

A Review of Scopes of Practice of
Health Professions in Canada:
A Balancing Act

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Health Council of Canada



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T A K I N G T H E P U L S E

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1.0 INTRODUCTION

Following its first report to Canadians, *Health Care Renewal in Canada: Accelerating Change* (January 2005), and in recognition that health reform efforts are entwined with the availability of appropriately trained health human resources, the Health Council of Canada convened a national summit on health human resources in June of 2003. A gap analysis prepared for the summit participants identified a number of issues relating to scopes of practice. In particular, the analysis highlighted:

- a lack of standardization of scopes, professional titles and licensure criteria for the same profession across jurisdictions;
- inconsistency in scopes in practice, i.e. an underemployment of professionals, the need to expand existing scopes, and a fear of working beyond existing scopes;
- the inconsistency of scope determination between regulatory bodies, employers and actual clinical practice; and
- the requirements of clarity of scopes, the appropriate determination and optimization of skill mix, and the potential liability issues due to new models of delivery and collaborative practice.

Recognizing that a clear understanding of professional scopes of practice is essential to the appropriate deployment of health human resources, the Council contracted a review of general definitions and position papers on scopes of practice.

2.0 METHODOLOGY

A search of the academic and grey literature to elicit general definitions and descriptions was conducted using the following key words: scope of practice, regulated scope of practice, domain of practice, practice role, competencies, entry to practice, scope of employment, scope enactment, patient safety, and evidence-based skill mix. The websites of national and provincial governments, regulatory, certifying and professional associations was also reviewed for relevant statements and position papers. The laws, regulations, and websites for physicians and surgeons, registered nurses, nurse practitioners/registered nurses extended class and pharmacists were examined more closely in British Columbia, Alberta, Ontario and New Brunswick.

3.0 WHY IS A CLEAR STATEMENT OF SCOPE OF PRACTICE IMPORTANT?

Health care is continually changing. Advancements in technologies – in diagnostic tools and practice and in medications – require additional competencies that may not have been envisioned in original definitions of professional-specific practice, requiring the training of new types of professionals or re-trained professionals; for example, cancer care necessitates the expertise of radiation therapists. Indeed one of the reasons given for there being no generally accepted definition of a medical act is the fact that medical knowledge is constantly changing.¹ Meanwhile many procedures formerly done by one type of professional can and are done by others, e.g. immunizations. These changes require the review and modification of existing professional scopes of practice or the development of new role definitions. Meanwhile in recognition of job demands, the evolution of a profession, or for worldwide parity and marketability, some existing professions have increased their entry-to-practice requirements.² Increasing clinical specialization within professions has established subspecialties requiring definition and the various professions take different approaches in how they deal with them. Within medicine each specialty has its own defined scope, whereas nursing on the whole has tried to accommodate nursing specialties within a general scope.

Human resource shortages have led to differences in application of scopes of practice over time and geographically. For example, in response to supply and demand of human resources in other professions, the boundaries of the nursing profession have accordingly expanded and contracted. Recently responding to a need to increase screening for colorectal cancers, nurses in a project were allowed to perform flexible sigmoidoscopies. Despite the safe and effective provision of this procedure, the project was cancelled due in part to professional regulatory and liability uncertainties.³ Similarly the scope of practice of nurses in remote areas is considerably different from their counterpart in urban areas – leading to questions of safety and liability and ultimately, why they are deemed capable of performing tasks in one setting but not another.⁴ Human resource issues have also led to the development of new models of care and collaborative practice, as well as a call for the efficient use of existing resources and an appropriate skill mix. There is considerable overlap in activities that can be performed by different health professionals and scopes of practice are no longer exclusive to a single profession.^{5,6} While the overlap in competencies is considered desirable to allow for flexibility in staffing and the ability to substitute one provider for another, it is difficult for employers to optimize existing human resources and assemble an appropriate skill mix without a clear understanding of the differences in educational preparation of these providers and the translation of this knowledge base into actual practice. Errors in staff mix can lead to clinical errors and possibly adverse patient outcomes. The overlap in activities, moreover, has resulted in role confusion, competition among providers, workplace tension, a lack of trust across professionals, a diminishing of professional identity, and both the under- and over-utilization of professionals. These issues have become prominent as workforce retention and educational recruitment problems.

Collaborative practice and optimal use of teams, as stated above, are recognized elements of health reform and solutions to workforce shortages. Numerous commissions and task forces have cited regulatory barriers as a significant inhibitor to integration and interdisciplinary practice. The effective implementation of collaborative practice not only requires the assembly of the right skill mix where providers' skills complement rather than compete, but also necessitates that professional providers have a clear understanding of their own roles as well as appreciate the capabilities and competencies of others in the team to ensure cooperative and coordinated care.^{7,8} Indeed the 2004 agreement between the Ontario Medical Association and the Ministry of Health and Long Term care defined a collaborative relationship as:

*"A collaborative relationship entails a physician and a RN (EC) [registered nurse (extended class)] using complementary skills to work together to provide care to patients based on mutual trust and respect and an understanding of each others skills and knowledge. This involves a mutually agreed upon division of roles and responsibilities which may vary according to the nature of the practice, personalities and skill sets of the individuals. The relationship must be beneficial to the physician, the RN (EC) and the patient."*⁹

Similarly, the authorized and appropriate delegation of acts from one provider to another under controlled circumstances is a way to ease workforce pressures. However, there is a tension between delegation and boundary protection. Over time there have been changes in the nature of acts that can be delegated. The medical profession has provided guidelines to its members to ensure that the delegation of an act does not compromise the doctor-patient relationship. It has further cautioned, "if medical acts become incorporated into the accepted scope of practice of other disciplines, the boundaries of medical practice may change."¹⁰

As far back as 1993, nurses have been calling for scope definition and redefinition. All member associations of the Canadian Nurses Association (CNA) reported they were experiencing pressure from numerous sources to clarify the scope of nursing practice. The main source of pressure was nurses themselves, who saw the rapid changes taking place in the health system resulting in a need to re-examine their roles. Other groups of health care workers involved in nursing care, nursing assistants and licensed practical nurses, were also pushing for role clarification, believing that they had been restricted in practice because of poor understanding of their roles and the scope of their practice. Those who collaborate with or whose practice overlaps with nursing – e.g. social workers, physicians and podiatrists – were also seeking role clarification with respect to boundary issues. In addition, governments and other employers wanted clarification on the roles of various provider groups and a review of the areas of exclusive practice – their goal being to ensure the most appropriate mix of providers giving care in the most cost-effective way.¹¹

Increasingly, governments and the public are demanding greater accountability of professionals in health care and placing more emphasis on patient safety and quality assurance. Professional accountability necessitates clarity on who can safely do what to

whom under which circumstances. Concern has been expressed by some regulated professions, in particular nursing, on the increasing use of unregulated health care workers without clear definitions of appropriate roles.¹² Delegation of controlled acts as envisioned in legislation can only safely occur if professionals understand the others' roles and trust that the latter can perform the various tasks asked of them. Collaborative practice has raised concerns mainly in the medical community about increased liability. Although the Canadian Medical Protective Association (CMPA) and the Canadian Nurses Protective Society (CNPS) have subsequently come out with a joint statement on liability protection for nurse practitioners and physicians in collaborative practice,¹³ there are unresolved issues in particular around vicarious liability.¹⁴

As one report summarized,

*"A profession's scope of practice encompasses the activities its practitioners are educated and authorized to perform. The overall scope of practice for the profession sets the outer limits of practice for all practitioners. The actual scope of practice of individual practitioners is influenced by the settings in which they practice, the requirements of the employer and the needs of their patients or clients. Although it can be difficult to define precisely, scope of practice is important because it is the base from which governing bodies prepare standards of practice, educational institutions prepare curricula, and employers prepare job descriptions. Consumers, too, need at least a general understanding of scope of practice to know who is qualified to provide different kinds of services."*¹⁵

In a rapidly changing health care environment, effective health human resource planning is dependent on the understanding and agreement of not only who does what but also who should do what and why.¹⁶

4.0 WHO ARE THE RELEVANT PLAYERS IN DETERMINING SCOPES OF PRACTICES AND WHAT ARE THEIR ROLES?

A health professional's scope of practice in theory and in practice is often the product of activities of a number of bodies at both the provincial and national levels. These include ministries of health and education, regulatory bodies, credentialing bodies, national and provincial professional associations, educational bodies, and employers.¹⁷ The actual functions of each of these organizations vary by jurisdiction.

Provincial ministries of health set legislation outlining which professions should be self-regulated and the requirements of self-regulation (quality assurance, patient protection and public accountability, title protection). In some provinces (e.g. Alberta, British Columbia, and Ontario), there is an omnibus act which sets a common framework for the regulation of health professionals and specifies controlled acts which only members of a regulated health profession may perform under the authority of their respective profession-specific Acts.¹⁸

Provincial ministries of education license health education programs in collaboration with ministries of health.

Various national associations, such as the Royal College of Physicians and Surgeons of Canada (RCPSC), the College of Family Practice of Canada (CFPC), and the Canadian Nurses Association (CNA), set standards for training, accredit training programs, and develop examinations used by regulatory colleges as a registration requirement. Accreditation of training programs may be done by a separate body or by a council of the national professional association. Academic accreditation serves to maintain consistent standards across the country and ensure quality. Some programs choose to be accredited by a US body to allow for mobility across North America.

Provincial regulatory colleges set the minimum entry-to-practice standards by determining the academic, practical training activities, and/or registration examination that an applicant must complete to meet the standards of qualification for entry into a health profession. Regulatory colleges typically require that the applicant has completed a program usually accredited by another body (be it the national association or a separate organization that accredits programs in that field), and passes a registration examination set by the regulatory college itself or by another organization such as the national association for the respective profession. With the exception of Ontario and British Columbia, where the regulatory function is separate from the professional function, the provincial or territorial professional associations have been granted responsibility for regulation. The professional associations are seen to act in the best interest of the profession and the regulatory colleges are first to act in the best interests of the public. In Ontario the regulatory function is the responsibility of the Colleges of Physicians and Surgeons of Ontario, the College of Nurses of Ontario, or the Ontario College of Pharmacists; BC uses a similar structure. Although provincial governments write the regulations governing health professions, they do so in consultation with provincial regulatory bodies (and professionals associations, where applicable). Draft regulations are circulated by government for input to the members of the profession in question and members of other health professions, as well as health organizations.¹⁹

Provincial/territorial professional associations also promote and enhance their profession and liaise with their national associations to further the profession.

Employers hire trained professionals and in effect operationalize the professional's scope or a portion of it into practice. Different settings will have different practice requirements. Employers can also induce a redefinition of a profession's scope because of new demands and skill requirements in the workplace.

There is concern that the legislators, regulators, accreditors, certifiers, educators and employers do not work in concert with each other in defining the scope and competencies of professionals, in ensuring that appropriately qualified health professionals are being trained to meet the needs of the workforce, and once in the workforce, allowing them to work to their potential. This has been increasingly of concern with the growing overlap of scopes across professions. A number of recent reports call for greater collaboration among these stakeholders.^{20,21,22}

5.0 WHAT ARE SCOPES OF PRACTICE AND HOW ARE THEY DEFINED?

While the term *scope of practice* is sometimes used in health care research, government policy documents, and professional position papers, no consistent definition was found. These documents more commonly refer to roles, functions, tasks and activities, professional competencies, standards of practice, entry to practice, registration requirements, the practice of medicine (nursing, pharmacy, etc.), domains of practice, scope of employment, or scope enactment.

Some of these concepts are used interchangeably with scope of practice or are inextricably intertwined with it. For example, the Canadian Nurses Association sees the term *role of nursing* as synonymous with a description of its scope of practice. Furthermore, they indicate that scope is related to practice in that the clarification of nursing scope of practice requires a clear definition of what nursing practice entails. Furthermore, they define scope as the “activities nurses are educated and authorized to perform, as established through legislated definitions of nursing practice complemented by standards, guidelines and policy positions issued by professional nursing bodies.”²³

In contrast, the Canadian Medical Association (CMA) sees roles and scopes of practice as distinct. They adopt a definition of role as “a pattern of predictable behaviour(s) developed in response to the demands or expectations of others or the pattern of responses to the persons with whom an individual interacts in a particular situation.” Scope of practice from their perspective refers “predominately to the boundaries of individual practice for each of the health care professional groups. Scope of practice embodies competencies unique to that particular group as well as shared competencies that are common with other groups. With overlapping scopes, the roles that physicians provide – advocates, collaborators, communicators, educators, managers, professionals and scholars – are distinguished from other professions by their medical expertise.”²⁴

Part of the confusion, as stated earlier, stems from the many stakeholders involved in defining a profession and a seeming lack of collaboration and consultation among them.* This is further compounded by the disparities in definitions and legislated approaches across Canada’s 13 jurisdictions. The legislated scopes of practice of nurse practitioners across the country illustrate the problem. Alberta limits the use of NPs to areas that are underserved by physicians, Ontario limits their practice to primary care, and Nova Scotia allows NPs to practice in both primary and specialty care and puts no limit on locale.²⁵

* “The research on setting and changing entry-to-practice credentials shows that one formal process is not used by every profession. While regulatory colleges are mandated to set the minimum entry-to-practice requirements, each college does not prescribe a specific program, but rather requires education accredited by another body, and a registration exam set by another organization. In many cases, these organizations are the respective national bodies. The advantage of requiring programs or using exams set by national bodies is the opportunity to accept applicants from all over Canada, and the ability for registrants to work across the country. However, this means that changes that outside bodies make either to their accreditation process or requirements to write the registration examination will in turn affect the entry-to-practice requirements as determined by the regulatory college. Therefore, entry-to-practice changes can and have been driven by varying organizations (professional associations, educators, and regulatory colleges) and the process used by each profession is unique.” (Ontario Hospital Association, 2003.)

