

Regulatory Body Perspectives on Complaints and Disciplinary Action Processes for Health Professionals

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ABSTRACT:

Background: Previous Canadian reviews of physician, pharmacist, and dentist disciplinary action have noted differences in discipline outcomes across professions and provinces. The objective of this study was to compare the disciplinary action process across provinces and professions, and to describe the perspectives of health professional regulatory bodies on the disciplinary action process.

Methods: Participation from medicine, pharmacy, nursing, and dentistry registrars or complaints directors from 10 Canadian provinces was sought. One-on-one, semi-structured interviews were conducted by telephone or video call.

Results: Nineteen interviews with regulators were conducted—8 pharmacy, 5 nursing, 5 medicine, and 1 dentistry. Complaints and discipline processes followed a similar overall pathway with some differences. Differences in process were largely due to differences in health regulation legislation and were noted across professions, across provinces, and within a province. Participants tended to be more aligned with regulators within their province rather than regulators of the same profession across the country.

Conclusion: To our knowledge, this paper is the first to describe Canadian health professional regulatory body perspectives on the complaints and discipline process. More research is needed to better understand the factors that affect discipline outcomes and to ultimately improve complaints and discipline processes.

Introduction

Reviews of regulatory body disciplinary action have been conducted for Canadian physicians, pharmacists, and dentists, exploring the reasons for disciplinary action, penalties, and demographic factors associated with health professionals subjected to discipline. Differences in disciplinary outcomes have been identified between jurisdictions and professions.¹⁻⁴ In Canada, physicians were most likely to be disciplined for sexual misconduct and clinical care concerns and dentists were most likely to be disciplined for clinical care.^{1,2} In contrast, Canadian pharmacists were most likely to be disciplined for professional misconduct violations, such as unethical or unprofessional conduct.^{3,4} Even within a profession, rates of disciplinary action, penalties used, and types of violations vary from province to province.¹⁻⁴ However, why such differences exist is unclear, especially since the mandate of health professional regulatory bodies is the same—protection of the public. Hypotheses as to

the reason behind these differences include variations in disciplinary processes and regulatory legislation in each jurisdiction, changes in the composition of the disciplinary committee as committee members serve terms that last a certain amount of time, and differences in scope of practice and practice setting among professions.⁵⁻⁸

The objective of this study was to compare the disciplinary action process across provinces and professions, and to describe the perspectives of health professional regulatory bodies on the disciplinary action process. This study will provide additional context to our previous work which reviewed disciplinary action cases for pharmacists and dentists in Canada and could help to explain any trends or differences observed.²⁻⁴

Methods

Ethics approval was obtained through a University of Waterloo Research Ethics Board (REB #43680).

Medicine, pharmacy, nursing, and dentistry regulatory bodies (often called “colleges” in Canada) from 10 Canadian provinces were contacted by e-mail to request their participation. If specific contact information was available on regulatory body websites, e-mails were addressed to the registrar or complaints director. If specific contact information was not available, the general information e-mail address or the online contact form on the regulator’s website was used. A follow-up e-mail was sent at least 4 weeks after the first e-mail if a response had not been received. A \$50 CAD honorarium was offered in appreciation of participants’ time.

One-on-one, semi-structured interviews were conducted by telephone or on Microsoft Teams. Written or verbal consent was obtained from each participant before the interview started. A lead researcher (AFR) and research assistant (RH) inductively coded 2 transcripts on NVivo 12 (released in 2018, QSR software) and met to compare codes and create a coding framework. The coding framework was applied to a third transcript and was approved and both researchers independently coded the remaining transcripts. Any discrepancies about the codes were resolved through discussion.

Data were analyzed according to the Framework Method, which was chosen based on its suitability for analyzing qualitative data involving multiple health professions.⁹ The steps in the Framework Method are as follows: transcription, familiarization with the interview, coding, developing a working analytical framework, applying the analytical framework, charting data into the framework matrix, and interpreting the data.

Interview Guide

Interview questions were based on topics that arose from previous reviews of pharmacist and dentist disciplinary action.^{2,4} The interview guide (Appendix A) included 4 main topics. The first topic was on structure of the disciplinary action process, where participants described the steps taken from a complaint being received to its resolution. The second topic was on the goal of disciplinary action and participants’ perspectives on current processes. The third topic was on the role of discipline and penalties on behaviour change. The fourth and final topic was on participants’ perceptions of the regulatory body by health professionals and the public.

