COLLEGE OF
REGISTERED NURSES
OF BRITISH COLUMBIA

CRNBC

Underlying Philosophies and Trends Affecting Professional Regulation

February 2012

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Background

Rationale

In the Spring of 2011, the College of Registered Nurses of British Columbia (CRNBC) undertook to explore the foundations of a regulatory philosophy and framework. Once articulated, the framework could assist the organization to set priorities and to rationalize activities and to communicate these to registrants and others. This regulatory philosophy and framework would need to take account of current trends, contemporary approaches to regulation, and related philosophical frameworks for regulatory practice among health and other professions. Sources for this exploration would include published literature and relevant documents but also the views of a wide range of key informants, including CRNBC staff and Board members past and present, representatives of other health and professional regulatory bodies in BC, Canada and North America, government policy makers, nurse leaders, nurse educators, academics, and patients themselves.

The published literature on the subject of regulatory philosophy for nursing — and indeed any professional regulation - is sparse. Key informant interviews confirmed that the undertaking was novel: few organizations have made the time for reflection on the influential trends and underpinning philosophy of regulation, and fewer still have conferred their thoughts to writing. In the course of conducting interviews it became clear that the exercise could not be compressed into a tightly constrained time frame. Many people were interested in sharing their views and in hearing what others had to say. Many key informants encouraged CRNBC to see this investigation as a "starting point" for a more structured engagement or dialogue with a wide range of interests, including nurse registrants and the public.

Purpose

This document presents an overview of views and ideas gleaned from the investigation – a review of the literature, relevant documents, and interviews with over 100 individuals. These may be considerations for CRNBC as the organization reflects on the philosophical underpinnings of its work as a regulatory body. The document presents views on the major trends that will affect the context in which CRNBC works, factors that may influence what the organization will be required to attend to, and views on how CRNBC might conduct its work under these circumstances.

Method

A formal search of the published and grey literature was conducted and was supplemented by sources identified by key informants (a bibliography is provided in Appendix A). A key informant list was developed by the CRNBC leadership team and was supplemented over the course of the consultation as other informants were identified (a list of the over 100 people who participated in one-on-one or focus group interviews is presented in Appendix B). Based on an initial review of the literature, an interview guide was developed and used as a basis for one-on-one telephone interviews and face-to-face or telephone focus groups (please see Appendix C for a copy of the interview guide).

II The Starting Point

Healthcare is "risky business", a field of practice that demands high levels of knowledge and skills. Patients, the public, and the governments that represent them have entrusted designated self-regulating health professions with the authority to oversee the quality and safety of many critical aspects of clinical service delivery. Professional regulation, thus, must

create a framework that maintains the justified confidence of patients in those who care for them as the bedrock of safe and effective clinical practice and the foundation for effective relationships between patients and health professionals.

> UK Secretary of State for Health; *Trust, Assurance and Safety – the Regulation of health Professionals in the 21st Century*; 2007

In spite of the faith placed in professional regulatory bodies and the efforts they, and other responsible players, make to ensure quality and safety in healthcare, neither professional care providers nor the healthcare systems they operate within will ever be perfect. Professional regulatory bodies, concerned with the behaviour of individual registrants, seek to anticipate and address three main classes of problem behaviours:

- ***Human Error:*** *an inadvertent action; inadvertently doing other than what should have done; slip, lapse, mistake.* Human error is a product of current system design and the exercise of personal choices.
- ***At-Risk Behaviour:*** *a behavioural choice that increases risk where risk is not recognized or is mistakenly believed to be justified.* At-risk behaviour is a conscious choice by an individual where risk is believed to be insignificant or justified. This kind of choice may, of course, be influenced by the culture or context in which the individual works if, for example, risky behaviour is tolerated, accepted or even celebrated.

and

- ***Reckless Behaviour:*** *a behavioural choice to consciously disregard a substantial and unjustifiable risk.* Again, this behaviour may be influenced by culture or context but it reflects a conscious disregard of a substantial and unjustifiable risk.