Scope is commonly defined as “an area in which something acts or operates or has power or control” and practice as “the exercise of an occupation or profession”²⁶ These definitions include concepts of a range of activity that can be performed by the member and authority to perform them. Indeed one nursing professional association defines scope of practice as “the range of roles, functions, responsibilities, and activities which members of a discipline are educated and authorized to perform.”²⁷

After reviewing legislation, regulations, policy statements and position papers, a number of interpretations and extrapolations regarding scope appear to emerge. What is clear is that the scope of a profession cannot adequately be found in one document. The extrapolated interpretations offered from all sources include:

- how professionals are defined – who can call themselves a member of the profession, i.e. the eligibility requirements;
- what professionals are trained to do;
- what professionals are authorized to do by legislation;
- what professionals actually do. In the field of nursing, while educational standards and entry-level competencies have changed, clinical competencies and the ability to work to their full scope have not, highlighting the difference between scope of practice (what the professional is trained to do) and scope of employment (what the professional does in the workplace);*
- how a professional does what he/she does. (standards of practice[†] – usually outline the knowledge, skills, judgment and attitudes necessary for safe practice, including accountabilities and responsibilities);²⁸
- what others expect a profession can do (delegation).‡

5.1 Legislation

It is the definition included in professional legislation that establishes the basis for the scope of practice in which a practitioner may engage. The definition is used by employers to define the job and the professional association to hold their members accountable to standards and to take disciplinary action.

A review of the provincial legislation for four regulated professions – physician, registered nurse, nurse practitioner, and pharmacist – yielded considerable variability. Most of the

* In the field of nursing, while educational standards and entry-level competencies have changed, clinical competencies and the ability to work to their full scope have not, highlighting the difference between scope of practice (what the professional is trained to do) and scope of employment (what the professional does in the workplace). (Mann A. Regulatory issues and challenges. Presented at the Canadian Nurses Association Think Tank (Dec 3, 2003). *Patient Safety: Developing the Right Staff Mix*. Ottawa: CNA.)

† A standard is an authoritative statement that sets out the legal and professional basis of nursing practice. Examples of College of Nurses of Ontario (CNO) standards of practice include the *Therapeutic Nurse-Client Relationship*, *Medication*, and the professional misconduct regulations. All standards of practice provide a guide to the knowledge, skills, judgment and attitudes that are needed to practice safely. They describe what each nurse is accountable and responsible for in practice. Standards represent performance criteria for nurses and can interpret nursing's scope of practice to the public and other health care professionals. Standards can be used to stimulate peer feedback, encourage research to validate practice and to generate research questions that lead to improvement of health care delivery. Finally, standards aid in developing a better understanding and respect for the various and complementary roles that nurses have.

‡ Delegation is the transfer of the authority established in legislation to a person not otherwise authorized to perform a controlled act. The person delegated to has a responsibility to ensure that he/she is competent to perform the act safely. (CNO, 2004).

wording in the legislation had to do with how professionals are defined and what they are authorized to do. (See Appendices 1 and 2. Quebec and the territories were not included in this review.)

Very few Acts use the words scope of practice. To try and unravel what might qualify as scope statements, the legislation was searched for definitions of the particular practitioner and the practice of their profession. Legislation almost always refers to who is the particular designated professional. Reference is made to a person who is registered with the regulatory college, licensed, certified authorized under law, and/or has specified education, training, or has passed specified examination. Occasionally, legislation requires a member of a profession to be a Canadian citizen and/or a person of good moral character.

There is usually a “what” clause. These clauses can either outline in very broad terms what the profession does. Physician legislation typically does not have a “what” clause, but occasionally states generally that the practice of medicine is “the assessment of the physical or mental condition of an individual and the diagnosis, treatment and prevention of any disease, disorder or dysfunction” (Ontario), or provides a little more detail as the *Manitoba Medical Act* does. However, as a precautionary statement, even the Manitoba legislation states in the preamble of the list of possible acts a physician can perform, “Without restricting the generality of the definition of practice of medicine... .” Flexibility is clearly the dominant principle for medicine.

“What” clauses in some nursing legislation are also broad indicating nursing services are for the care of the sick and prevention of disease (e.g. Newfoundland and Labrador, Prince Edward Island) or cover health promotion, assessment, care provision, treatment, prevention, palliation, rehabilitation (e.g. Nova Scotia, British Columbia). Others specifically indicate that the functions are based on nursing principles and knowledge base (e.g. Manitoba, Saskatchewan, and Alberta). In addition to the description of general services, other jurisdictions list specific restricted acts (e.g. Ontario, Manitoba, British Columbia).

Nurse practitioners (NPs)/registered nurses (extended class) are usually incorporated into the legislation for registered nurses.* They all included “who” clauses. The “what” clauses include the functions outlined for nurses plus the additional controlled acts NPs can perform, which include making and communicating a diagnosis to patients, prescribing drugs, and ordering the application of certain forms of energy, some in greater detail (British Columbia) than others (Newfoundland/Labrador). New Brunswick also includes in its legislation a qualifying condition that NPs must have reasonable access to a physician.

Five of the Acts for pharmacists included both “who” and “what” clauses, three included only “who” clauses, and one included only a “what” clause. The functions usually described include manufacturing, compounding, or preparing a drug; packaging and labeling; dispensing; giving expert instruction or advice. Some legislation includes the operation of a retail pharmacy. Two Acts (Nova Scotia, British Columbia) refer to complying with bylaws that restrict specific practice.

* No reference to nurse practitioners could be found in PEI legislation.

5.1.1 Different approaches to regulation

The models for legislating and regulating health professions vary across Canada. Quebec, the Atlantic provinces, Manitoba, Saskatchewan and the three territories use a model of licensure or certification for the regulation of professions, or both (Quebec and Saskatchewan). Under licensure, the legislation typically prohibits all who are not licensed from providing services that fall within the scope of practice. Under certification, there is no such prohibition in legislation; rather the legislation only prohibits others from using the title of the regulated profession. The scope of practice is limited to authorizing members of the regulated profession to provide services that fall within it. “Whereas licensure gives a legislated monopoly to members of a regulated profession, certification is limited to giving them a competitive advantage.”²⁹

On the other hand, Ontario, Alberta and British Columbia have taken another approach. In 1991, Ontario passed the *Regulated Health Professions Act (RHPA)*, which provides a common framework for the regulation of the province’s regulated health professions, replacing exclusive scopes of practice (i.e. scopes of practice statements are no longer protected) with a system of 13 controlled acts.* This approach licenses acts rather than professions. As a result, health care services not involving a controlled act are in the public domain and may be performed by anyone, acknowledging the overlapping scopes of practice of health professions. However, no one can perform a controlled act unless the law that applies to their health profession allows them to do so. Because of overlaps in practice, more than one profession can be authorized to perform the same, or parts of the same, controlled acts. On the other hand, not all of the regulated health professions are authorized to perform controlled acts.³⁰ Moreover, in accordance with a profession’s regulations, the *RHPA* allows a regulated health professional who has authority to perform a controlled act to delegate the performance of that act to another regulated health professional who does not have the authority to perform the act or to an unregulated person.³¹ Fundamentally, the change was introduced to balance flexibility and protection from harm, i.e. to allow greater flexibility as to who delivers health care services and to allow patients greater choice of provider while still protecting the public from harm.³²

The scope of practice mechanism in the *RHPA* is composed of four elements:

- scope of practice statement
- controlled/authorized acts
- harm clause
- title protections.

The scope of practice statement is a brief description which generally provides three types of information about a given profession:

- what the profession does
- the methods it uses
- the purpose for which it does it.³³

* Controlled acts are those procedures that, if not done correctly and by a competent person, have a high element of risk. (Health Professions Regulatory Advisory Council, 2001).

A recent review of the Ontario legislation found that the system of controlled acts achieves a good balance between choice and public protection from harm. However, it found that the professions regulated under the *RHPA* have interpreted the controlled acts differently and the meanings of terms vary or are complex. Particularly noted were: communicating a diagnosis, disorder and dysfunction, drug and substance, prescribing and administering, and hearing aid prescription. However, none of the submissions to the review suggested that the system of controlled acts should be discarded or that Ontario return to the previous system of exclusive scopes of practice.

The *RHPA* framework was found to permit focused changes in profession-specific legislation and regulation, allowing for legislative amendments to expand professions' scopes of practice or regulatory adjustments responding to changing needs that give definition or set limits on controlled acts authorized to a profession. For optimum flexibility, it was recommended that there be regular reviews of profession-specific Acts.³⁴

In 1999, Alberta adopted a similar piece of legislation, the *Health Professions Act*, to regulate its 30 self-regulated health professions. Like the Ontario legislation, the Act sets out the same requirements for governance, registration, and discipline for each profession. The Act also contains schedules for each profession outlining the profession's practice statement and the services generally provided by the profession. The Act comes into force on a profession-by-profession basis as their regulations are approved and enacted. Under the new legislation, health professionals are not bound by exclusive scopes of practice, but by their abilities and the range of services they can provide in a safe and competent manner, subject to the standards of their regulatory college.³⁵ In 2003, British Columbia followed suit and adopted similar provisions in its *Health Professions Act*.³⁶

Although the controlled act model is promoted as one that offers more flexibility to government, professions, employers and the public, it may make the restrictiveness of the law more rigid and inflexible. That is, although the legislation narrows the range of activities that are put beyond the reach of most professions, it makes that exclusion more definitive than the traditional models.³⁷

5.2 Professional regulations and rules

Legislation in most jurisdictions is intentionally broad, providing few restrictions on practice. These broad definitions are interpreted and applied by national and provincial professional associations/colleges through their rules and regulations. They outline the eligibility requirements as to who can call themselves a member of the profession, what the required competencies and standards are, and the tasks they can perform. It is in their rules that issues of scope are more clearly set out.

National and provincial bodies also put out numerous policy and position papers and reports on issues dealing with professional boundaries, delegation, and collaboration, all of which shed some clarity on issues of scope but also require an understanding on the profession's scope. Below are some examples of how scopes are defined by national and provincial bodies.

The Royal College of Physicians and Surgeon of Canada (RCPSC)

The Royal College* highlights scope of practice in their Maintenance of Certification Program where the third educational principle is, “Scope of Practice: Learning activities relate to and reflect the learner’s practice, professional responsibilities and career plans.”³⁸ Furthermore, there is a definition of each medical specialty under sections dealing with specialty training and requirements; e.g. “Cardiology is a medical subspecialty concerned with the prevention, diagnosis, management, and rehabilitation of patients with diseases of the cardiovascular system. A cardiologist is a specialist who is an expert in the diagnosis and management of all aspects of cardiovascular disease.” The document sets out in considerable detail the general and specific objectives to be achieved for certification and the training requirements. The specific objectives include medical expert/clinical decision-maker of the major disease processes encountered in cardiology listing each condition and outlining the specific domains of knowledge and the clinical problems that should be mastered. Other objectives are communicator, collaborator, manager, health advocate, scholar, and professional. Under each of these are outlined general and specific requirements.³⁹ (See Appendix 3.)

College of Family Physicians of Canada (CFPC)

The CFPC[†] defines family physicians as physicians who “provide diagnosis and medical treatment; health protection, and promotion; coordination of care; advocacy on behalf of patients; and office-based care, as well as care in hospitals, homes, nursing homes, and community facilities. They provide not only first-line medical services, but also a substantial amount of secondary and tertiary care in all communities, particularly in rural and remote settings.”⁴⁰

Rather than listing a set of tasks a family physician can perform, the College outlines the four principles of family medicine:

- The family physician is a skilled clinician.
- Family medicine is a community based discipline.
- The family physician is a resource to a defined practice population.
- The patient-physician relationship is central to the role of the family physician.

An explication of each principle highlights the type of practitioner a family physician is and the conditions and terms of practice under which he/she conducts his/her practice.⁴¹ (See Appendix 4 for a detailed description of each principle.)

* The RCPSC is a national, private, nonprofit organization established by a special Act of Parliament to oversee the medical education of specialists in Canada. The College:

- prescribes the requirements for specialty education in 60 areas of medical, surgical and laboratory medicine plus two special programs
- accredits specialty residency programs
- assesses the acceptability of residents’ education
- conducts certifying examinations (except in Quebec where it shares this responsibility with the Collège des médecins du Québec)
- assures a standard of specialist care through its Maintenance of Certification Program
- promotes professional and ethical conduct among its members.

(RCPSC. About the College. <http://rcpsc.medical.org/about/index/php>).

† The CFPC is a voluntary association of family physicians responsible for setting standards for training, the accreditation of family residency training programs, and for a national certification examination for graduates of these programs. (CFPC, www.cfpc.ca).

Comparable to the RCPSC, the College also sets out requirements for certification, which include having completed a medical degree, having undertaken a minimum of 24 months of training from an accredited family medicine program, and being a member of the College.⁴²

Canadian Nurses Association (CNA)

The Canadian Nurses Association* defines a nurse practitioner (NP) as a registered nurse (RN) whose practice is focused on providing services to manage the health needs of individuals, families, groups and communities. It states that the NP role is grounded in the nursing profession's values, knowledge, theories and practice and is a role that complements, rather than replaces, other health care providers. NPs have the potential to contribute significantly to new models of health care based on the principles of primary health care (PHC). NPs integrate elements into their practice such as diagnosing and treating health problems and prescribing drugs. NPs work autonomously, from initiating the care process to monitoring health outcomes, and also in collaboration with other health care professionals. NPs practice in a variety of community, acute care and long-term care settings. These include, but are not limited to, community health centres, nursing outposts, specialty units and clinics, emergency departments and long-term care facilities.^{43,44}

College of Registered Nurses of British Columbia (CRNBC)

The CRNBC, which has just replaced the Registered Nurses Association of British Columbia, is responsible for setting standards of nursing practice for its registrants. These requirements are set out in three types of documents: professional standards, practice standards and scope of practice standards. However, the practice standards and scope of standards documents were not available on the CRNBC website. Rather registered members are invited to inquire about these documents.