Table 1
Main Sources of Variation Across Provinces and Professions and Implications for Regulatory Reform

| Source of variation | Reason for variation | Implications for regulatory reform |
|-----------------------------------|--|---|
| Differences in legislation | Legislation governing the profession outlines the structure and operation of the process. In some provinces, professions are governed by the same legislation, while in other provinces, professions are governed by separate legislation. | Legislation could be coordinated across professions within a province. Legislative change will require a coordinated effort by multiple professions and government. |
| Differences between professions | Differences in practice setting or business models between professions result in different types of cases. Differences in how certain types of violations are handled also contributes to variation in discipline processes (eg: fraudulent billing by physicians is handled by the government in some provinces and by the regulator in other provinces). | Coordinating higher-level disciplinary processes across multiple professions in a province could decrease variation disciplinary outcomes. However, reasons for disciplinary action will continue to differ between professions due to differences in practice setting and scope of practice. Comparison of disciplinary outcomes between professions is not straightforward. |
| Size of regulatory body | Small regulatory bodies have fewer resources to allot to the discipline process. Small regulators also have fewer disciplinary cases, and therefore fewer opportunities to refine their processes. | A coordinated body that handles discipline cases for multiple professions within a province could provide more standardized disciplinary processes. |
| Culture or approach to discipline | Some regulatory bodies might take a more punitive approach to discipline compared to regulatory bodies who have adopted a just culture/systems approach to discipline. This would result in differences in the types of cases that progress to the higher-level discipline committee and the types of penalties applied. | As more regulatory bodies shift to a just culture approach, types of violations that are disciplined and the types of penalties applied might change. |

Results

Medicine, pharmacy, nursing, and dentistry regulatory bodies from all 10 Canadian provinces were contacted. Overall, 19 interviews were conducted—8 pharmacy regulators, 5 nursing regulators, 5 medicine regulators, and 1 dentistry regulator. Interviews ranged from 38 minutes to 80 minutes, lasting an average of 52 minutes. Table 1 highlights the main sources of variation across provinces and professions.

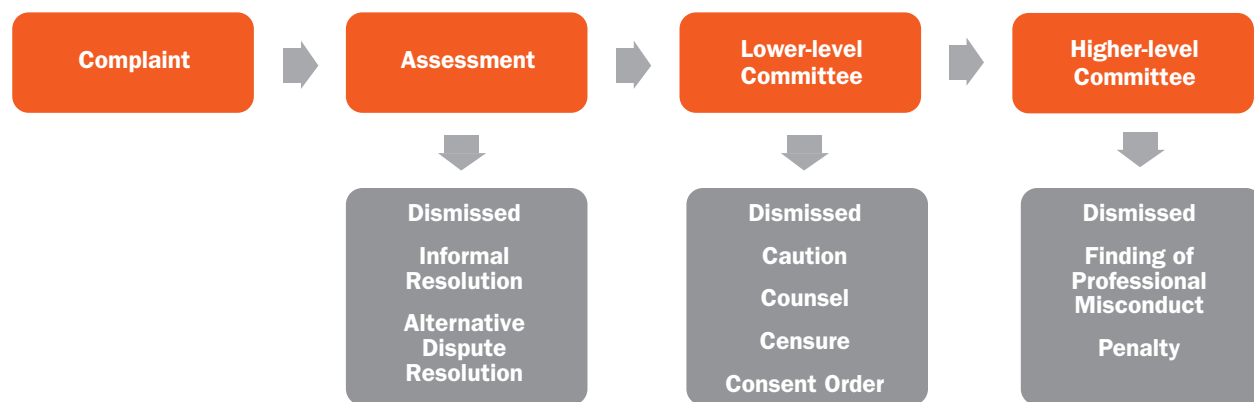
Complaints and discipline process

Complaints and discipline processes varied according to the legislation in each province that governs health professions and outlines such processes. For example, some provinces have legislation that encompasses multiple regulated health professions, while other provinces have profession-specific legislation. Despite these legislative differences, participants described processes that followed a similar overall pathway which is outlined in Figure 1.

Some colleges had well-developed “alternative to discipline processes”, called expedited or alternative resolution (EAR), or alternative dispute resolution (ADR) that allowed a complaint to be resolved outside of the complaints and discipline process if all parties consent to the process; such processes are like informal resolution at a lower-level committee through a consent order. Some participants expressed a desire to have these tools available to them, and participants who did have these processes credited them with improvements in timely resolution of cases.

