulated care aides. To practice collaboratively, team members must know their own scope of practice and the scopes of practice of other team members (Weinberg et al. 2011).
Care needs to be taken in changing scopes of practice: There must be careful deliberation by all parties and sectors involved in quality, safe care delivery. In BC for instance, there is a current initiative to address health professionals’ scope of practice (BC Health Professions Council 2013). The Health Professions Council, at the direction of the Minister of Health Planning, has been reviewing the scopes of practice and the legislative framework for BC health professions. This initiative is proposing a shift from scopes of practice of regulated health professions that are in “exclusive and restrictive terms” to a new regulatory framework where scope of practice statements for health professions are defined in broad, non-exclusive terms. Defined in these terms, aspects of the scope of practice for each nursing group are likely to overlap, or be shared with those of other health professions. The movement towards scope overlap or scope sharing has the potential to generate confusion and anxiety among the different nurse-regulated groups, and even between nurses and other health professionals. We would be wise, therefore, to consider Australia’s systemic strategy that: (a) promotes stakeholder collaboration, (b) clear scopes of practice and (c) an educational/career pathway to generate more RNs to meet complex care needs of an aging population.

The Expansion of Newly Regulated CAM Professions
Nursing regulation takes place in the context of a highly hierarchical multi-disciplinary system where nurses are legally regulated subordinate to other professions. This has been of particular concern with the movement to recognize the value of advanced practice nursing (APN) in Canada and the need to amend legislation and regulatory systems to accommodate APN (Doran et al. 2014; Garrett 2012; Naylor and Kurtzman 2010; Neville and Swift 2012). However, further regulatory concerns arise when we examine the recent increase in newly regulated health professions and their regulatory status in Canada. Over the past two decades, there has been increasing government support for CAM in Canada (Boon et al. 2006). Canadian citizens are great users of CAM therapies (over 50% of Canadians use some form of CAM) and so there is a significant public demand (Boon et al. 2006). However, regulatory problems are now arising in Canada with respect to CAM practitioners and their place within the provincial/territorial healthcare acts relative to nurses.

In BC, for example, under the BC Healthcare Act, nurses are now regulated under naturopaths and are required to take orders from them (CRNBC 2009), while in Ontario, the Nursing Act currently does not allow RNs to take orders from naturopaths (CNO 2012). Naturopaths may employ nurses as privately paid practitioners and utilize them in clinics to manage therapies such IV chelation treatments. First, this is problematic in terms of educational preparation: University-prepared, hospital-trained RNs find themselves regulated under CAM professionals who have non-university and non-hospital-based
professional education and training. Most RN programs in BC are taught at universities and colleges that are members of the Association of Universities and Colleges in Canada (AUCC), which represents public and private not-for-profit universities and university degree-level colleges nationally. In BC, these universities and colleges are established degree-granting institutions under the BC University Act or the BC College and Institute Act. Additionally, all RN students are required to undertake significant hospital-based training in a variety of clinical areas to gain exposure to diverse clinical conditions and health issues. In contrast, the recently opened BC School of Naturopathy (the Boucher Institute) is accredited by the BC Private Career Training and Institutions Agency, whose academic requirements are significantly lower than those of the AUCC. Naturopaths also undertake all of their clinical training under the mentorship of other naturopaths in private clinics, so have minimal exposure to acute care or diverse patient populations. Second in terms of hierarchical status, the legislators (and CRNBC) may have considered the title of naturopathic doctor (ND) in their decision-making here. However, the title of ND is awarded on the basis of accreditation from the Council on Naturopathic Medical Education and the Association of Accredited Naturopathic Medical Colleges (both privately funded US bodies). Despite these very different educational and accreditation standards, the BC Health Professions Council has accepted the ND title. For nurse educators preparing RNs for practice, nurse regulatory accountabilities to CAM practitioners become difficult to rationalize particularly when there is evidence that naturopaths do not adhere to best evidence practices, such as opposition to national immunization policy (Cage 2012; Wilson et al. 2005; Attwood & Barrett, 2001).

There are moves from other CAM practitioners to gain legal recognition and regulatory status across Canada, and how these will be regulated in relationship to nursing has yet to be seen. However, in BC, the educational preparation and new licensing of CAM practitioners seems to reflect historical work practices and perceptions of status (i.e., CAM practitioners might want to employ nurses in their private clinics) rather than systematic analysis of education, training and how regulation should best protect public well-being. So far Ontario has resisted amending its legislation to allow nurses to be directed by naturopaths. Nevertheless, the rise in newly regulated health professions again demonstrates the need for better standardization of regulation (and public protection) at national and provincial/territorial levels in Canada, and the problems inherent with a lack of professional advocacy in the existing fragmented systems.