The College of Nurses of Ontario

The CNO defines the scope of nursing practice as the promotion of health and the assessment of, the provision of care for and the treatment of health conditions by supportive, preventive, therapeutic, palliative and rehabilitative means in order to attain or maintain optimal function. In addition, nursing is authorized to perform three of the 13 controlled acts under the *Regulated Health Professions Act*. They are:

- performing a prescribed procedure below the dermis or a mucous membrane;
- administering a substance by injection or inhalation;
- putting an instrument, hand or finger i) beyond the external ear canal, ii) beyond the point in the nasal passages where they normally narrow, iii) beyond the larynx, iv) beyond the opening of the urethra, v) beyond the labia majora, vi) beyond the anal verge, or vii) into an artificial opening into the body.

It further explains that with some exceptions, a registered nurse (RN) or registered practical nurse (RPN) may perform a controlled act authorized to nursing if it is ordered by a physician, dentist, chiropractor, midwife or a registered nurse (extended class) [RN(EC)]; or if it is initiated by an RN in accordance with conditions identified in regulation. RNs or RPNs

* The CNA is the federation of 11 provincial and territorial registered nurses associations and colleges, which represent more than 120,000 registered nurses and nurse practitioners.

who are competent to do so may perform specified procedures initiated (ordered) by an RN in the general class or in the extended class. Any RN who performs or orders a procedure must have the knowledge, skill and judgment to perform the procedure safely, effectively and ethically; have the knowledge, skill and judgment to determine whether the client's condition warrants performance of the procedure; determine that the client's condition warrants performance of the procedure having considered the risks and benefits to the individual, the predictability of outcomes, the safeguards and resources available to safely manage the outcomes of performing the procedure; and accept sole accountability for determining that the client's condition warrants performance of the procedure. The reference document further outlines the acts that nurses in the extended class have the authority to perform, and the conditions under which a nurse can delegate acts or accept delegation of acts.⁴⁵

The College provides numerous support documents in their Compendium for Standards* of Practice,⁴⁶ such as the *Guide to Decide* which assists nurses in making decisions about the performance of procedures and in understanding their individual accountability.⁴⁷

5.3 Professional policy and position statements

That definitions of scopes of practice are problematic has been raised by national and provincial associations representing diverse professions. More than 10 years ago, the CNA identified the problems associated with scope of practice: defining the role of the nurse, clarifying shared practice and overlap with others, and the need for consistency in articulating nursing scopes in different circumstances and settings. Defining the scope of nursing practice in a way that recognizes the diverse forces of change highlighted earlier was seen as one of the most significant challenges for the profession. In doing so the profession recognized the need to move away from a listing of the diverse tasks nurses could perform, the list often being outdated by the time it was printed. Central to an understanding of scope of practice is the knowledge that “nursing care is not merely a collection of tasks,” but must consider “the context of care, specific client factors and knowledge base of the provider.”^{48,49,50} Similar to approaches in the UK and US, the profession has now moved toward broader scope of practice statements and an increased emphasis on standards. This new approach recognizes that it will never be possible to define precisely, in detail and for all time, which activities are inside or outside the boundaries of the profession. There is a trend of defining nursing practice in terms of nursing knowledge and nursing principles, which will allow nurses to practice in a wide range of roles and diverse settings, and address some of the overlap issues with other professions. It is proposed

* A standard is an authoritative statement that sets out the legal and professional basis of nursing practice. Examples of CNO's standards of practice include the *Therapeutic Nurse-Client Relationship, Medication*, and the professional misconduct regulations. All standards of practice provide a guide to the knowledge, skills, judgment and attitudes that are needed to practice safely. They describe what each nurse is accountable and responsible for in practice. Standards represent performance criteria for nurses and can interpret nursing's scope of practice to the public and other health care professionals. Standards can be used to stimulate peer feedback, encourage research to validate practice and to generate research questions that lead to improvement of health care delivery. Finally, standards aid in developing a better understanding and respect for the various and complementary roles that nurses have.

that what distinguishes nursing performance of activities that overlap with other professions is their knowledge base and principles.^{51,52}

According to the Canadian Medical Association, the medical profession needs to adopt a vision that is stable and enduring. This vision should consider both what physicians do and who they are. Although the vision for medicine should be constant, the role of physicians and their scopes of practice must be flexible and adaptable in response to external change and forces. It calls on medicine to develop principles and processes to address areas of shared competency, the criteria for the determination of scopes of practice, and better guidelines and processes for legislative change. Discussion with other professions about scopes of practice will benefit from a set of principles or criteria to determine which acts should be restricted to one profession, performed under the supervision of the profession, shared with another profession(s), and which should be open to any profession or group. In reviewing legislation the CMA recommends its members adopt a number of guidelines, which include that:

- The scope of a profession must be based on patient needs, and be supported by the educational preparation of the practitioners and demonstrated competency.
- Tasks or activities may be included in the scope of more than one profession provided each member of that profession has the appropriate training, and demonstrated competency.
- A change in the scope of practice of any profession should be permitted if it enhances patient care, the profession has the research base and body of knowledge, and after consultation with groups with overlapping or shared competencies.
- Any expansion in scope of a profession should be supported by research.

Finally, although the regulation of health professions is the prerogative of the provincial/territorial association, the CMA recommends national standards of education and competency assessment.⁵³

In response to the many factors affecting a profession's scope of practice and the activities of national and provincial associations, there is growing appreciation that scopes of practice must be flexible enough to reflect and adjust to these changes. Accordingly, to assist in this endeavour, the CMA, CNA, and the Canadian Pharmacists Association recently issued a joint statement approving the principles and criteria for the determination of scopes of practice.⁵⁴

Principles include:

- *focus* (on high quality care, needs of patients and public, timely, affordable, competent providers);
- *flexibility* (to enable providers to practice to the full extent of their education, training, experience, competency, etc.);
- *collaboration and cooperation* (in order to support interdisciplinary approaches to patient care and good health);
- *coordination* (patient care should be provided by a qualified health care provider);
- *patient choice* (scopes of practice should take into account patient choice).

The criteria are more helpful in determining a scope statement. They include:

- *accountability* – the scope should reflect the degree of accountability, responsibility and authority that the provider assumes for the outcomes of their practice.;
- *education* – scopes should reflect the breadth and relevance of the training and education of the provider;
- *competencies and practice standards* – scopes should reflect the knowledge, values, attitudes and skills of the provider group;
- *quality assurance and improvement* – scopes should reflect measures of quality assurance and improvement that have been implemented for the protection of patients and the public;
- *risk assessment* – scopes should consider risk to patients;
- *evidence-based practices* – scopes should reflect the degree to which practices are based on scientific evidence;
- *setting and culture* – scopes should be sensitive to place, context and culture;
- *legal liability and insurance* – scopes should reflect case law and liability assumed by practitioner;
- *regulation* – scopes should reflect the legislative and regulatory authority of the provider.

The Principles of Family Medicine document in Appendix 4 addresses most if not all these principles and criteria.

6.0 A BALANCING ACT

Given the number of jurisdictions and the myriad of stakeholders involved, it is not surprising that there is little consistency or coherence in the general and profession-specific definitions of scopes of practice. For this reason the Senate Committee headed by Senator Michael Kirby recommended a comprehensive review of the contents of professional scopes of practice.⁵⁵ Because of the rapidity and inevitability of change in Canadian health care, national and provincial associations have called for the development of a flexible and transparent system for defining and redefining professional roles and boundaries.

Work in this area will need to balance a number of potentially competing interests and needs:

- the prerogative of provincial/territorial governments to use their own model for regulating health professions;
- allowing flexibility for professions so they are not unnecessarily restricted in their practice, versus professional need to circumscribe their own practice to the exclusion of others;
- providing professionals clarity and certainty of their own and other professionals' scopes of practice, versus the need for flexibility;
- maximizing choice for patients of providers with overlapping scopes, versus the need to protect the public from harm;
- maximizing flexibility for employers to employ the most cost-effective and appropriate provider, versus public protection from harm;
- maximizing flexibility for employers to employ the most cost-effective and appropriate provider, versus the standardization of professional practice;
- allowing for professional self-determination and pride through increasing competency and eligibility requirements, versus rationalization of resources; and
- balancing the scopes to which professions are trained and authorized to perform with the scopes they actually practice.

The bottom line for determining professional scopes of practice should be the needs of patients and the public.

Recommendations

As a starting point to clarifying scopes of practice in Canada, the Health Council of Canada recommends the following:

1. The content of health professional education and health human resources planning should be more strongly connected.
2. Employers, regulators, unions, educators and health human resource planners should meet to discuss and resolve critical issues surrounding scopes of practice.
3. National associations, governments, regulators and employers should collaborate in a leadership role to clarify the confusion around scopes of practice.

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APPENDIX 1

Provincial Legislation* for Physicians, Registered Nurses, Nurse Practitioners, and Pharmacists

Jurisdiction	Legislation
Newfoundland and Labrador	
Physician	<p>(i) “medical practitioner” means a person who is registered in the medical register or who holds or has held a licence;</p> <p>(ii) “practice of medicine” means the practice of medicine or surgery on the human body, and includes cardiology, dermatology, geriatrics, gynecology, neurology, obstetrics, ophthalmology, orthopedics, pathology, pediatrics, psychiatry and radiology and other specialities and subspecialties of medicine;</p> <p>16. (1) A person who has</p> <p>(a) fulfilled the educational requirements prescribed by the regulations before entering upon the study of medicine;</p> <p>(b) completed the entire course of studies required by, and holds a medical degree or diploma in medicine from, a university, college or school of medicine recognized and approved by the council;</p> <p>(c) completed post-graduate training that may be required by the regulations;</p> <p>(d) provided to the council evidence of identification satisfactory to it; and</p> <p>(e) produced to the council a certificate of good standing from the responsible officer of a medical body having jurisdiction in the place at which the person may previously have been licensed, and satisfactory evidence that the benefit of that licensure has not been lost by misconduct or for another cause, is entitled to registration in the medical register upon payment of the fee for registration fixed by the council.</p> <p><i>Medical Act, www.hoa.gov.nl.ca/hoa/statutes/m04-01.htm#2</i></p>
Registered Nurse	<p>(h) “registered nurse” means a person possessed of the qualifications required by this Act, and who is authorized to offer services for the care of the sick and to give care intended for the prevention of disease and to receive remuneration, and who is a member in good standing of the association;</p> <p><i>Registered Nurses Act, www.hoa.gov.nl.ca/hoa/statutes/r09.htm#1</i></p>
Nurse Practitioner	<p>(e.3) “nurse practitioner” means</p> <p>(i) a registered nurse who has successfully completed a course of study prescribed by the council and is licensed to practise as a nurse practitioner under this Act, or</p> <p>(ii) a nurse who, in the opinion of the council, has knowledge and skills sufficient as prescribed by the regulations to be licensed to practise as a nurse practitioner under this Act</p>

* Quebec and the territories not included.

Jurisdiction**Legislation**

- 11.1 (1) A nurse practitioner licensed under this Act may
- (a) communicate to a patient or that person's substitute decision maker a diagnosis made by that nurse practitioner identifying a disease or disorder
 - (b) order the application of a form of energy
 - (c) order laboratory or other tests
 - (d) prescribe a drug
- (2) A nurse practitioner shall not communicate a diagnosis made under paragraph (1)(a) unless he or she has complied with the standards and scope of practice respecting collaboration with members of other health professions
- (a) prescribed in the regulations; or
 - (b) set by a practice protocol issued to him or her by the council under the regulations.

Registered Nurses Act, www.hoa.gov.nl.ca/hoa/statutes/r09.htm#1

Pharmacist

- (m) "pharmacist" means a person registered under section 21 of this Act;
21. (1) A person
- (a) registered and in good standing as a pharmaceutical chemist under the former Act;
 - (b) who holds a Bachelor of Science degree in Pharmacy from the Memorial University of Newfoundland and has successfully completed a licensing examination based upon the professional competency requirements that the board may establish;
 - (c) who has graduated from a Faculty of Pharmacy approved by the board and has successfully completed a licensing examination based upon the professional competency requirements that the board may establish; or
 - (d) who, immediately before making an application for a licence under this Act, was registered, licensed, in good standing and practising as a pharmacist under the laws of another province or territory of Canada, may apply for registration under this Act.

An Act to Regulate the Practice of Pharmacy, www.hoa.gov.nl.ca/hoa/statutes/P12-1.htm#2

Nova Scotia**Physician**

3 The words "duly qualified medical practitioner", "duly qualified practitioner", "legally qualified medical practitioner", "legally qualified physician", "physician" or any like words or expressions implying a person recognized by law as a medical practitioner or member of the medical profession in the Province, when used in any regulation, rule, order or by-law made pursuant to an Act of the Legislature enacted or made before, at or after the coming into force of this Act, or when used in any public document, includes a person registered in the Medical Register, Temporary Register, Defined Register or the Medical Education Register who holds a licence.

Medical Act. 1995-96, c. 10, s. 1, www.hoa.gov.nl.ca/hoa/statutes/m04-01.htm#2

2(f) "scope of practice" means the medical specialty in which the member is registered in the Medical Specialists Register, the discipline of family medicine or any other non-clinical medical practice.

Jurisdiction

Legislation

Scope of Practice

- 6 It is a term, condition and limitation of registration that the member practise only within the scope of practice in which he/she is educated and experienced.
- 7 When considering the scope of practice in which the member is educated and experienced, the Council may take into account their
 - (a) graduate education in family medicine;
 - (b) graduate education in those medical specialties in which the Royal College of Physicians and Surgeons of Canada grants certificates;
 - (c) qualifying examinations in family medicine, and medical and surgical specialties;
 - (d) non-clinical medical practice, where registration is a requirement of employment;
 - (e) graduate education in, and appropriate evaluation of, medical or surgical disciplines not included in (a) or (b) above, but considered appropriate by the Council; and
 - (f) scope of practice in which they were engaged in the 3 years prior to initial registration or annual renewal of licence.
- 8 Should a member wish to change the scope of practice from the one that he/she has practised for the previous 3 years, or wish to re-enter clinical practice after a 3 year absence, the Council may request that the member provide the Council with evidence that he/she is competent to engage in that scope of practice.
- 9 All requests from members to change their scope of practice shall be handled on an individual basis.