“So I think one strength is being able to use [expedited or alternative resolution] or resolution agreements so that you can have, ultimately, timely access to justice...It opens up the queue, if you will, for the ones that need to go to an investigation or to a hearing when you're resolving the ones that can be resolved in a different way.... We've moved down from what used to be sometimes over a year to resolve a complaint, to now we can often resolve them within or under 60 days.” (Participant 4)

Figure 1
Typical Processes Used in Handling a Complaint



An **assessment** of the complaint for merit is conducted by the registrar, complaints director or associate complaints director, administrator of complaints, or the complaint might go directly to the lower-level committee. Depending on the regulatory body, a preliminary investigation may be conducted, an interim penalty may be imposed if necessary, and the registrant may be given an opportunity to provide a response.

Lower-level committees typically assess the complaint and can order an investigation to be completed. Most have limited authorities and can take the following actions: dismissal, caution (warning), counsel (provide advice or recommend professional development), or censure (reprimand). Some lower-level committees can sanction the registrant through a consent order (where the regulator, the registrant, and the complainant all agree to the terms) or mandate professional development through a process called SCERP (Specified Continuing Education or Remediation Programs).

Higher-level committees typically operate as a quasi-judicial system where there is a formal hearing of the case where lawyers and witnesses may be involved. A formal finding of professional misconduct can be pronounced by the higher-level committee and a decision on penalties is made. Typically, only serious cases or certain violations (such as sexual misconduct violations) are heard by the higher-level committee. Most cases are resolved before proceeding to the higher level.

Interim Restrictions

Most participants described a process in place for imposing an interim restriction or interim suspension while an investigation was ongoing in order to protect the public. Different pathways exist for the interim restriction to come into effect—through an undertaking by consent with the registrant, initiation by the lower-level committee, through the registrar, or by recommendation to the lower-level committee by the registrar or complaints director. Some participants were satisfied with the authorities they had available to them, while others sought change, such as the authority to issue a variety of interim restrictions, rather than only interim suspensions. Another participant described how their college is seeking legislative change to enable the registrar to impose an interim penalty:

“It takes a lot of time to get to the stage in the process where an interim restriction or suspension can be done by the [lower-level committee]...There have been times in the past, before I was working here, I understand, where they basically had to jump the line and call the [lower-level committee] in to get to that point because there was a risk [to] public safety.” (Participant 11)

Fitness-to-practice/Incapacity Process

At most colleges, fitness-to-practice processes that handle cases of mental health, substance use, or incapacity are not separate from the complaints and disciplinary action process. Some participants were content with this because they felt that they had the ability to handle a fitness-to-practice complaint differently than a competence or professional misconduct concern. Other participants expressed that they would prefer a separate fitness-to-practice arm:

“So how do you deal with a physician who has an addiction, who has a mental health issue, has some other health issue that’s affecting the way they practice medicine? Well, we’re left with discipline and competency, which are pretty rough tools. They’re really not intended for physicians who need help with a health issue. So we hope that we will get a legislative change that will allow us to try to more effectively deal with health-related concerns, and improve our ability to try to ensure that those physicians are receiving the care that they need.” (Participant 13)

Deciding How to Process a Case or Issue a Penalty

Some colleges had a decision-tree or algorithm that outlined how a certain type of case should be processed or that outlined the types of penalties that would be administered. Other colleges did not have such a resource, but participants expressed their desire to develop one to decrease subjectivity.

Participants described that the type of violation influenced the penalty applied, where violations involving intent or criminal activity (eg: fraud, sexual misconduct, or personal health information violations) were more likely to attract severe penalties and minor clinical concerns were more likely to attract professional development or restrictions on one’s license.

“I think you’ll find that if there is a clinician that has been to discipline a few times and is really demonstrating that they have got poor clinical skills, you’re very often going to see suspensions in addition to terms, conditions and limitations either again to try and remediate or at that point to restrict because maybe remediation has already been attempted and the dentist has not improved. Where you’ve got a history of a dentist progressing through discipline, like a couple of times or more, then you’re going to see an escalation in the penalties. When it comes to sexual abuse, there’s a zero-tolerance policy for sexual abuse of patients.” (Participant 12)

Participants described how they consult other regulators across the country within the same profession to help determine an appropriate penalty for a similar case. They also described the challenges they face when deciding on a penalty.