**The Need for Collaborative Leadership**

Collaborative leadership is needed between nurse regulatory bodies, nurse education programs, nurses’ unions and the government and health authorities. Research on health systems’ transformation and workforce redesign has shown
that collaborative leadership is associated with enhanced stakeholder engagement, better communications, enhanced teamwork and a true collaborative culture (Registered Nurses Association of Ontario 2006; VanVactor 2012). Collaboration means shared problem-solving and decision-making, and collaborative leaders are known for breaking down silos, emphasizing stakeholder interdependence and reinforcing egalitarian approaches to discussing problems and making decisions (Weber et al. 2007). Unfortunately, research has shown that collaboration (leadership, teams, teams, partnerships) within healthcare is often lacking. Those at the top of a hierarchy often make healthcare decisions “because of their level of education, social status and regulatory and financially based decision-making authority” (Weinberg et al. 2011: 716). Commitment to pre-existing hierarchical structures can override more collaborative approaches to problem-solving and decision-making.

Nurse leaders from diverse sectors (e.g., education, administration, government, practice) have a duty to forge collaborative capacity with respect to our profession’s self-regulation. The CNA has begun this collaborative work, for instance, by creating a national framework for APNs (CNA 2008). Frameworks, however, are conceptual, and they must be operationalized. Collaborative partners need to make commitments to develop evidence-based policies and actions that respect their interdependencies and meet super-ordinate goals, such as optimization of nurses’ scopes of practice for the delivery of quality, safe care.

In 2004, first ministers acknowledged the need for closer collaboration among “health, post-secondary and labour market sectors” (Health Canada 2004). A pan-Canadian strategy for collaborative health human resource planning was proposed and adopted by federal and provincial/territorial governments (Health Canada 2007). This strategy assumed that collaboration across sectors would happen. Regan et al. (2009) examined the progress of the collaborative process between just two nursing sectors (practice and education). They highlighted how these two sectors have different cultures that operate under different legislation and different governmental ministries. Rather than enabling closer collaboration across these two sectors, “decisions made by each ministry may be carried out behind closed doors … this top-down, exclusionary approach role models behaviours that then play out in both the educational and practice sectors” (p. 34). This one example illustrates the challenges associated with diverse stakeholder engagement and collaboration.

Conclusions and Recommendations
There is a serious risk we are proceeding down a slippery slope of further regulatory fragmentation and piecemeal governing practices. The complex system of healthcare and nursing regulation in Canada seems to be fragmenting further
across the country each year, and evolving in a way that reflects localized politics and workforce issues, rather than good leadership and systematic planning. Issues of professional regulation and representation have become contentious, professional nursing groups have become siloed, disciplinary procedures are questionably inconsistent and the status of nursing relative to new health professions is problematic. National systematic reform and collaborative leadership at the provincial and federal level are urgently needed to legally and safely optimize our current nursing regulatory structures, rather than further attempts to patch up the existing systems on a localized basis.

Scope clarity, linked to specific educational qualifications, licensure and rigorous regulation, is foundational to quality, safe care delivery. As we delve into issues related to education, competencies and scopes of practice, a national regulatory framework (enacted at provincial/territorial levels) for RNs, LPNs/RPNs and psychiatric nurses would seem worthy of exploration. Three over-arching regulatory frameworks at a national level may promote better communications within the professional nursing family.

Given the primary directives of public protection safety, and risk avoidance in nursing regulation, a more consistent approach to complaints and disciplinary action across Canada seems worthy of exploration. Regulatory processes need to be better harmonized and more transparent across the country, so that the different nursing groups and other healthcare professionals can collaborate more effectively in the delivery of evidence-based care. This requires action and advocacy from national professional nursing organizations at the federal level.

As recommended by Pringle et al. (2004) a decade ago, the creation of councils with representatives from each regulated group to enhance intra-professional education and collaborative practice between provincial nursing regulatory bodies would seem more relevant than ever. The CCRNR, CCPNR CFMHN, RPNC, CNA and CASN (Table 1) need a national forum to work together to address these important issues and explore options for reform alongside our colleagues in other healthcare professions. Given the current expanding healthcare demands, a federal working group to review the roles of all healthcare professions and their regulation across the country would also seem timely.

Without effective collaborative leadership at the highest levels to address these issues, we fear the result of the current ad hoc approaches to healthcare and nursing regulation across Canada will be the accelerated dissolution of nursing in the Canadian healthcare system. The result being that public protection becomes weakened, and that nursing practice itself becomes increasingly devalued in the system. This is unlikely to result in better public healthcare services or protection, so let us not stand by and see that happen.
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