College of Physicians and Surgeons Registration Regulations,
www.gov.ns.ca/just/regulations/regs/medreg.htm

- Registered Nurse
- (aj) “registered nurse” means a health-care practitioner whose name appears on the Register and who is licensed in the active-practising class;
 - (y) “practice of nursing” means the performance of professional services requiring substantial specialized knowledge of nursing theory and the biological, physical, behavioural, psychological and sociological sciences as the basis for
 - (i) assessment, planning, intervention and evaluation in
 - (A) the promotion and maintenance of health,
 - (B) the facilitation of the management of illness, injury or infirmity,
 - (C) the restoration of optimum function, or
 - (D) palliative care, or
 - (ii) research, education, management or administration incidental to the objectives referred to in subclause (i),
- and includes the practice of a nurse practitioner;

Registered Nurses Act. 2001, c. 10, s. 1., www.gov.ns.ca/legislature/legc/

- (d) “competencies” means the specific knowledge, skills and judgment required for a registered nurse to be considered competent in a designated role and practice setting;
- (e) “competent” means, in relation to a registered nurse, able to integrate and apply the knowledge, skills and judgment required to practise safely and ethically in a designated role and practice setting;

Registered Nurses Regulations, www.gov.ns.ca/just/regulations/regs/rnregs.htm

Jurisdiction	Legislation
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| Nurse Practitioner | <p>(t) “nurse practitioner” means a registered nurse whose name appears in the specialty nurse-practitioner class or the primary health-care nurse-practitioner class pursuant to the regulations;</p> <p>(z) “practice of a nurse practitioner” means the practice in which a nurse practitioner may, subject to a collaborative-practice agreement and in accordance with standards of practice of nurse practitioners,</p> <p>(i) make a diagnosis identifying a disease, disorder or condition,</p> <p>(ii) communicate the diagnosis to the client,</p> <p>(iii) order and interpret screening and diagnostic tests approved through the process set out in the regulations,</p> <p>(iv) select, recommend, prescribe and monitor the effectiveness of drugs and interventions approved through the process set out in the regulations, and</p> <p>(v) perform such procedures approved through the process set out in the regulations;</p> |
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Registered Nurses Act. 2001, c. 10, s. 1., www.gov.ns.ca/legislature/legc/

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| Pharmacist | <p>2 (p) “pharmacist” means a person licensed to practise pharmacy pursuant to this Act;</p> <p>(r) “practice of pharmacy” means the practice of pharmacy as described in this Act and includes professional services provided by a pharmacist related to the use, dispensing, compounding or distribution of drugs to or for the public and the responsibility for taking all reasonable steps to ensure pharmaceutical and therapeutic appropriateness of the therapy;</p> |
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- Practice Responsibilities
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| 25 | <p>(1) The primary responsibility of a pharmacist is the provision of optimal patient care.</p> <p>(2) The practice of pharmacy includes the practice of and responsibility for</p> <p>(a) the interpretation and evaluation of prescriptions;</p> <p>(b) the provision of information respecting drug and non-drug therapy;</p> <p>(c) the compounding, dispensing and added labeling of drugs and devices;</p> <p>(d) taking all reasonable steps to ensure pharmaceutical and therapeutic appropriateness of a drug therapy;</p> <p>(e) monitoring drug therapy;</p> <p>(f) the identification, assessment and recommendations necessary to resolve or prevent problems in patients related to drugs;</p> <p>(g) counselling persons respecting the therapeutic values, content, hazards, side effects and proper use and storage of drugs and devices;</p> <p>(h) the safe storage of drugs and devices;</p> <p>(i) the maintenance of proper records for drugs and devices, including patient records;</p> <p>(j) services, duties and transactions necessary to the management, operation and control of pharmacies;</p> <p>(k) the sale of drugs and devices; and</p> <p>(l) other professional services authorized by law.</p> <p>(3) Every pharmacist shall ensure that each patient has sufficient information and advice for the proper use of the drug or device dispensed.</p> <p>(4) A pharmacist is responsible for the accuracy of every prescription dispensed.</p> <p>(5) A pharmacist is responsible for the validity of every prescription dispensed.</p> |
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2001, c. 36, s. 25.
Pharmacy Act. 2001, c. 36, s. 1, www.gov.ns.ca/legislature/legc/

Jurisdiction	Legislation
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- (2) Pharmacists may be classified as
 - (a) practising direct patient care;
 - (b) practising indirect patient care; or
 - (c) non-practising.
- (3) A pharmacist who is not registered to practise direct patient care may be referred to as a pharmacist and may use the designation Ph. C., Reg. Pharm. or similar designation, but shall not dispense drugs or practice direct patient care pharmacy.

Practice of Pharmacy Regulations, www.gov.ns.ca/just/regulations/regs/pharmprc.htm

Prince Edward Island

Physician

- 1 (m) “medical practitioner” means a person who is registered in the Medical Register or the Temporary and Limited Register;
- (q) “practice of medicine” means the practice of medicine, surgery, obstetrics, pathology, radiology and the specialities thereof, but does not include veterinary surgery;
- 15. (1) The Council shall direct the Registrar to enter in the Medical Register the name, address and qualifications of any person who Qualifications for registration
 - (a) holds a medical degree from a medical school approved by the Council;
 - (b) has completed a program of preregistration physician training satisfactory to Council;
 - (c) produces a certificate under the hand of the Registrar of the Medical Council of Canada that his name appears in the Canadian Medical Register in pursuance of the *Canada Medical Act* R.S.C. 1952, Chap. 27;
 - (d) produces a letter of good standing from the jurisdiction in which he has practised medicine prior to applying under this section; and
 - (e) complies with the requirements of section 24.

Medical Act, www.gov.pe.ca/law/statutes/pdf/m-05.pdf

Registered Nurse

- (g) “nurse” means any person who is possessed of the qualifications required by this Act, and who is authorized to offer service for the care of the sick and to give care intended for the prevention of disease and to receive remuneration thereof, and any member of the Association; nurse
- (h) “practice” means the practice of nursing; practice
- (i) “profession” means the nursing profession;

Nurses Act, www.gov.pe.ca/law/statutes/pdf/n-04.pdf

Nurse Practitioner

Pharmacist

- (m) “pharmacist” or “licensed pharmacist” means a person holding a license, signifying entitlement to practise pharmacy;
- (o.1) the “practice of pharmacy” means
- (i) manufacturing, compounding or otherwise preparing a drug, including packaging, repackaging or labelling, (ii) dispensing a drug, or (iii) giving expert instruction or advice on the use of or appropriateness of a drug, the performance of which skill, in the opinion of the Board, requires specialist knowledge and judgment concerning the properties of drugs;

Pharmacy Act, www.gov.pe.ca/law/statutes/pdf/p-06.pdf

Jurisdiction	Legislation
New Brunswick Physician	<p data-bbox="475 321 613 348">3. Definitions</p> <p data-bbox="475 352 1195 380">“health professional” means a person who provides a service related to</p> <ul style="list-style-type: none"> <li data-bbox="475 384 1174 411">(a) the preservation or improvement of the health of individuals, or <li data-bbox="475 415 1339 464">(b) the diagnosis, treatment or care of individuals who are injured, sick, disabled or infirm, <p data-bbox="475 468 1317 552">“medical practitioner” means a person who is registered in the Medical Register or Regulated Licenses Register, or on the Medical Education Register under paragraph 32(3)(c);</p> <p data-bbox="475 556 1255 611">“practice of medicine” includes the practice of medicine and surgery and the specialties and subspecialties of medicine and surgery;</p> <p data-bbox="475 638 1138 665"><i>Medical Act, www.cpsnb.org/english/MedicalAct/med-act-toc.html</i></p> <p data-bbox="475 695 1339 835">NOTE: Applicants for full licensure on the Medical Register require the Licentiate of the Medical Council of Canada (“LMCC”) and a “period of satisfactory pre-registration training”. Applicants without the LMCC may be registered on the Regulated Licenses Register (see section 4 below) or with a Public Service License (see Regulation #6).</p> <ol style="list-style-type: none"> <li data-bbox="475 865 1339 1266">1. For all purposes under the Act, and Regulations, an applicant for registration shall be deemed to have undertaken “satisfactory pre-registration training” if the applicant is: <ul style="list-style-type: none"> <li data-bbox="524 953 1339 980">a. Certified in Family Practice by the College of Family Physicians of Canada; <li data-bbox="524 984 1263 1012">b. Certified in Family Practice by the Collège des médecins du Québec; <li data-bbox="524 1016 1339 1064">c. Certified in a specialty by the Royal College of Physicians and Surgeons of Canada; <li data-bbox="524 1068 1243 1096">d. Certified in a specialty by the Collège des médecins du Québec; or <li data-bbox="524 1100 1339 1266">e. Not certified in any of the above manners, but has successfully completed an acceptable internship of not less than two years which, in the opinion of the College, will have adequately prepared the applicant for independent practice in the setting and circumstances intended in selected circumstances. This requirement may be abridged at the discretion of the College. <li data-bbox="475 1270 1339 1436">2. Notwithstanding Section (1), applicants for registration who have graduated and obtained their medical degree prior to January 1, 1993 may be deemed to have “satisfactory pre-registration training” if they have successfully completed an acceptable internship of not less than 12 months which, in the opinion of the College, will have adequately prepared them for independent practice in the setting and circumstances intended. <li data-bbox="475 1440 1339 1581">3. For purposes of section 1(e) and section 2, an “acceptable internship” shall, except in exceptional circumstances as judged by the College, be undertaken in a program approved by the Accreditation Committee of the Federation of Medical Licensing Authorities of Canada or the Accreditation Council for Graduates in Medical Education of the United States. <p data-bbox="475 1610 1013 1665"><i>CPSNB, Regulations: Registration and Licensing, www.cpsnb.org/english/Regulations/regulation-2.html</i></p> <p data-bbox="277 1694 1243 1749">Registered Nurse “nurse” means a person who is registered under the laws of the Province as authorized to practice as a nurse;</p> <p data-bbox="475 1778 979 1808"><i>Health Act, www.gnb.ca/0062/PDF-acts/h-02.pdf</i></p>

Jurisdiction

Legislation

“nurse” means a person whose name is entered in the register kept pursuant to paragraph 11(1)(a);

“nursing” means the practice of nursing and includes the nursing assessment and treatment of human responses to actual or potential health problems and the nursing supervision thereof; “practice of nursing” includes the practice of a nurse practitioner;

Nurses Act, 1984.

www.nanb.nb.ca/pdf_e/Publications/General_Publications/NursesAct_E&F.pdf

Nurse Practitioner “nurse practitioner” means a person who is registered under the laws of the Province as authorized to practice as a nurse practitioner;

Health Act, www.gnb.ca/0062/PDF-acts/h-02.pdf

“nurse practitioner” means a nurse whose name is endorsed in the register as a nurse practitioner;

“practice of a nurse practitioner” means the practice in which a nurse practitioner may

- (a) diagnose or assess a disease, disorder or condition, and communicate the diagnosis or assessment to the patient,
- (b) order and interpret screening and diagnostic tests, approved through the process set out in section 10.3,
- (c) select, prescribe and monitor the effectiveness of drugs approved through the process set out in section 10.3, and
- (d) order the application of forms of energy approved through the process set out in section 10.3;

10.3(5) A nurse practitioner is authorized to engage in all practices specified in the rules made by the Board and approved by the Minister of Health and Wellness under this section and may diagnose or assess a disease, disorder or condition, and communicate the diagnosis or assessment to the patient.

10.4 No person shall engage in the practice of a nurse practitioner unless the person has reasonable access to a medical practitioner for the purposes of consultation with respect to any patient and is able to refer or transfer any patient to the care of a medical practitioner.

Bill 44: An Act to Amend the Nurses Act, 2002. www.gnb.ca/legis/bill/editform-e.asp?ID=114&legi=54&num=4

Pharmacist

“licensed pharmacist” means a person registered hereunder as a pharmacist holding a valid licence issued under section 31;

3 New Brunswick Pharmaceutical Society, incorporated by An Act to incorporate the New Brunswick Pharmaceutical Society, and to regulate the sale of Drugs and Medicines, being Chapter 20 of 47 Victoria, 1884 shall continue to be a body corporate for the purpose of ensuring that for the safety of the public all persons engaged in the sale or dispensing of drugs and medicines within the Province should be acquainted with their properties and uses and possess a competent practical knowledge of pharmacy, and that the profession of pharmacy is practised by its members in accordance with acceptable standards.