“I think in some ways we feel hamstrung by our hearing tribunals and how they’re being wedded to precedent and therefore not considering a wider range of penalties and including more severe penalties for unprofessional conduct. But I don’t know if this would be any different than any other college, that they are not comfortable with pushing the envelope on penalty.” (Participant 18)

“I think where our frustration lies is that the [lower-level complaints committee] is simply relying on decisions that they’ve historically made. And, as I said, that maybe those decisions that were made 10 years ago do not really fit, or demonstrate right-touch regulation,

or professional accountability for that conduct in today's world." (Participant 6)

Influence of Legislation

The influence of legislation on outlining processes was clear.

"Before [an act that consolidated multiple professions] came in 2014, the college's complaint and discipline process was less defined...We were kind of on our own. We had to develop our own process, which I will say probably wasn't as well developed as other colleges...So, at the time, we looked at that and said, "This is wonderful." It really gives us a very defined framework." (Participant 7)

This participant further described how they continue to be pleased with the structured process provided by the act, but acknowledged that there are elements of the legislation that they find limiting, and aspects of the legislation that they have worked with the government to amend since 2014.

Another participant mentioned how their legislation provided many different tools that can be used to address a complaint and to avoid going to discipline.

"I think our legislation does a good job of recognizing that the specifics of all complaints are not the same, and thus you shouldn't be using necessarily the same tool to address all of them. And again, previously, under our old act, the one tool was investigation. And so when a complaint came in, if it was deemed that it met the criteria for a complaint, the only option was to either dismiss it or send it for investigation. And at the end of the investigation, the only options were to dismiss it or send it forward to hearing. And so again, under our legislation, there's about 7 or 8 different options that we have once a complaint is established." (Participant 15)

Similarly, participants also mentioned that prescribed timelines for processing cases was a strength.

"I think one of the concerns that I had when I came to the college was that things were not done in a timely manner, which is not very fair, but [the Act] put timelines to that. So, all I have to do is enforce those and it's not difficult." (Participant 5)

Effectiveness

Participants expressed uncertainty when asked if they perceived their processes to be effective.

"Well, that's, in a way, an impossible question to answer. That's like asking if our jail sentences are effective." (Participant 10)

"I think it's always a work in progress, is what I'm going to say. I know we have so much more room to improve. We are always looking to how other regulators are functioning and what they're doing, and especially really big regulators. And we really like to look at how their processes are and what they've developed and used." (Participant 6)

Participants identified 4 ways that they assess effectiveness: recidivism rate, number of cases appealed to the health professions review board in their province or the number of complaints lodged with the provincial ombudsman, surveys to gauge registrant and complainant satisfaction with the process, and key performance indicators outlined by government in some provinces that must be reported on by all health colleges, such as timeliness, fairness, objectivity, and transparency.

Differences Between Professions

Participants described differences between professions and practice setting, leading to differences in discipline outcomes. A few participants highlighted that professions that are more "hands on, clothes off" (Participant 17) are more likely to be involved with sexual misconduct allegations, such as massage therapy, medicine, nursing, and physiotherapy.

One participant described how nurses are increasingly being self-employed outside of a hospital.

"Normally, what we would do is, we would say to the employer, 'Here's your opportunity to monitor this individual. Make sure that they complete the learning, etc.' And an employer will obviously be very motivated as well to make sure that that nurse is competent. But if that nurse is working in a sole practice or a practice where they are not being supervised, then we may have to put in lots more monitoring structures and reporting structures to make sure that they are in fact following the requirements of the college." (Participant 16)

Another participant described that practice setting affects the violations seen and penalties applied:

“I think nursing colleges adopt a bit more of a remediative approach in terms of coursework, performance plans, in contrast to fines or suspensions. But I think that’s a function of the nature of the profession. What I mean by that is nurses, as a type of health professional, are far more likely to be employees of a greater employer. And so, with that comes more commonly complaints about skills, about communication or a dynamic in the workplace, as opposed to business practices. And so, other colleges, like dentists or even physicians who also have a function of running a business, and have regulators interested in regulating that aspect, you’re going to see, I think more commonly, more punitive measures like suspensions or fines, because those are arguably more appropriate when the misconduct goes to the business practice.” (Participant 4)

Comments from a pharmacy regulator suggest that the business aspect also affects pharmacists:

“I do think that the commercial interface with pharmacy and as well as the diversity and the difference between big corporate pharmacy and little guy pharmacy...and the little guys, well, they’re all very business oriented. And that becomes a tension and a driving force for what things people will do. And people do bad things if they figure that they might lose their business and their livelihood, because they can’t make a commercial goal of it.” (Participant 17)

Participants described how it is difficult to prove clinical incompetency at the higher-level discipline committee:

“When this fault concerns the clinical expertise, it must be shown that there is a standard that applies to it, and that the physician has deviated significantly from it. The burden to prove an expertise misconduct is then difficult to achieve.” (Participant 19)

Differences Within and Between Provinces

As mentioned above, some provinces have legislation that governs all regulated health professionals while some provinces have specific acts for each profession. Even in provinces with overarching legislation, differences in process still occur:

The legislation is just like the Constitution for us. It’s the broad strokes of what we do. And we could probably do a kind of a whole different process and still be within the legislation as generally described. (Participant 2)

Differences within a province were also attributed to size of the college.

“The main difference is essentially what we have is a couple of really big colleges and a whole bunch of really little colleges. And so, it’s a question of resources. And so, I think some of the smaller colleges, it’s a strain for them to have very robust systems because it takes a lot of resources and money.” (Participant 10)

Some provinces also handle certain violations in different ways. For example, cases of physicians who fraudulently bill the provincial insurance plan are handled by the government in British Columbia and Alberta, but such cases are handled by the regulator in other provinces or for other professions.

A few participants mentioned formal networks within a province, such as an umbrella organization of health regulators that meets throughout the year to present a unified voice to government and promote standardization across health regulation. Others discussed informal networks where a regulator might reach out to others for consultation, or how smaller regulators often reach out to larger regulators. Most participants mentioned that they are more aligned with regulators within their own province compared to regulators of the same profession across the country.

“In terms of how we interpret various things in the process and the approach we take to certain things, I do lean heavily on my counterparts in the province, I would say more so than across the country. When I’m going across the country, the collaboration we do there is more so about precedent, whereas in terms of process and approaches and, I guess, the culture, I would think I feel more affiliated with my provincial health regulatory counterparts.” (Participant 11)

Challenges of Being a Small College

Being a small college presents unique challenges. First, participants from smaller colleges expressed that it takes more time to develop robust processes, since fewer cases are processed.

Second, smaller colleges typically have fewer staff and resources.

“Resources are a big issue. The smaller colleges need to depend more on vendors, on persons external to the college to deliver some aspects of their services when they get really busy. There’s sometimes more of a reliance on external legal counsel because they can’t have an in-house lawyer handling things like discipline and so on. Smaller colleges sometimes can have difficulty with timelines because they’re, again, they just don’t have as many people to be handling their cases, particularly with complex and challenging ones that they may not be as familiar with.” (Participant 12)

Third, having fewer staff also meant that there is less separation between functions of the discipline process.

“The hard part for the tiny colleges, in all honesty, is that they struggle, for example, with who’s giving instructions to counsel on a discipline matter, and who’s doing the hearings office, where often they’re the same people and that’s very difficult. Because in the ideal world, you probably should be fairly separate, but there’s simply not resourced for that, to really separate out the function to that degree.” (Participant 3)

Changes to Discipline Processes

Participants described many changes to discipline that have occurred over past years, such as: improved transparency in publication and in discipline processes, disassociation from the advocacy function to solely a regulatory function, creation of decision-making frameworks, improvements to timely resolution of cases, and implementation of new committees and authorities such as informal dispute resolution processes, fitness-to-practice processes, or interim restrictions. One participant whose college had recently amalgamated with others described how their discipline processes had been intentionally thought out.