> K. Scott Griffith, CEO, Outcome Engineering, LLC; *Presentation to the National Council of State Boards of Nursing 2011 Midyear Meeting;* 2011

(To this one might add "intent to harm" or wanton malpractice to complete the spectrum of behavioural sources of adverse events. But, once detected, there is little ambiguity about how to respond.)

In the face of evidence of an adverse event or receipt of a complaint, the professional regulatory body's task is to assess the role of human agency in the situation, specifically, the intent, the level of risk-taking, the decisions made, and the exercise of prudential judgment of the individual nurse. But exploration of problem behaviour gives rise to the question of the level of intervention required to remediate or, ideally, prevent its

(re-)occurrence. This, in turn, begs the question of root causes. Does the problem behaviour stem from the knowledge, skills, abilities and attitudes:

- *of the individual health professional?*
- *of the healthcare group or team?*
- *of the organization providing the healthcare?*

or

- *of the larger healthcare system or environment in which these are embedded?*

> Winslade, Nancy E. et al; Integrating Performance Assessment, Maintenance of Competence, and Continuing Professional Development of Community Pharmacists; 2007

Historically, professional regulatory bodies have focused their attention on the first of these root causes – a limitation or flaw in the knowledge, skills, abilities and attitudes of the individual health professional, a registrant of their respective College. Several important trends in healthcare, as well as broader social and economic trends, are giving rise to considerations for new approaches to managing and, ideally, preventing problem behaviour.

III Some Relevant Trends

3.1 Social and Economic Trends

The Economy

At a fundamental level, the roots of the economic downturn, in speculative financing, poor judgment and sheer personal greed, have had an impact on the philosophical foundations of regulation. Once a growing trend in regulation of financial institutions in the UK and Europe and with much to commend it, faith in principle-based regulation to govern the conduct of financial institutions was shattered by the recent financial crisis. With a legal system seeking the certainty and predictability of codification and rules, this faith has not been restored in the ensuing recession and the turbulent economic times that have followed. The demonstrable failure in the contrasting US reliance on regulation to shape the conduct of financial institutions has left the international financial sector in a quandary about the philosophical underpinnings of its approach to oversight and governance. The US experience shows clearly that more rules and regulations are not the answer.

At an individual level, as personal resources and discretionary incomes have become more constrained, people are becoming more attentive to how their personal resources are being disbursed. In the course of interviews with representatives, many professional regulatory bodies reported rising concerns about "value for money" among their licensees and, in the case of affected US bodies, their respective State funding bodies. For Canadian professional regulatory bodies this has led to a requirement for clearer articulation of the role and benefits of professional regulation as well as a closer accounting and reporting of budgets and expenditures. For US-based nursing regulators, it has led to increased attention to their profile and to justification of their role to the healthcare system and the public whom they serve.

The general economic downturn has had an impact on the practice of nursing as well. While the demographic profile of the profession, with many nurses approaching retirement, has been known for years to have been tilting to the older age groups, the economic downturn has led many older nurses to defer retirement and has required or induced others to return to work in the healthcare system. While this brings the benefit of experience and wisdom to practice settings, several key informants noted the deleterious impact this has had on the culture of nursing at some sites where innovations in practice and progress towards evidence- and principle-based approaches were stifled in preference for more conservative, rule-based, codified approaches.

Technology

There can be no doubt that the world, and healthcare as a sector in particular, is increasingly dependent on technologies of various kinds. In healthcare, the complexity and ever-changing nature of new technologies gives rise to the imperative for professional providers to not only maintain but to enhance their competencies in order to keep pace with current practice. In many cases, it is difficult or even impossible to conduct clinical activity in the absence of technology, so that technology itself is beginning to define the clinical experience and the expression of the clinical profile. Not surprisingly, increasing technological complexity has given rise to a trend to increasingly narrow credentialing, including certification of specific practices or use of

technologies. While this may ensure quality and safety in the application of sophisticated technologies and interventions, it is seen to have led to narrower conceptions and definitions of professional roles. Ultimately this hyper-credentialism is perceived to lead to an erosion of the confidence, independence and critical thinking that is needed among all health professionals.