Jurisdiction	Legislation
	<p>27(l) An applicant who is registered as a student is entitled to have his name entered in the register of pharmacists upon production to the Council of evidence satisfactory to it that he has (a) good moral character;</p> <p>(b) (i) received a degree of Bachelor of Science in Pharmacy from Dalhousie University, or (ii) received a degree in Pharmacy from any university other than Dalhousie University which has been approved by the Council and has in addition a certificate from the Examination and Credentials Committee that he has the qualifications to be registered as a pharmacist and has passed all examinations set or approved by the Committee;</p> <p>(c) completed a training period of such length and under such conditions as may be required by the by-laws and regulations;</p> <p>(d) sufficient ability to speak and read one of the official languages of New Brunswick as to be competent to discharge the duties and obligations of a pharmacist;</p> <p>(e) Canadian citizenship or is a resident of Canada;</p> <p>(f) such other qualifications as may be required by the regulations.</p> <p>CHAPTER 100 CONSOLIDATION, <i>Pharmacy Act</i>, Assented to June 30, 1983. Consolidated to July 19, 2002 www.napra.org/pdfs/provinces/nb/pharmacyact.pdf</p>
Ontario Physician	<p>Scope of Practice</p> <p>3. The practice of medicine is the assessment of the physical or mental condition of an individual and the diagnosis, treatment and prevention of any disease, disorder or dysfunction.</p> <p>(The <i>Medicine Act</i> specifies the controlled acts under the RHPA that physicians can do.</p> <p><i>Medicine Act</i> 1991, c. 30, www.e-laws.gov.on.ca/DBLaws/Statutes/English/91m30_e.htm</p>
Registered Nurse	<p>Scope of Practice</p> <p>3. The practice of nursing is the promotion of health and the assessment of, the provision of care for and the treatment of health conditions by supportive, preventive, therapeutic, palliative and rehabilitative means in order to attain or maintain optimal function.</p> <p>Authorized Acts</p> <p>4. In the course of engaging in the practice of nursing, a member is authorized, subject to the terms, conditions and limitations imposed on his or her certificate of registration, to perform the following:</p> <ol style="list-style-type: none"> 1. Performing a prescribed procedure below the dermis or a mucous membrane. 2. Administering a substance by injection or inhalation. 3. Putting an instrument, hand or finger, <ol style="list-style-type: none"> i. beyond the external ear canal, ii. beyond the point in the nasal passages where they normally narrow, iii. beyond the larynx, iv. beyond the opening of the urethra, v. beyond the labia majora, vi. beyond the anal verge, or vii. into an artificial opening into the body. 1991, c. 32, s. 4. <p><i>Nursing Act</i> 1991, c. 32, www.e-laws.gov.on.ca/DBLaws/Statutes/English/91n32_e.htm</p>

Jurisdiction	Legislation
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Nurse Practitioner	<p>This Bill will allow registered nurses who hold an extended certificate of registration to provide, with members of other health professions, primary health care services. The Bill will expand the scope of practice of registered nurses who hold such a certificate by allowing them to perform certain controlled acts, such as communicating a diagnosis to patients, prescribing certain drugs and ordering the application of certain forms of energy.</p>
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Consequential amendments are made to the *Healing Arts Radiation Protection Act*, the *Medical Laboratory Technology Act, 1991*, the *Respiratory Therapy Act, 1991* and the *Vital Statistics Act*.

Expanded Nursing Services for Patients Act, 1997.
www.ontla.on.ca/documents/bills/36_parliament/session1/G97127e.htm

Pharmacist	<p>Scope of Practice</p> <p>3. The practice of pharmacy is the custody, compounding and dispensing of drugs, the provision of non-prescription drugs, health care aids and devices and the provision of information related to drug use.</p>
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Pharmacy Act 1991, c. 36,
http://www.e-laws.gov.on.ca/DBLaws/Statutes/English/91p36_e.htm

Manitoba	
Physician	

“practice of medicine” means, subject to section 2, the carrying on for hire, gain, or hope of gain or reward, either directly or indirectly, of the healing art or any of its branches; (« exercice de la médecine »)

Persons deemed practising medicine

- 2(1) Without restricting the generality of the definition of practice of medicine, a person shall be deemed to be practising medicine within the meaning of this Act who
- (a) by advertisement, sign, or statement of any kind, written or oral, alleges or implies or states that he is, or holds himself out as being, qualified, able, or willing, to diagnose, prescribe for, prevent, or treat, any human disease, ailment, deformity, defect, or injury, or to perform any operation or surgery to remedy any human disease, ailment, deformity, defect, or injury, or to examine or advise upon the physical or mental condition of any person; or
 - (b) diagnoses, or offers to diagnose, or attempts by any means whatsoever to diagnose, any human disease, ailment, deformity, defect, or injury, or who examines or advises upon, or offers to examine or advise upon, the physical or mental condition of any person; or
 - (c) prescribes or administers any drugs, serum, medicine, or any substance or remedy, whether for the cure, treatment, or prevention, of any human disease, ailment, deformity, defect, or injury; or
 - (d) prescribes or administers any treatment, or performs any operation or manipulation, or applies any apparatus or appliance, for the cure, treatment, or prevention, of any human disease, ailment, deformity, defect, or injury, or acts as a midwife; or
 - (e) repealed, S.M. 1999, c. 39, s. 3.

Jurisdiction

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Exceptions

2(2) The definition of practice of medicine does not include or apply to the practice of dentistry or pharmacy, or to the vendors of dental or surgical instruments, apparatus, or appliances, or apparatus, or appliances, or [other professions acting within scope of relevant legislation].

The Medical Act, <http://web2.gov.mb.ca/laws/statutes/ccsm/m090e.php>

Registered Nurse

Part 2

Practice Of Nursing

Practice of nursing

2(1) The practice of nursing is the application of nursing knowledge, skill and judgment to promote, maintain and restore health, prevent illness and alleviate suffering, and includes, but is not limited to,

- (a) assessing health status;
- (b) planning, providing and evaluating treatment and nursing interventions;
- (c) counselling and teaching to enhance health and well-being; and
- (d) education, administration and research related to providing health services.

Included practices

2(2) In accordance with any requirements set out in the regulations, a registered nurse may do any of the following in the course of engaging in the practice of nursing:

- (a) order and receive reports of screening and diagnostic tests designated in the regulations;
- (b) prescribe drugs designated in the regulations;
- (c) perform minor surgical and invasive procedures designated in the regulations.

Registered Nurses Act, www.canlii.org/mb/laws/sta/r-40/index.html

Nurse Practitioner

Eligibility for registration as a registered nurse extended practice

1(1) Eligibility for registration as a registered nurse extended practice are as follows:

- a) The applicant must be on the register of practising registered nurses in Manitoba.
- b) The applicant must have satisfactorily completed one of the following:
 - i. a program of nursing education at an “advanced level” approved by the board,
 - or
 - ii. a program of nursing education at an “advanced level” that the board considers to be substantially equivalent to a nursing education program at an “advanced level” approved by the board at the time the applicant graduated,
 - or
 - iii. an assessment process approved by the college of the applicant’s ability to perform the Competencies for the Registered Nurse Extended Practice Register.
- c) An applicant, applying under 1(1)(b)(i) or 1(1)(b)(ii), must have satisfactorily completed a demonstration of the Competencies for the Registered Nurse Extended Practice Register.
- d) Pay the fee provided for in the by-laws.

Jurisdiction

Legislation

Screening and diagnostic tests

2(1) For the purpose of section 2(2)(a) of the Act, registered nurses on the Extended Practice register may order and receive reports on x-rays, ultrasounds and other forms of energy, and laboratory tests as specified in Appendix A and as amended from time to time, and

- a) she/he is authorized and competent to order, and
- b) are relevant to the nurse's area of practice and client population served.

Extended Practice Regulation Page 2

Approved in Principle: April 19, 2004

Prescribe drugs

3(1) For the purpose of section 2(2)(b) of the Act, a registered nurse on the Extended Practice register may prescribe drugs, when

- a) she/he is authorized and competent to order,
- b) the drugs are relevant to the nurse's area of practice and client population served, and
- c) she/he has been issued a prescriber number by Manitoba Health.

3(2) For the purpose of section 2(2)(b) of the Act, a registered nurse on the Extended Practice register may prescribe:

- a) drug(s)/device(s) listed in Part I and Part 2 of the Specified Drugs Regulation of *The Prescription Drugs Cost Assistance Act of Manitoba*, and
- b) non-prescription drug(s) for the purpose of accessing a drug plan that has coverage for non-prescriptive drugs, and
- c) drug samples for those drugs in Part I and Part II of The Specified Drug Regulation, and
- d) where the nurse is employed by an agency, in accordance with that agency's drug formulary and written policy, and
- e) refill prescriptions for clients being managed collaboratively with other health care providers with prescriptive authority, and
- f) all immunizing agents.

Minor surgical and invasive procedures

4(1) For the purpose of section 2(2)(c) of the Act, a registered nurse on the Extended Practice register may perform any of the following procedures in accordance with policies established by the Board:

- a) Suturing, except below the fascia and except in cases which there may be underlying injury.
- b) A procedure that, for the purpose of assessing, diagnosing or treating an individual or assisting an individual with health management activities, requires putting an instrument,
 - i. beyond the point in the individual's nasal passages where they normally narrow,
 - ii. beyond the individual's uvula,
 - iii. beyond the opening of the individual's urethra,
 - iv. below the dermis or below a mucous membrane.
- c) A procedure that, for the purpose of assessing or treating an individual, assisting an individual with health management activities or making a diagnosis with respect to an individual, requires putting an instrument or finger,
 - i. beyond the individual's anal verge, or
 - ii. into an artificial opening into the individual's body.

Jurisdiction	Legislation
	<ul style="list-style-type: none"> d) A procedure that, for the purpose of assessing or treating an individual, assisting an individual with health management activities or making a diagnosis with respect to an individual, requires putting an instrument, hand or finger beyond the individual's labia majora. e) Creating an opening into the body that, for the purpose of assessing or treating an individual, assisting an individual with health management activities or making a diagnosis with respect to an individual, requires putting an instrument into the individual's body. <p><i>Extended Practice Regulation. Approved in principle. April 19, 2004. www.nursepractitioner.ca/draftreg.pdf</i></p>
Pharmacist	<p>“pharmacist” means a person registered as a pharmacist under this Act; (« pharmacien »)</p> <p>“practice of pharmacy” means</p> <ul style="list-style-type: none"> (a) responsibility for preparing, distributing and controlling drugs in a pharmacy, (b) compounding a prescription, (c) dispensing a drug, (d) selling a drug by retail, (e) operating a pharmacy insofar as the operation relates to the practice of pharmacy, (f) disseminating information on the safe and effective use of a drug when dispensing or selling a drug, or (g) subdividing or breaking up a manufacturer's original package of a drug for the purpose of re-packaging the drug in larger or smaller quantities for re-distribution or sale by retail; (« exercice de la pharmacie ») <p><i>The Pharmaceutical Act, www.canlii.org/mb/laws/sta/p-60/20050801/whole.html</i></p>
Saskatchewan	
Physician	<ul style="list-style-type: none"> (i) “member” means a member of the college as described in section 4; (k) “practice” means the practice of medicine, surgery or midwifery; <p>Part II</p> <p>Members of college</p> <p>4 All persons who are members pursuant to The Medical Profession Act on the day before the coming into force of this section and any other persons who become members pursuant to section 28, 29 or 30 are members of the college.</p> <p><i>Medical Profession Act, 1981. www.canlii.org/sk/laws/sta/m-10.1/20050801/whole.html</i></p>
Registered Nurse	<ul style="list-style-type: none"> (j) “nurse” means a graduate nurse or a registered nurse; (k) “practice of registered nursing” means the performance or co-ordination of health care services including but not limited to: <ul style="list-style-type: none"> (i) observing and assessing the health status of clients and planning, implementing and evaluating nursing care; and (ii) the counselling, teaching, supervision, administration and research that is required to implement or complement health care services; for the purpose of promoting, maintaining or restoring health, preventing illness and alleviating suffering where the performance or co-ordination of those services requires:

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- (iii) the knowledge, skill or judgment of a person who qualifies for registration pursuant to section 19 or 20;
- (iv) specialized knowledge of nursing theory other than that mentioned in subclause (iii);
- (v) skill or judgment acquired through nursing practice other than that mentioned in subclause (iii); or
- (vi) other knowledge of biological, physical, behavioural, psychological and sociological sciences that is relevant to the knowledge, skill or judgment described in subclause (iii), (iv) or (v);
- (n) “registered nurse” means a person who is registered pursuant to section 19 and whose registration is not suspended or who is not expelled;

The Registered Nurses Act, 1988.

www.qp.gov.sk.ca/documents/English/Statutes/Statutes/R12-2.pdf

Nurse Practitioner The following is an excerpt from The Registered Nurses Act, 1988 which relates to the RN(NP).

Practice

24(3) Subject to any conditions or restrictions on the nurse’s licence, a registered nurse who meets the requirements set out in the bylaws may, in accordance with the bylaws:

- a. order, perform, receive and interpret reports of screening and diagnostic tests that are designated in the bylaws;
- b. prescribe and dispense drugs in accordance with the bylaws;
- c. perform minor surgical and invasive procedures that are designated in the bylaws;
- d. diagnose and treat common medical disorders.

Registered Nurses Act, 1988.

www.qp.gov.sk.ca/documents/English/Statutes/Statutes/R12-2.pdf

Pharmacist

18(1)The council may register as a member, and issue a licence to, a person who produces evidence establishing to the satisfaction of the council that the person:

(a) either:

- (i) has a bachelor’s degree in pharmacy from the University of Saskatchewan or other educational institution recognized by the council;

or

- (ii) in the case of a person who is registered as a pharmacist in a jurisdiction outside Saskatchewan that is recognized by the council, is a member in good standing in that jurisdiction;

- (b) has successfully completed any period of practical training in accordance with the bylaws;
- (c) has successfully completed any examination prescribed in the bylaws;
- (d) has paid the prescribed fees; and
- (e) has complied with the bylaws with respect to registration.