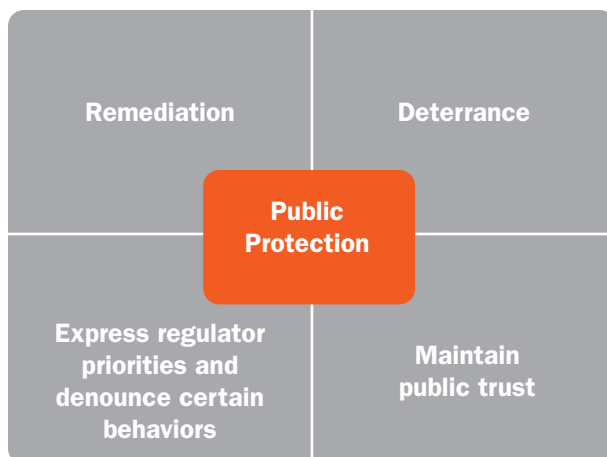
“Sometimes organizations have systems and those systems have been around for quite a while and they may be perfectly fine, but no one necessarily remembers why they became the way they are...I guess you could say [our systems] are very conscious...They’re certainly intentional because they’re new.” (Participant 10)

Participants also described changes in their culture or approach to discipline. One participant described how while their college would previously take a punitive approach by sending a pharmacist who made a dispensing error to discipline, such a case would be addressed with a remedial approach today. Another participant described taking a team approach to a pharmacy error, since community pharmacists and pharmacy technicians often work in a team environment. These changes also reflect the shift to just culture that was discussed by other participants.

Goal of Complaints and Disciplinary Action Processes

Participants communicated that the overall mandate for the complaints and discipline process was protection of the public, and described 4 main goals that fall under the mandate (Figure 2).

Figure 2
Goals of the Complaints and Disciplinary Action Processes



The following quotes illustrate some of these goals:

“I think the best way to describe it is that ultimately our goal is to fulfill the mandate, the statutory mandate, which is protection of the public. So, everything focuses on the protection of the public. And that means resolving complaints through both remedial and punitive measures to ultimately deter future misconduct and help remediate current practices.” (Participant 4)

“The goal, I would say, at a high level, is to hold pharmacy professionals accountable for

any actions that would be in conflict with any of our foundational standards or code of ethics that would result in potentially placing the public or a patient at risk...We're at a crucial time where there's probably more scrutiny on the complaints process and self-regulatory colleges than in the past. It's important to maintain the trust in that process where the outcome is based on a fair determination from that public protection standpoint.” (Participant 14)

Transparency

Participants spoke about the importance of transparency in the complaints and discipline process, where the complainant and the health professional are informed about the process. For example, one participant described how the public member that complained would be sent a copy of the health professional's response to the complaint. Others mentioned how complainants were given more voice in the process, and how pharmacists were able to provide a response to the college soon after the complaint was lodged.

Participants also spoke of the importance of transparency related to publication of the outcomes of the complaints and discipline processes, viewing publication as a key way to hold professionals accountable, for professionals to learn from each other, and to inform the public about their practitioners.

“You can't regulate under a rock; you have to regulate in the public interest. And the public interest is that they're informed.” (Participant 5)

Participants also described improved transparency over the years, with more cases and more detail being published. Some regulators have created internal policies to ensure more transparency than what is mandated in legislation. In contrast, some participants described that non-publication of the case can be negotiated as part of the terms of the consent agreement. Most colleges described publication of only the higher-level disciplinary cases, and not lower-level complaints cases, which limits comparisons across provinces.

“I think it's hard to know exactly what is going on because, for example, many dispositions from our [lower-level committee] are not made public. So, I assume that I am unable to see all that is transpiring in other provinces. We can only access what's available publicly, and

sometimes that's just a small picture of what's happening.” (Participant 1)

Public Perception

Most participants described a lack of awareness on behalf of the public about the regulatory body.

“I suspect the average patient, unless they're engaged in a complaint process with the college, is probably completely unaware of the college. And they probably confuse the college with the advocacy group, and that is an important task for us.” (Participant 8)

Participants described a mismatch between the public's expectations of disciplinary outcomes and the actual outcome. To mitigate this, some participants established realistic expectations with the complainant when they lodged the complaint. One participant described frustration, feeling someone would be displeased regardless of the outcome.

“If you dismiss the complaint, the complainant often says, ‘Well, what do you expect? You're just a bunch of people protecting doctors.’ If you discipline the physician, the physician's response often is, ‘Well, what do you expect? You just took the patient's word and treated me unfairly, and I didn't get a just result.’” (Participant 13)

Participants described strategies to increase awareness, such as increasing their social media presence, updating regulatory body websites, involvement in community events, and seeking public input on regulatory matters.

Registrants' Perception

Participants described a spectrum of attitudes toward the regulator, ranging from those that are pro-regulation and involved in the college, to those that do not pay much attention to the regulator, to those that have negative perceptions, such as being “terrified of any interaction with their regulator” (Participant 3) and having a “lack of respect for the regulator” (Participant 7).