Information and communication technologies, and notably social media, are seen to present both opportunities and challenges in the provision of healthcare. On the one hand, social media may help with communication to patient cohorts that are more comfortable with them than other modes of communication. For example, a less personal "text message" communication may be easier to receive for someone who is intimidated by a health professional in face-to-face communication. For younger patients, ubiquitous social media are seen as convenient, efficient, and effective means of communicating. However, key informants noted that there is a risk that caregivers resort to social media because it is easier for them – a quick and easy communication that does not require personal interaction - without due regard for the needs or wishes of the patient. Furthermore, the very public nature of social media makes its use a fertile ground for breaches of patient and provider confidentiality and privacy, giving rise to the need to provide clear guidelines on the use of social media in healthcare delivery. It behooves all health professional regulatory bodies to clarify for registrants the appropriate role of social media in the exercise of their profession.

Self Regulation and Self Interest:

As noted above, the economic crisis and destructive role of individuals acting in self interest, even in the face of purported regulatory controls designed to protect unsuspecting shareholders and the public, has rocked the public trust. But, perhaps more significant for professional regulatory bodies, the experience – including the very public prosecution of leading figures - has helped to raise awareness and change public opinion regarding conflict of interest. Public sensitivity to what constitutes a conflict of interest, real or perceived, and how it should be remedied has been piqued. Key informants observed that this, added to the media attention accorded to failures in judgment and conduct of healthcare professionals, has given rise to an acute sense of distrust in the effectiveness of professional self-regulation in healthcare.

[Some of the forces driving change include] the widespread view that self-regulation is particularly susceptible to regulatory capture; dramatic examples of regulatory failure on the part of the self-regulating professions; and a widespread view that the traditional configuration of self-regulation among health care professionals has become a significant barrier to reform and improvement in the delivery of health care services.

> William Lahey; *Collaborative Self-Regulation and Professional Accountability in Nova Scotia's health Care System*; 2009

Adding to this generalized unease among members of the public regarding the ability of professional self-regulation to protect their interests, a 2007 Competition Bureau review of self-regulated professions, including health professions, underlined concerns about professional protectionism and its deleterious effects on the market. The Bureau's contention is that the potential for conflict of interest among self-regulating professions necessitates limits to regulation that needlessly inhibit competition. The hyper-credentialism noted above, where health professionals, including nurses, advocate increasing specificity in "qualifications for practice" in the name of protecting the public from misuse of complex technologies, is seen as further proof of self-serving turf protection by several key informants. Proponents of effective regulation advocate judicious application of

the constraints needed to protect the public while stopping well short of interfering with personal expression, preferences or conduct.

While the nature and rigour of regulation varies across professions, the net result is that the professions have not traditionally been subject to the full forces of competition that prevail in other sectors of the economy, thus reducing the many ways in which consumers benefit from a competitive environment. The regulatory restrictions that have the greatest potential to hamper competition are restrictions on market entry, including restrictions on entering the profession, mobility and on overlapping services and scope of practice, and restrictions on market conduct, including rules controlling advertising, pricing and compensation, and business structure.

Competition Bureau; Self-regulated professions - Balancing competition and regulation; 2007.

3.2 Trends in Healthcare

Quality and Safety

Healthcare is but one of many intrinsically hazardous endeavors in society where human lives are at risk on a daily basis and are in the hands of trained professionals working as individuals and teams.

Gaba, David M., What Can Health Learn from Other Industries of High Intrinsic Hazard? CRICO/RMF, Forum, March 2010, pp3-5.

There can be no doubt that concerns for quality and safety in healthcare have been a driving force of administrative, program, and clinical practice reform in recent years. *The 1999 publication of the* US Institute of Medicine (IOM) *report,* To Err is Human, drew attention to the tens of thousands of Americans who die each year from medical errors and effectively put the issue of patient safety and quality on the radar screen of public and private policy-makers. Two years later, the IOM's *Crossing the Quality Chasm* report described broader quality issues and defined six system aims, that care should be: safe, effective, patient-centered, timely, efficient and equitable. The release of the landmark *Canadian Adverse Events* study in 2004 revealed that the Canadian experience closely resembled that of the US:

The overall incidence rate of [Adverse Events or] AEs of 7.5% in our study suggests that, of the almost 2.5 million annual hospital admissions in Canada similar to the type studied, about 185 000 are associated with an AE and close to 70 000 of these are potentially preventable.