The Pharmacy Act, 1996. www.napra.org/pdfs/provinces/sk/skact.pdf

Jurisdiction	Legislation
Alberta	
Physician	<p>3(1) In their practice of medicine, physicians, surgeons and osteopaths do one or more of the following:</p> <ul style="list-style-type: none"> (a) assess the physical, mental and psychosocial condition of individuals to establish a diagnosis, (b) assist individuals to make informed choices about medical and surgical treatments, (c) treat physical, mental and psychosocial conditions, (d) promote wellness, injury avoidance, disease prevention and cure through research and education, (e) engage in research, education and administration with respect to health, and (f) provide restricted activities authorized by the regulations. <p><i>Health Professions Act, Profession of Physicians, Surgeons, Osteopaths and Podiatrists, Schedule 21 www.canlii.org/ab/laws/sta/h-7/20050801/whole.html</i></p>
Registered Nurse	<p>3 In their practice, registered nurses do one or more of the following:</p> <ul style="list-style-type: none"> (a) based on an ethic of caring and the goals and circumstances of those receiving nursing services, registered nurses apply nursing knowledge, skill and judgment to <ul style="list-style-type: none"> (i) assist individuals, families, groups and communities to achieve their optimal physical, emotional, mental and spiritual health and well-being, (ii) assess, diagnose and provide treatment and interventions and make referrals, (iii) prevent or treat injury and illness, (iv) teach, counsel and advocate to enhance health and well-being, (v) co-ordinate, supervise, monitor and evaluate the provision of health services, (vi) teach nursing theory and practice, (vii) manage, administer and allocate resources related to health services, and (viii) engage in research related to health and the practice of nursing, and (b) provide restricted activities authorized by the regulations. <p><i>Health Professions Act, Profession of Registered Nurses, Schedule 24 www.canlii.org/ab/laws/sta/h-7/20050801/whole.html</i></p>
Nurse Practitioner	<p>2 A regulated member of the College and Association of Registered Nurses of Alberta may, as authorized by the regulations, use any of the following titles and initials:</p> <ul style="list-style-type: none"> (a) registered nurse; (b) certified graduate nurse; (b.1) nurse practitioner; <p><i>Health Professions Act, Profession of Registered Nurses, Schedule 24 www.canlii.org/ab/laws/sta/h-7/20050801/whole.html</i></p>

Jurisdiction

Legislation

On June 30, 2002, the *Registered Nurses Providing Extended Health Services Regulation* under the *Alberta Public Health Act* expired and was replaced with the *Nurse Practitioner Regulations* under the *Public Health Amendment Act (2002)* - Subject to this Regulation, a nurse practitioner may provide the following health services:

- (a) diagnosis and treatment;
- (b) ordering and performing laboratory, radiological and other diagnostic tests and the interpretation of those test results;
- (c) prescribing drugs as defined under the *Pharmaceutical Profession Act*.

According to the amendment, "No person shall employ or engage a registered nurse as a nurse practitioner unless the registered nurse is entered on the Nursing Profession Extended Practice Roster under the *Nursing Profession Act (NPA)*." The amendment also states that "No registered nurse shall provide health services as a nurse practitioner unless the registered nurse is entered on the Nursing Profession Extended Practice Roster under the *Nursing Profession Act*." The regulations and the NPA will both be repealed once the registered nursing profession is proclaimed under the *Health Professions Act (HPA)*. When the *Health Professions Act (HPA)* and pursuant regulations for registered nurses are proclaimed and the NPA is repealed, legislative authority for the regulation of nurse practitioners will be included. The RN (NP) designation will replace the current RN (EP) designation and the title "nurse practitioner" will be protected by law, as are the titles "registered nurse" and "certified graduate nurse." Although the regulation for nurse practitioners under HPA is not the same as the nurse practitioner amendment to the *Public Health Act*, the policies behind the legislation are not substantially different.

Regulation of Nurse Practitioners,
www.nurses.ab.ca/pdf/NP%20pdfs/Fact%20Sheet%20%20Regulation%20of%20NPs.pdf

Pharmacist

3 In their practice, pharmacists promote health and prevent and treat diseases, dysfunction and disorders through proper drug therapy and non-drug decisions and, in relation to that, do one or more of the following:

- (a) assist and advise clients, patients and other health care providers by contributing unique drug and non-drug therapy knowledge on drug and non-drug selection and use,
- (b) monitor responses and outcomes to drug therapy,
- (c) compound, prepare and dispense drugs,
- (d) provide non-prescription drugs, blood products, parenteral nutrition, health care aids and devices,
- (e) supervise and manage drug distribution systems to maintain public safety and drug system security,
- (f) educate clients, patients and regulated members of the Alberta College of Pharmacists and of other colleges in matters described in this section,
- (g) conduct or collaborate in drug-related research,
- (h) conduct or administer drug and other health-related programs, and
- (i) provide restricted activities authorized by the regulations.

Health Professions Act, Profession of Pharmacists, Schedule 19
www.canlii.org/ab/laws/sta/h-7/20050801/whole.html

Jurisdiction	Legislation
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British Columbia

Physician

1. “member” means a member as defined in section 4 and, for the purposes of sections 21, 28 and 53 to 61, includes a former member; “profession” means the practice of medicine or osteopathic medicine.

Qualifications for registration

34 (1) A person is entitled to be registered under this Act if the person does all of the following:

- (a) produces a diploma of qualification issued to the person by a college or school of medicine that at the time the person graduated from it was approved by the council;
- (b) produces satisfactory evidence of identification, experience, good professional conduct and good character as a citizen;
- (c) passes before a board of examiners appointed or approved by the council an examination touching the person’s fitness and capacity to practise as a physician and surgeon;
- (d) pays the fee set by the council for registration.

(1.1) [Repealed 2001-32-15.]

(2) If an applicant fails to authorize a criminal record check under the *Criminal Records Review Act* or the deputy registrar under that Act has determined that an applicant for registration presents a risk of physical or sexual abuse to children and that determination has not been overturned by the registrar under that Act, the council must take the failure or the determination into account when deciding whether to register the applicant or whether to set limits or conditions on the practice of the profession by the applicant.

Medical Practitioners Act, RSBC 1996 Chapter 285 [Updated to November 2001]
www.qp.gov.bc.ca/statreg/stat/M/96285_01.htm#section34

Registered Nurse

1 In this regulation:

“nursing” means the health profession in which a person provides or performs the following services:

- (a) health care for the promotion, maintenance and restoration of health, and
- (b) prevention, treatment and palliation of illness and injury, primarily by
 - (i) assessment of health status,
 - (ii) planning and implementation of interventions, and
 - (iii) coordination of health services;

Scope of Practise

5 A registrant may practise nursing.

Reserved actions

8 (1) A registrant in the course of practising nursing may

- (a) make a nursing diagnosis identifying a condition as the cause of the signs or symptoms of the individual,
- (b) for the purpose of wound care, perform a procedure on tissue below the dermis or below the surface of a mucous membrane,
- (c) for the purposes of collecting a blood sample or donation, perform venipuncture,
- (d) for the purposes of establishing intravenous access, maintaining patency or managing hypovolemia,
 - (i) perform venipuncture, or
 - (ii) administer a solution by instillation through a parenteral method,

Jurisdiction

Legislation

- (e) administer
 - (i) oxygen or humidified air by inhalation, or
 - (ii) nutrition by instillation through an enteral method,
 - (f) for the purposes of assessing an individual or ameliorating or resolving a condition identified through the making of a nursing diagnosis, administer a solution
 - (i) by irrigation, or
 - (ii) by instillation through an enteral method,
 - (g) for the purposes of assessing an individual or ameliorating or resolving a condition identified through the making of a nursing diagnosis, put an instrument or a device, hand or finger
 - (i) into the external ear canal, up to the eardrum,
 - (ii) beyond the point in the nasal passages where they normally narrow,
 - (iii) beyond the pharynx,
 - (iv) beyond the opening of the urethra,
 - (v) beyond the labia majora,
 - (vi) beyond the anal verge, or
 - (vii) into an artificial opening into the body,
 - (h) for the purposes of assessing an individual or ameliorating or resolving a condition identified through the making of a nursing diagnosis, put into the external ear canal, up to the eardrum,
 - (i) air that is under pressure created by the use of an otoscope, or
 - (ii) water that is under pressure created by the use of an ear bulb syringe,
 - (i) apply ultrasound for the purposes of bladder volume measurement, blood flow monitoring or fetal heart monitoring,
 - (j) apply electricity using an automatic external defibrillator,
 - (k) compound, dispense or administer by any method a drug specified in Schedule II of the Drug Schedules Regulation, B.C. Reg. 9/98, or
 - (l) dispense or administer the following drugs specified in Schedule I of the Drug Schedules Regulation, B.C. Reg. 9/98:
 - (i) epinephrine, for the purpose of treating anaphylaxis;
 - (ii) dextrose in concentrated solutions for parenteral nutrition, for the purpose of treating hypoglycemia.
- (2) Section 9 (2) does not apply to the provision or performance by a registrant of a service that includes the provision or performance of an activity described in subsection (1).

Reserved actions for services under an order

9 (1) A registrant in the course of practising nursing may

- (a) perform a procedure on tissue below the dermis, below the surface of a mucous membrane or in or below the surface of the cornea,
- (b) administer a substance, other than a drug that is specified in a Schedule of the Drug Schedules Regulation, B.C. Reg. 9/98,
 - (i) by injection,
 - (ii) by inhalation,
 - (iii) by mechanical ventilation,
 - (iv) by irrigation, or
 - (v) by instillation through an enteral or parenteral method,
- (c) put an instrument or a device, hand or finger
 - (i) into the external ear canal, up to the eardrum,
 - (ii) beyond the point in the nasal passages where they normally narrow,

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- (iii) beyond the pharynx,
 - (iv) beyond the opening of the urethra,
 - (v) beyond the labia majora,
 - (vi) beyond the anal verge, or
 - (vii) into an artificial opening into the body,
 - (d) put into the external ear canal, up to the ear drum, a substance that is under pressure,
 - (e) apply electricity for the purposes of
 - (i) cardioversion, including defibrillation,
 - (ii) adjusting a pacemaker,
 - (iii) adjusting or setting implanted cardiac devices, or
 - (iv) electro-cauterization,
 - (f) compound, dispense or administer by any method a drug specified in Schedule I or IA of the Drug Schedules Regulation, B.C. Reg. 9/98,
 - (g) design or compound a therapeutic diet if nutrition is administered through an enteral method,
 - (h) conduct allergy challenge testing or allergy desensitizing treatment that involves injection, scratch tests or inhalation,
 - (i) conduct allergy challenge testing by any method if the individual being tested has had a previous anaphylactic reaction, or
 - (j) conduct a cardiac stress test for the purposes of diagnosis and treatment planning.
- (2) The following limits or conditions apply to the provision or performance by a registrant of a service that includes the provision or performance of an activity described in subsection (1):
- (a) the registrant must not provide or perform the service except for the purpose of complying with an order;
 - (b) before the provision or performance of the service,
 - (i) the health professional who gives the order must be authorized under an enactment to provide or perform the service, and
 - (ii) the registrant must be authorized under the Act, the regulations and the bylaws to provide or perform the service.

Health Professions Act, Nurses (Registered) And Nurse Practitioners Regulation.
www.qp.gov.bc.ca/statreg/reg/H/HealthProf/233_2005.htm#section1

Nurse Practitioner 1 In this regulation:

“nurse practitioner” means a registrant who is authorized under the bylaws to practise nursing as a nurse practitioner;

Scope of Practice

5 A registrant may practise nursing.

Health Professions Act, Nurses (Registered) And Nurse Practitioners Regulation
www.qp.gov.bc.ca/statreg/reg/H/HealthProf/233_2005.htm#section1

Pharmacist

“pharmacist” means a person who is currently registered under section 15 or 16 as a pharmacist;

“practice of pharmacy” includes the practice of and responsibility for

- (a) interpretation and evaluation of prescriptions,
- (b) compounding, dispensing and added labelling of drugs and devices,
- (c) monitoring drug therapy,

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- (d) identification, assessment and recommendations necessary to resolve or prevent drug related problems in patients,
- (e) advising persons of the therapeutic values, content and hazards of drugs and devices,
- (f) safe storage of drugs and devices,
- (g) maintenance of proper records, including patient records, for drugs and devices,
- (h) services, duties and transactions necessary to the management, operation and control of a pharmacy or to provide pharmacy services in a hospital, facility or care centre, and
- (i) sale of drugs by pharmacists;

15 (1) A person must be registered as a pharmacist and is entitled to use the designation "R. Ph." or "R. Pharm." if the person

- (a) is registered as a student and has graduated with a degree of Bachelor of Science in Pharmacy from the University of British Columbia, is registered as a qualifying candidate or is on the non-practising register,
- (b) meets the assessment requirements of this Act and the bylaws,
- (c) has served the period of practical training specified by the bylaws,
- (d) applies to the registrar and pays the fees specified by the bylaws,
- (e) satisfies the board of the good character of the person consistent with the responsibilities of a registrant and the standards expected of a registrant, and
- (f) attests that there is compliance with this Act and the bylaws.

(2) If the bylaws establish a special practice area and specify criteria for practice, or exclusion from practice, in the special practice area, a registration under this Act may limit the registrant in accordance with these criteria,

- (a) to practise only in the special practice area, or
- (b) from practice in the special practice area.

(3) The registrar must issue proof of registration in the form specified in the rules to a person registered as a pharmacist.

(4) If a pharmacist practises in a pharmacy, this proof of registration must be displayed by the pharmacist in a position conspicuous to the public in the pharmacist's principal place of practice.

(5) A registration under this section is for 12 months and may be renewed under section 16.

*Pharmacists, Pharmacy Operations And Drug Scheduling Act,
www.bcpharmacists.org/legislation/provincial/ppods/#definitions*

APPENDIX 2

Summary Table of Provincial Legislation* for Physicians, Registered Nurses, Nurse Practitioners, and Pharmacists

Physicians

Province	Use of phrase Scope of Practice	Legislation/Regulation
Newfoundland	N	Who: Registered person, eligibility requirements (education)
PEI	N	Who: Registered person, eligibility requirements
Nova Scotia	Y	Who: “Scope” means specialty member is registered; “scope” determined by education, examination, experience
New Brunswick	N	Who: Registered person, eligibility requirements (education)
Ontario	Y (in <i>Medicine Act</i> not in <i>RHPA</i>)	What: Broad definition of practice of medicine (“assessment of the physical or mental condition of an individual and the diagnosis, treatment and prevention of any disease, disorder or dysfunction”), plus list of authorized acts
Manitoba	N	What: Broad definition of practice (“healing art or any of its branches”), What they do - person is practicing medicine if he/she does... (i.e., diagnoses, prescribes or treats).
Saskatchewan	N	Who: Member of the college
Alberta	N	What they do: (i.e. assess, assist patient choice, treat, promote wellness, engage in research, provide authorized restricted activities
British Columbia	N	Who: member of college

* Quebec and the territories not included.