“We will always have that segment of registrants that think we just make them pay registration fees each year to be able to practice. Some see us as police department of the profession that gives them citations and penalties when rules are not followed. For registrants that don't understand professional regulation or the role of the college we are

perceived as a series of hoops and hurdles.”
(Participant 9)

Some expressed that registrants’ negative perceptions did not matter to them, since regulatory bodies exist for the public. In contrast, others felt that good relationships with the profession were important to establish the regulator as a legitimate body and in order for self-regulation to function properly.

Participants expressed that registrants, similar to the public, confuse the role of the advocacy body with the role of the regulator. Participants are aiming to better educate registrants on the complaints and disciplinary processes through professional development strategies.

Discussion

Complaints and disciplinary action processes across Canada for medicine, pharmacy, nursing, and dentistry regulatory bodies follow a similar structure with variations that are largely due to differences in legislation. Participants tended to be more aligned with other regulators within their province rather than regulators of the same profession across Canada. This paper provides

of an independent disciplinary panel that makes decisions regarding all health professions, as well as increased standardization in health professions regulation in the province. Such changes aim to improve efficiency, effectiveness, and cost-savings. Our research shows that participants desire more standardization in the form of decision-making frameworks or algorithms as well as changes to the types of penalties administered. In addition, there is redundancy in the system as each college (except in Quebec) conducts their own complaints and discipline investigations and hearings. Further work in Canada is needed to evaluate different models of health regulation and disciplinary action, and to examine the cost-effectiveness of new processes such as those that have been proposed in British Columbia.¹¹

Differences in Disciplinary Outcomes Due to Differences in Profession

Previous Canadian research found that fraudulent billing accounted for 10% of physician violations, but 20% and 22% of violations for pharmacists and dentists, respectively.^{1,2,4} As this study highlighted, these differences could be because some physician regulators do not handle cases that involve fraudulent billing of provincial health insurance, leading to underreporting of fraudulent billing cases compared to jurisdictions where such cases are handled by the regulatory body. While participants highlighted that pharmacists have a business conflict of interest, physicians also have a significant business conflict. Most pharmacists are employees of a pharmacy, and medications and services that are billed to insurance companies or the provincial health plan are paid to the pharmacy store. In contrast, physicians are often sole proprietors or incorporations, and the physician is paid by the provincial health plan. It is possible that the increased incidence of fraudulent billing in pharmacy is not because pharmacists have a business conflict and other professions do not, but because it is more straightforward to pursue financial fraud in pharmacies where pharmacists sell a product that is easy to track, while physicians and dentists sell a service.

Differences in Legislation

Our results highlight that differences in disciplinary practices originate from the practices outlined in the governing legislation. To reduce variation, more similar legislation would be required. Our previous

AT MOST COLLEGES, FITNESS-TO-PRACTICE PROCESSES THAT HANDLE CASES OF MENTAL HEALTH, SUBSTANCE USE, OR INCAPACITY ARE NOT SEPARATE FROM THE COMPLAINTS AND DISCIPLINARY ACTION PROCESS.

context to our previous work by explaining some differences in discipline outcomes across provinces and professions. This paper is, to our knowledge, the first to describe Canadian health professional regulatory body perspectives on the complaints and disciplinary action processes.

Scant research has been conducted on the effectiveness of different regulatory models,¹⁰ and different disciplinary processes in Canada have not been compared. Our research highlights differences in processes between provinces and professions, but it is unknown whether these variations are consequential or if they are simply different ways of achieving a similar outcome.

In 2020, British Columbia proposed an overhaul of health professions regulation, including a reduction in the number of health regulators and the creation

review of pharmacist disciplinary action found that Quebec, like other provinces, used fines and suspensions as common penalties for disciplinary action, but rarely used professional development and conditions or restrictions on one's license to practice.⁴ According to our interviews, this could be because under Quebec legislation, the higher-level disciplinary committee has the authority to use only fines, suspensions, and reprimands.

OUR RESULTS HIGHLIGHT THAT DIFFERENCES IN DISCIPLINARY PRACTICES ORIGINATE FROM THE PRACTICES OUTLINED IN THE GOVERNING LEGISLATION.