Baker, G. Ross and Peter G. Norton, et al. The Canadian Adverse Events Study: the incidence of adverse events among hospital patients in Canada; CMAJ p1678

An important conclusion of the studies and reports conducted was that adverse events (AEs) were most often the result of the failures not of individuals but of the systems in which they operated. Healthcare policy- and decision-makers were enjoined to move away from the historical "blame and shame" approach that led to a tendency to hide rather than report errors, to consider the role of the *system* in giving rise to errors, and to seek to learn from, if not prevent AEs from occurring.

Many have said that a culture of blame has been pervasive in healthcare. Because medicine was often viewed as the work of a sole physician (or other professional) working with an individual patient, when something did not go well the automatic reaction was to try to determine who was at fault and, often, to discipline them. This "shame and blame" approach leads to hiding rather than reporting of errors, and thus is the antithesis of a culture of safety. Recent efforts have tried to change this—to encourage people to report problems rather than hide them, so they can be addressed. Forward-thinking healthcare organizations remember that their primary reason for existence is to take care of patients, and they want to keep them as safe and healthy as possible.

Duke University Medical Center;
http://patientsafetyed.duhs.duke.edu/module_c/culture_healthcare.html

The attention drawn to patient safety and quality improvement spawned the creation of a number of new oversight bodies at all levels of the healthcare system. The presence of these new bodies gives rise to the question of how they interact. Viewing healthcare as a system, as opposed to a loose affiliation of discrete players with independent roles and functions, and returning to the question of human agency raised above, gives rise to the question of where and when do the roles of one oversight body end and another begin, where do roles overlap, where and how are roles co-dependent, and what could or should be done to synchronize roles?

Most people want to regulate behaviour but structure, conditions and circumstances, always trump - and can work to extinguish - desired behaviour.

Porter-O'Grady, Tim; Personal Communication; November 21 2011.

Interprofessional Practice

Changing population demographics and the increasing prevalence of chronic disease has led to a shift in approaches to care at all levels. The once-dominant solo-practitioner model of primary care, for example, has given way to a vision of interprofessional practice that sees a wide range of professional disciplines working as an interdependent team to meet the needs of each patient. However, while this model of care has been embraced in theory, it is not always well understood or supported in practice.

Key informants noted that, like many other health professionals, Registered Nurses are not well educated in how to work as a team, even in teams comprised of those in complementary nursing professions such as Registered Psychiatric Nurses and Licensed Practical Nurses, where there are shared and overlapping competencies. Though they have entry level competencies in teamwork, new graduates do not always have a clear sense of what their profession brings to the team in terms of scope of practice and distinct competencies.

Furthermore, the legal framework for interprofessional practice has not kept pace with the practice model reforms that are taking place. The tendency of the law of negligence to individualize liability means that accountability may be misallocated among members of an interprofessional team, often disproportionately on physician members who have the widest scope of practice and the authority to delegate to other professionals.

..since the premise of interprofessional practice is shared and even overlapping competencies, a different notion of clarity is inherent. Boundaries between the various professions and their respective scopes of practice are to be adjusted, made fluid, or perhaps blurred. Tasks historically carried out by one profession will be done (and done equally well and more efficiently) by other professions…. If interprofessional practice is to become a dominant model, it will require professions to collectively promote a vision for interprofessional practice that addresses accountability issues and "educates" the courts.

Lahey W, Currie R. Regulatory and medico-legal barriers to interprofessional practice. J Interprof Care 2005 May; Suppl 1:197-223

Patient-centred Care

Linked to interprofessional practice is the trend towards a more patient-centred model of care that sees the active engagement of patients and families in defining and meeting their healthcare needs. A patient-centred approach demands much more transparency than has historically been present in patient-provider encounters and the system as a whole.