Registered Nurses

Province	Use of phrase	Scope of Practice	Legislation/Regulation
Newfoundland		N	Who: qualified and authorized; What: services for care and prevention
PEI		N	Who: qualified and authorized; What: services for care and prevention
Nova Scotia		N	Who: registered, licensed; What: services requiring knowledge to perform assessment, planning, intervention and evaluation in health promotion/maintenance, disease management, restoration of function, palliative care, OR research, education, management/administration.
New Brunswick		N	Who: registered and authorized What: practice includes assessment, treatment, supervision.
Ontario		Y	What: "Scope of practice of nursing" is health promotion, assessment, care provision, treatment, prevention, palliation, rehabilitations plus authorized acts.
Manitoba		N	Who: registered What: application of nursing knowledge, skill judgment to promote, maintain, and restore health, prevention, palliation, etc. plus specific acts.
Saskatchewan		N	Who: graduate, registered What: performance or coordination of services including but not limited to observing, assessing, planning, implementing, etc according specialized nursing knowledge and skill.
Alberta		N	Who: registered, certified, nurse practitioner What: based on nursing principles and knowledge base, RNs assist, assess, prevent, teach, counsel, advocate, coordinate, supervise, monitor, evaluate, teach, manage, administer, engage in research, provide restricted activities.
British Columbia		Y	Who: a registrant What: care for the promotion, maintenance, restoration of health, prevention, treatment, palliation by assessment, planning and implementation, coordination plus reserved acts. Detailed description of acts can do or delegated to do.

Nurse Practitioner

Province	Use of phrase Scope of Practice	Legislation/Regulation
Newfoundland	N (under nursing legislation)	Who: eligibility (education, skills); authorized (licensed) What: diagnose, order tests/energy application, prescribe drugs plus conditions
PEI	N (under nursing legislation)	Who: qualified and authorized, member What: service for care of sick and give care to prevent disease.
Nova Scotia	N (under nursing legislation)	Who: RN whose name appears in specialty class What: diagnose, communicate diagnosis, order and interpret tests, prescribe drugs, perform procedures under regulations.
New Brunswick	N (under nursing legislation)	Who: registered and authorized under law What: diagnose and communicate to patient, order and interpret, prescribe drugs, order application of energy. Under what condition: reasonable access to physician.
Ontario	Y (under explanatory note for <i>Expanded Nursing Services for Patients Act, 1997</i>)	Who: registered nurses who hold a certificate allowing them What: to perform certain controlled acts, such as communicating a diagnosis to patients, prescribing certain drugs and ordering the application of certain forms of energy
Manitoba	N (under draft regulation under <i>Nurses Act</i>)	Who: registered, educational requirements, examined, pay fee What: general and detailed description of acts.
Saskatchewan	N (under <i>Registered Nurses Act</i>)	Who: RN who meets requirements of bylaws. What: order, perform, receive and interpret reports of screening and diagnostic tests; prescribe and dispense drugs; perform minor surgical and invasive procedures; diagnose and treat common medical disorders.
Alberta	N (under <i>Registered Nurses Act</i> yet to be proclaimed and Nurse Practitioner Regulations under <i>Public Health Amendment Act 2002</i>)	Who: registered nurse entered on NP roster What: diagnosis and treatment; ordering and performing laboratory, radiological and other diagnostic tests and the interpretation of those test results; prescribing drugs

Province	Use of phrase Scope of Practice	Legislation/Regulation
British Columbia	N (Under Nurses (Registered) and Nurse Practitioners Regulation)	Who: registrant authorized under bylaws; What: perform services that for RNs are reserved services under order, make a diagnosis identifying a disease, disorder or condition as the cause of the signs or symptoms of the individual, manage normal labour in an institutional setting if the primary maternal care provider is absent or unavailable, or give an order to apply X-ray for diagnostic or imaging purposes, except X-ray for computerized axial tomography; set or cast simple fracture of a bone, reduce dislocation of a joint, apply X-ray for diagnostic or imaging purposes, except X-ray for computerized axial tomography, give an order to apply forms of energy, prescribe, administer or give an order to dispense a drug

Pharmacist

Province	Use of phrase Scope of Practice	Legislation/Regulation
Newfoundland	N	Who: registered, education
PEI	N	Who: licensed person What: manufacturing, compounding, preparing drugs, dispensing, giving instruction/advice on drug use, etc.
Nova Scotia	N	Who: licensed person What: practice of pharmacy services related to use, dispensing, compounding or distribution of drugs plus list of practice responsibilities e.g. interpretation and evaluation of prescriptions, provision of information, safe storage of drugs, etc.
New Brunswick	N	Who: registered and licensed as pharmacist, education, character, Canadian, etc.
Ontario	Y	What: "Scope of practice of pharmacy" is custody, compounding and dispensing of drugs, provision of non-prescription drugs, health care aids/devices, and provision of information re drug use.
Manitoba	N	Who: registered under Act What: practice of pharmacy means responsibility for preparing, distributing and controlling drugs, compounding, dispensing, selling retail, operating pharmacy, disseminating information on drug use, etc.

Province	Use of phrase Scope of Practice	Legislation/Regulation
Saskatchewan	N	Who: holds a license; educational/training requirements, examination, paid fees, complied with bylaws.
Alberta	N	Who: regulated member of College What: promote health, prevent, treat disease through drug therapy, plus do the following: assist/advice patient/providers, monitor drug therapy, compound/dispense, supervise, educate clients, conduct research, etc.
British Columbia	N	Who: registered, educational requirements, good character What: practice includes interpretation/evaluation of prescriptions, compounding/dispensing/labelling drugs, monitoring, identification, assessment, recommendation of drug problems, advising re drugs, safe storage, etc.

APPENDIX 3

Scope of Practice in a Medical Specialty: the Example of Cardiology

Source: Royal College of Physicians and Surgeons of Canada (RCPSC). Objectives of Training and Specialty Training Requirements in Adult Cardiology.

<http://rcpsc.medical.org/information/index.php?specialty=405&submit=Select>.

Cardiology

GENERAL OBJECTIVES

On completion of the cardiology residency program the cardiologist will be able to function as a consultant in the essential roles and key competencies of cardiologists: medical expert/clinical decision maker, communicator, collaborator, manager, health advocate, scholar, and professional. The graduate cardiologist will have achieved the following general educational objectives and be able to:

- provide excellent, comprehensive, and evidence based diagnosis and management for patients with cardiovascular disorders;
- counsel patients and the broader community on prevention and rehabilitation of diseases of the cardiovascular system;
- communicate effectively and compassionately with patients and their families;
- communicate constructively and effectively with other physicians (especially referring physicians) and other health care professionals;
- function as a member of the health care team, and coordinate the team as appropriate;
- contribute to the education of students, other physicians, other health care professionals, and patients and their families;
- perform necessary technical skills specific to management of patients with cardiovascular diseases;
- maintain complete and accurate medical records;
- be able to undertake accurate self-appraisal, develop a personal continuing education strategy, and pursue lifelong mastery of cardiology;
- be able to critically evaluate the cardiology literature and apply pertinent information to patient management.

During the cardiology residency program the resident must undertake a broad range of practical clinical experiences including acute and chronic cardiac care, ambulatory care, and prevention and rehabilitation; attend a program of formal education activities; and have exposure to and involvement with current research activities. The resident must demonstrate the knowledge, skills and attitudes relating to gender, culture and ethnicity pertinent to adult cardiology. In addition, all residents must demonstrate an ability to incorporate gender, cultural and ethnic perspectives in research methodology, data presentation and analysis. The resident must assume graduated responsibility for clinical decision making and patient care, and be able to function as an independent clinical decision maker at graduation.

SPECIFIC OBJECTIVES

(Revised into CanMEDS format – May 2000)

The educational objectives detail the knowledge, skills, and attitudes essential in the training of the cardiologist.

Medical Expert/Clinical Decision-Maker

General Requirements

- Demonstrate diagnostic and therapeutic skills for ethical and effective patient care.
- Access and apply relevant information to clinical practice.
- Demonstrate effective consultation services with respect to patient care, education, and legal opinions.

Specific Requirements

Cardiologists are experts in all aspects of the diagnosis and management of cardiovascular disease. The cardiologist is able to practice contemporary, evidence-based, and cost-effective medicine, and avoid unnecessary or harmful investigations or management. The cardiologist has specific technical skills in diagnostic and therapeutic techniques.

Cardiologists must be able to provide care to diverse communities. Residents must demonstrate the appropriate knowledge, skills, and attitudes relating to gender, culture, and ethnicity, and must understand the importance of these perspectives in research methodology, data presentation, and analysis.

The resident will demonstrate the following knowledge and skills necessary for excellent patient care:

Knowledge

These objectives are based on the major disease processes encountered in cardiology. Objectives are listed once in the most appropriate category. Each section includes specific domains of knowledge, and clinical problems that should be mastered by the graduate cardiologist.

For each clinical problem the graduate cardiologist is able to perform a complete and accurate cardiovascular history and physical examination, formulate appropriate differential and provisional diagnoses, develop an appropriate plan of investigation and interpret the results, develop a therapeutic plan, develop a plan of secondary prevention, and demonstrate appropriate clinical judgment including consideration of such factors as: the patient's age and other health status; risks, benefits, and costs of diagnostic and therapeutic strategies; and alternative management approaches.

Where the term pharmacology is used it refers to mechanisms of action, clinically relevant pharmacokinetics, indications, contraindications, and adverse effects.

1. Coronary Artery Disease

Knowledge

- Normal coronary anatomy
- Physiology of normal and abnormal coronary blood flow
- Normal and abnormal endothelial function
- Pathogenesis of atherosclerosis
- Risk factors for atherosclerosis and their management
- Pathophysiology of acute coronary syndromes
- Non-atherosclerotic causes of ischemia and infarction
- Diagnostic techniques for coronary disease, including their sensitivity and specificity
- Pharmacology of anti-ischemic, antiplatelet, anticoagulant, thrombolytic and lipid-lowering agents
- Revascularization procedures: percutaneous transluminal coronary angioplasty (PTCA) and coronary artery bypass graft (CABG), their indications, contraindications and benefits.
- Gender differences important in the diagnosis and management of coronary artery disease
- Ethnic differences important in the incidence of coronary artery disease

Clinical problems

- chest pain - acute and chronic
- chronic stable angina
- acute coronary syndromes
- acute myocardial infarction including complications
- hypotension/shock
- post-myocardial infarction management
- asymptomatic coronary artery disease.

2. Valvular Heart Disease

Knowledge

- Normal valve structure and function
- Pathology of valvular disease
- Pathophysiology and hemodynamics of valvular stenosis and regurgitation
- Diagnostic techniques
- Valve surgery: indications, timing, outcome
- Prosthetic valves: types, complications, natural history

Clinical Problems

- Acute and chronic mitral regurgitation
- Mitral valve prolapse
- Acute and chronic aortic regurgitation
- Aortic stenosis
- Mitral stenosis
- Tricuspid valve disease
- Endocarditis: diagnosis, treatment, and prophylaxis
- Rheumatic fever: diagnosis and prophylaxis
- Patients with prosthetic valves: management and follow-up

3. Congenital Heart Disease

Knowledge

- Basic cardiac embryology
- Intracardiac shunting: hemodynamics, pathophysiologic effects
- Congenital lesions in which survival to adulthood is likely
- Congenital lesions in which post-operative survival to adulthood is likely

Clinical Problems

- Atrial septal defect
- Ventricular septal defect
- Patent ductus arteriosus
- Coarctation of the aorta
- Ebstein's anomaly
- Congenital coronary anomalies
- Eisenmenger's syndrome
- Cyanotic congenital heart disease in the adult
- Tetralogy of Fallot

4. Congestive Heart Failure

Knowledge

- Physiology of normal and abnormal ventricular systolic and diastolic function
- Hemodynamic abnormalities in heart failure
- Neurohormonal abnormalities in congestive heart failure
- Ventricular remodeling
- Etiology, prognosis, and natural history of congestive heart failure
- Pharmacology of diuretics, vasodilators, inotropes, and beta blockers in patients with congestive heart failure

Clinical Problems

- Chronic congestive heart failure
- Acute exacerbation of congestive heart failure
- Congestive heart failure in the patient with coronary artery disease
- Dilated cardiomyopathy
- Myocarditis
- Hypertrophic cardiomyopathy: obstructive and non-obstructive
- Restrictive cardiomyopathy
- Cardiac transplantation: indications, contraindications, prognosis, management of the post-transplant patient

5. Hypertension

Knowledge

- Definition
- Diagnosis
- Effect of hypertension on target organs
- Effect of treatment on mortality and complications
- Secondary causes: screening, diagnosis, and management
- Pharmacology of antihypertensive agents

Clinical Problems

- The “new” hypertensive patient
- Chronic hypertension
- Hypertensive urgencies and emergencies

6. Pulmonary Vascular Disease

Knowledge

- Normal pulmonary vascular physiology
- Hemodynamics of pulmonary hypertension
- Pharmacology of pulmonary vasodilator agents

Clinical Problems

- Pulmonary embolism
- Primary pulmonary hypertension: natural history, diagnosis, and management
- Secondary causes of pulmonary hypertension: etiology, diagnosis, and management

7. Pericardial Disease

Knowledge

- Pericardium: normal anatomy and function
- Effect of pericardial disease on cardiac hemodynamics and function
- Pathology and etiology of pericardial diseases

Clinical Problems

- Pericarditis: acute, chronic, and relapsing
- Post-cardiotomy syndrome
- Pericardial effusion
- Pericardial tamponade
- Pericardial constriction

8. Aortic, Cerebrovascular, and Peripheral Vascular Disease

Knowledge

- Cerebrovascular disease: etiology and risk factors, presentations, cardiac causes of stroke and transient ischemic attack (TIA), treatment options
- Aortic disease: pathology, etiology
- Peripheral vascular disease: risk factors, clinical presentations, treatment options