Our results established that legislation influences complaints and discipline processes, which affects publication of complaints and discipline cases and affects discipline outcomes. For example, provinces that triage complaints into a separate fitness-to-practice arm divert these cases from the complaints and discipline stream, leading to differences in outcomes. This is because fewer fitness-to-practice cases would be heard by the lower- and higher-level committees, and fewer penalties would involve drug testing or ongoing fitness-to-practice monitoring. Provinces that funnel clinical complaints into a quality assurance arm might also see fewer clinical cases at the lower-level committee. Similarly, jurisdictions with robust alternative to discipline processes or the authority to arrange a consent order at the lower level might have fewer cases that progress to discipline than jurisdictions with limited authorities at the lower level.

Differences in Regulatory Body Size

Lastly, our results show that regulatory bodies believe regulatory body size influence disciplinary processes. Specifically, small regulators have fewer resources, staff, and time to devote to complaints and disciplinary processes, which could result in more cases being handled through informal resolution, fewer disciplinary hearings, and greater potential bias due to less separation between the college and the investigation arm. For example, Canada's third smallest province, Nova Scotia, recently approved a new regulatory act that replaces 21 acts with a single act.¹² This change specifically aimed to increase efficiencies and standardize practices.¹³ An explicit example of the

efficiencies is how the legislation will allow regulators to convene a joint panel from a pool of potential members in place of a regulatory body's statutory committee (eg: complaints or conduct committee), where a joint panel consists of at least 1 member of the same health profession as the professional it concerns, other regulated health professionals, and public members. This will provide organizations with access to shared resources, which could be particularly beneficial for small regulators.

Limitations

A few limitations should be considered. First, lack of dentistry participants limits the generalizability of this research to Canadian dental regulators. Second, a larger sample size would have been preferred. Some regulatory bodies declined interviews due to the COVID-19 pandemic and associated challenges related to workload and staffing.

Conclusion

Complaints and discipline processes vary across provinces, within provinces, and across professions in Canada. As this study demonstrated, regulation in Canada is dynamic, with regulators improving processes and looking for ways to better protect the public. While this study identified that legislation and policy play an important role in discipline processes, more research is needed to better understand how such policies influence discipline processes and outcomes, to describe factors that influence differences in discipline outcomes between professions, and to better understand the relationship between complaints cases and discipline cases. In addition, studies that assess registrant and public perceptions of the college are needed to create strategies to address negative perceptions and increase awareness of the college. Such research will ultimately lead to changes to better protect the public and improve health professional regulation in Canada.

| Appendix A |
|---|
| Structure of the disciplinary action process |
| <p>1. Please describe the committees involved and steps taken in the complaints and disciplinary action process.</p> <p>Prompts:</p> <ol style="list-style-type: none"> Are there separate committees that handle complaints and discipline? Please explain the difference between these committees. Are there times when a complaint might bypass the complaints/inquiry committee and proceed directly to the higher level of disciplinary action? Does the college have a framework or decision tree to help decide how the complaint is processed? Please describe this. |
| Goal of disciplinary action |
| <p>2. As a regulatory body director, please describe the goal of regulatory body complaints and disciplinary action processes.</p> <p>Prompts:</p> <ol style="list-style-type: none"> Is there a difference in how the college approaches complaints about clinical competence versus professionalism or financial fraud? Please explain. Would you say that the processes are effective at achieving this goal—what are some strengths? What are some areas for improvement? We have noticed some differences in the types of violations that some provinces discipline. How do you perceive your college's culture and attitude towards disciplinary action to be compared to other Canadian regulators of the same profession? Would you say that your processes are similar or different from other Canadian regulators? |
| Behavior change and recidivism |
| <p>3. How do regulatory bodies motivate health professionals who have been disciplined or are flagged for incompetence to change their behavior?</p> <p>Prompts:</p> <ol style="list-style-type: none"> What strategies or programs do you have in place to motivate or monitor health professionals that have been disciplined? What types of penalties are used by your college in the complaints and disciplinary action processes? What is the goal of these penalties? Do you find penalties to be effective? |
| Perception by members and the public |
| <p>4. How would you describe members' perceptions of the college?</p> <p>5. How would you describe the public's perception of the college?</p> <p>Prompts:</p> <ol style="list-style-type: none"> Anecdotally, some perceive the college to be the 'watchdog' or 'out to catch you'. How would you ideally like to be perceived by members of the profession? What would be some strategies to achieve this goal? |
| Final comments |
| <p>6. Do you have any final comments to add before we end the interview?</p> |

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