Clinical Problems

- Aortic dissection: diagnosis, medical management, indications for surgery, and follow-up
- Aortic aneurysms: prognosis, indications for surgery
- Marfan’s syndrome
- Acute peripheral arterial occlusion: principles of diagnosis and management
- Claudication: principles of diagnosis and management
- Stroke and transient ischemic attack: principles of diagnosis and management
- Management of patients with combined cardiac disease and carotid or peripheral vascular disease

9. Acute Cardiac Care

Knowledge

- Hemodynamics: normal and abnormal systemic and pulmonary flows, pressures, and resistances
- Ventilation in patients with primary cardiac disease: indications, principles of management
- Pharmacology of inotropes, vasopressors, vasodilators
- Systemic and non-cardiac complications in the critically ill patient

Clinical Problems

- Acute pulmonary edema
- Cardiogenic shock
- Cardiac arrest
- Recurrent ventricular arrhythmias (“electrical storm”)

10. Electrophysiology

Knowledge

- Normal cellular electrophysiology
- Normal sinoauricular (SA) node, auriculoventricular (AV) node, and conducting system function
- Mechanisms of arrhythmogenesis
- Mechanisms of conduction abnormalities
- Pharmacology of antiarrhythmic agents
- Temporary and permanent cardiac pacing: techniques, indications, and follow-up
- Antitachycardia devices
- Invasive electrophysiology studies: indications, techniques, complications
- Invasive ablative techniques for tachyarrhythmias: indications, complications

Clinical Problems

- Palpitations
- Syncope
- Resuscitated sudden death
- Supraventricular tachyarrhythmias
- Atrial fibrillation
- Wolff-Parkinson-White syndrome
- Ventricular tachyarrhythmias
- Bradyarrhythmias

11. Pregnancy in Patients with Cardiovascular Disease

Knowledge

- Normal cardiovascular physiologic changes in pregnancy and their effect in patients with heart disease
- Use of cardiovascular drugs in pregnancy

Clinical Problems

- High-risk cardiac lesions in pregnancy (cyanotic congenital heart disease, pulmonary hypertension, cardiomyopathy and congestive heart failure, Marfan’s syndrome, valvular obstruction)
- Common congenital and valvular diseases
- Patients with prosthetic valves
- Arrhythmias
- Hypertension

12. Other topics

- Perioperative evaluation and management of the patient with cardiovascular disease undergoing noncardiac surgery
- Cardiac trauma: diagnosis and management
- Cardiac tumours: diagnosis, natural history, management
- Cardiac complications of systemic diseases

Skills

1. Expertise in the complete cardiovascular history and assessment.
2. Mastery of all aspects of the cardiovascular examination including carotid and peripheral arterial assessment, jugular veins, precordium, auscultation, and systemic manifestations of cardiovascular disease.
3. Problem solving and clinical decision making, including the ability to correlate, evaluate, and prioritize information acquired by clinical assessment, formulate an appropriate problem list, and develop and implement a diagnostic and therapeutic plan using appropriate knowledge derived from clinical appraisal of relevant literature.
4. Technical skills: the resident will understand the indications, contraindications, complications, and interpretation and have experience in the performance of the following: electrocardiogram (ECG), exercise stress testing, Holter monitoring, pericardiocentesis, temporary transvenous pacing, hemodynamic monitoring (arterial line and Swan-Ganz catheter), and electrical cardioversion.
5. The resident will understand the indications, contraindications, complications, and interpretation of the following techniques: cardiac catheterization and angiography, echocardiography (transthoracic, transesophageal, and Doppler studies), percutaneous coronary interventions, invasive electrophysiologic studies, nuclear imaging techniques, permanent pacemaker insertion, and intra-aortic balloon counterpulsation.
6. Consultation skills, including the ability to present clear and pertinent assessments and recommendations in written and verbal form, participate constructively as part of a team of other physicians and other health professionals, ensure appropriate follow-up and reassessment of the patient's progress, and ensure maintenance of appropriate records.

Communicator

General Requirements

- Establish therapeutic relationships with patients and families.
- Obtain and synthesize relevant history from patients, families and their communities.
- Listen effectively.
- Discuss appropriate information with patients and families and the health care team.

Specific Requirements

To provide the best possible care the cardiologist must establish effective relationships with patients, families, other physicians, and other health professionals. Communication skills are essential to obtain a history from and convey information to patients and families, and to establish a relationship characterized by trust, understanding, and compassion.

The resident will demonstrate the ability to:

- Listen carefully, obtain and synthesize relevant history from patients and families.
- Present relevant information clearly, concisely, and accurately, in written and verbal format, and maintain appropriate records.
- Educate patients, families, and other health professionals in formal and informal settings with regard to the patient's condition, management, risk factors, and secondary prevention.
- Demonstrate caring, empathy, understanding, and confidentiality.
- Understand the impact of such factors as age, gender, disability, ethnocultural background, and socioeconomic background on the patient's history, relationships, and ability to comply with a therapeutic program.
- Identify and discuss end-of-life issues with the patient and family, demonstrating compassion, respect, and understanding.

Collaborator

General Requirements

- Consult effectively with other physicians and health care professionals.
- Contribute effectively to other interdisciplinary team activities.

Specific Requirements

Cardiologists work in partnerships with other health professionals involved in the care of their patients, and it is essential for cardiologists to collaborate effectively with a multidisciplinary team of health care workers.

The resident will demonstrate the ability to:

- Consult with other physicians and other health care professionals, and to understand their roles and contributions.
- Contribute effectively and constructively to multidisciplinary team activities, contribute to team development, and recognize areas of expertise and value opinions of other team members.

Manager

General Requirements

- Utilize resources effectively to balance patient care, learning needs, and outside resources.
- Allocate finite health care resources wisely.
- Work effectively and efficiently in a health care organization.
- Utilize information technology to optimize patient care, life-long learning, and other activities.

Specific Requirements

Cardiologists function as managers when they make practice decisions involving co-workers, resources, and policies. Cardiologists must prioritize and execute tasks, work effectively with colleagues, and make appropriate decisions regarding the location of finite health care resources. Cardiologists frequently assume positions of leadership in the health care system.

The resident will demonstrate:

- Practice and time management skills including punctuality, planning, prioritization, and triage skills.
- Understanding of the advantages and disadvantages of health care in a variety of settings, including hospitals, ambulatory care clinics, offices, homecare, and chronic care and rehabilitation facilities.
- Understanding of the cost and cost-effectiveness of therapeutic and preventive health programs, and the ability to make appropriate decisions based on evidence of benefit to the patient and population served.
- Understanding of quality assurance and quality improvement programs, and the ability to develop appropriate programs in their areas of responsibility.
- The ability to use information technology as an important tool in optimal patient management.
- The ability to organize and coordinate the work of the health care team as a patient's most responsible physician.

Health Advocate

General Requirements

- Identify the important determinants of health affecting patients.
- Contribute effectively to improved health of patients and communities.
- Recognize and respond to those issues where advocacy is appropriate.

Specific Requirements

Cardiologists have an important role in advocating health promotion for individual patients, their practice populations, and the broader community. Health advocacy is undertaken by individual cardiologists and their professional organizations.

The resident will:

- Be able to identify the biologic, psychosocial, environmental, and economic determinants of health, utilize this information in a management and prevention plan, and ensure that the patient accesses appropriate health and social services in the management of individual patients.
- Be able to identify patient groups at risk of cardiovascular disease and its complications within

a practice population, and apply available knowledge regarding primary and secondary prevention.

- Identify issues and opportunities for contributing to the improvement of cardiovascular health in the broader community.

Scholar

General Requirements

- Implement, and monitor a personal continuing education strategy.
- Critically appraise sources of medical information.
- Facilitate learning of patients, housestaff/students and other health professionals.
- Contribute to development of new knowledge.

Specific Requirements

Cardiologists undertake a lifelong pursuit of mastery of cardiology, and have the responsibility for ongoing self-directed learning. They contribute to the education of students, patients, and colleagues, and contribute to research and its appraisal and application.

The resident will:

- Be able to develop and utilize a self-directed continuing education strategy.
- Know and be able to apply the principles of critical appraisal to sources of medical information.
- Know and apply the evidence based standards of care to cardiovascular diseases.
- Understand the importance of ongoing research in cardiovascular disease, will participate and contribute to clinical and/or basic research, and will demonstrate a questioning and inquisitive approach to medical information.
- Contribute to the education of students, patients, and other health professionals.

Professional

General Requirements

- Deliver highest quality care with integrity, honesty, and compassion.
- Exhibit appropriate personal and interpersonal professional behaviours.
- Practice medicine ethically consistent with obligations of a physician.

Specific Requirements

Cardiologists have a unique role in society as professionals dedicated to improving the cardiovascular health of patients in their communities. Cardiologists are committed to the highest standards of excellence in clinical care and ethical conduct, and are committed to acting with integrity, honesty, and compassion.

The resident will:

- Understand and apply the basic principles of medical ethics including: informed consent, advanced directives, research ethics, patient autonomy, and justice.
- Understand the nature of professional interpersonal relationships and boundaries with patients, co-workers, and students.
- Understand legal and professional obligations that apply to cardiology including preparation of timely and accurate medical-legal reports, responses to regulatory bodies, notification of coroners, and substitute decision making.
- All of the resident's clinical care, education, and research activities will be characterized by integrity and honesty.

Specialty Training Requirements

(These specialty training requirements apply to those who began training on or after July 1, 2000. Please see also the 1994 requirements pertaining to those who began training on or after June 1, 1996 and the 1981 training requirements pertaining to those who began training before June 1, 1996.)

1. Royal College Certification in Internal Medicine. (See requirements for this specialty.)
2. Three years of approved residency in an approved Adult Cardiology residency program.
The following core experiences are required. Some learning experiences can occur simultaneously and/or longitudinally (e.g., electrocardiogram (ECG) interpretation, ambulatory clinics).
 - a. 14 months of clinical residency:
 - i. 4 months acute cardiac care
 - ii. 6 months clinical cardiology (including cardiology CTU and consultation)
 - iii. 2 months ambulatory cardiology (may be done longitudinally)
 - iv. 2 months pediatric cardiology (which may include adult and congenital heart disease)
 - b. 14 months of laboratory based residency:
 - i. 4 months cardiac catheterization
 - ii. 4 months echocardiography
 - iii. 2 months electrophysiology/pacemaker
 - iv. 2 months ECG/ambulatory ECG monitoring/exercise stress testing
 - v. 2 months nuclear cardiology
 - c. 4 months elective
 - d. 4 months research (clinical and/or basic)

* Quoted from The Postgraduate Family Medicine Curriculum: An Integrated Approach
Source: College of Family Physicians of Canada (CFPC). Four Principles of Family Medicine.
www.cfpc.ca/English/cfpc/about%20us/principles/default.asp?s=1.

APPENDIX 4

Four Principles of Family Medicine*

The family physician is a skilled clinician.

Family physicians demonstrate competence in the patient-centred clinical method; they integrate a sensitive, skillful, and appropriate search for disease. They demonstrate an understanding of patients' experience of illness (particularly their ideas, feelings, and expectations) and of the impact of illness on patients' lives.

Family physicians use their understanding of human development and family and other social systems to develop a comprehensive approach to the management of disease and illness in patients and their families.

Family physicians are also adept at working with patients to reach common ground on the definition of problems, goals of treatment, and roles of physician and patient in management. They are skilled at providing information to patients in a manner that respects their autonomy and empowers them to "take charge" of their own health care and make decisions in their best interests.

Family physicians have an expert knowledge of the wide range of common problems of patients in the community, and of less common, but life threatening and treatable emergencies in patients in all age groups. Their approach to health care is based on the best scientific evidence available.

Family medicine is a community-based discipline.

Family practice is based in the community and is significantly influenced by community factors. As a member of the community, the family physician is able to respond to people's changing needs, to adapt quickly to changing circumstances, and to mobilize appropriate resources to address patients' needs.

Clinical problems presenting to a community-based family physician are not pre-selected and are commonly encountered at an undifferentiated stage. Family physicians are skilled at dealing with ambiguity and uncertainty. They will see patients with chronic diseases, emotional problems, acute disorders (ranging from those that are minor and self-limiting to those that are life-threatening), and complex biopsychosocial problems. Finally, the family physician may provide palliative care to people with terminal diseases.

The family physician may care for patients in the office, the hospital (including the emergency department), other health care facilities, or the home. Family physicians see themselves as part of a community network of health care providers and are skilled at collaborating as team members or team leaders. They use referral to specialists and community resources judiciously.

The family physician is a resource to a defined practice population.

The family physician views his or her practice as a "population at risk", and organizes the practice to ensure that patients' health is maintained whether or not they are visiting the office. Such organization requires the ability to evaluate new information and its relevance to the practice, knowledge and skills to assess the effectiveness of care provided by the practice, the appropriate use of medical records and/or other information systems, and the ability to plan and implement policies that will enhance patients' health.

Family physicians have effective strategies for self-directed, lifelong learning.

Family physicians have the responsibility to advocate public policy that promotes their patients' health.

Family physicians accept their responsibility in the health care system for wise stewardship of scarce resources.

They consider the needs of both the individual and the community.

The patient-physician relationship is central to the role of the family physician.

Family physicians have an understanding and appreciation of the human condition, especially the nature of suffering and patients' response to sickness. They are aware of their strengths and limitations and recognize when their own personal issues interfere with effective care.

Family physicians respect the privacy of the person. The patient-physician relationship has the qualities of a covenant – a promise, by physicians, to be faithful to their commitment to patients' well-being, whether or not patients are able to follow through on their commitments. Family physicians are cognizant of the power imbalance between doctors and patients and the potential for abuse of this power.

Family physicians provide continuing care to their patients. They use repeated contacts with patients to build on the patient-physician relationship and to promote the healing power of interactions. Over time, the relationship takes on special importance to patients, their families, and the physician. As a result, the family physician becomes an advocate for the patient.