"Patient-centeredness" is a dimension of health care quality in its own right, not just because of its connection with other desired aims, like safety and effectiveness. Its proper incorporation into new health care designs will involve some radical, unfamiliar, and disruptive shifts in control and power, out of the hands of those who give care and into the hands of those who receive it. Such a consumerist view of the quality of care, itself, has important differences from the more classical, professionally dominated definitions of "quality."

Berwick, Donald M. What 'Patient-Centered' Should Mean: Confessions of an Extremist; Health Affairs, 28, no.4 (2009):w555-w565

Key Informants noted that population growth and changing demographics will play a role in how the patient-centred approach is realized. Elderly patients with multiple co-morbidities present challenges in the creation of effective, comprehensive care teams. Baby boomers are seen as a more demanding cohort who will have clear expectations that they will insist be met.

Evidence-Based/Evidence-Informed Practice:

The drive for evidence-based practice — or the application of scientifically derived knowledge to practice decisions — has been growing in prominence for decades. (Recognizing the importance of "context" and the play of individual factors in shaping best practice and clinical decision-making, the term "evidence-based" has been replaced in many cases by the term "evidence-informed".) The need to seek out and apply the best available evidence has become a requirement for many aspects of healthcare decision-making, from decisions about policy options to those about programs and services, as well as to clinical or practice decisions. Supporting the drive for quality and safety, many practice settings are embracing a "plan-do-study-act" model of continuous assessment and practice improvement.

Evidence-informed decision-making is a continuous interactive process involving the explicit, conscientious and judicious consideration of the best available evidence to provide care. It is essential to optimize outcomes for individual clients, promote healthy communities and populations, improve clinical practice, achieve cost-

effective nursing care and ensure accountability and transparency in decision-making within the health-care system.

CNA Evidence-Informed Decision-Making and Nursing Practice; CNA Position 2010

Not surprisingly then, key informants underlined the importance of basing decisions on evidence, encouraging professional nurses to apply the evidence of what actually "worked" or achieved a desired outcome, rather than complying with a rulebook or following a checklist of actions. The advent of information and communication technologies that can provide real-time evidence of the impact of decisions and interventions raises the moral imperative to immediately "stop" doing things that clearly do not work and to "start" doing more of what does, without waiting for the rulebook to catch up.

The understanding of practice as evidence-driven suggests that practice foundations should shift quickly and efficiently as soon as the evidence of the need for a shift exists.

Porter-O'Grady, Tim; *Confronting the Realities of Regulation in a New Age of Practice;* Journal of Nursing Regulation; Volume 1, Issues 2; pp4-7.

IV Emerging Concepts and Applications to Health Professional Regulatory Bodies

A question asked by one key informant, Bill Lahey, is whether the regulatory role is limited to the prevention of bad things or does it extend to responsibility for ensuring that good things happen? If the latter, as many have concluded, health professional regulatory bodies will need to assess their roles in the light of major social, economic, and healthcare trends and make adjustments accordingly. Several concepts and initiatives by professional regulatory and oversight bodies are already gaining traction.

Just Culture

Linked to contemporary thinking about quality and safety and evidence-informed decision-making, the concept of Just Culture holds that organizations are accountable for the systems that they design and for the ways in which people working within these systems behave. Individuals are responsible for the quality of the decisions they make and for reporting errors or system vulnerabilities. The collective responsibility is to learn from mistakes and prevent their occurrence or recurrence. Just Culture sees a re-balancing of "the three duties" — the duty to follow a procedural rule, the duty to produce an outcome and the duty to avoid causing unjustifiable risk or harm — that places less emphasis on the first in favour of more emphasis on the latter two.

In a just culture of safety, the leaders and all staff are committed to providing the safest possible care to patients. There is a shared commitment to learn from adverse events and close calls, and to make improvement. The interests of both patients and providers are protected.

> CMPA; Just culture of safety: Why protecting quality improvement reviews is important for everyone; 2010.

An organization with a Just Culture accepts that mistakes will occur… but does not wait for them to happen to make needed changes. Though it may not be possible to design for perfection, the organization works to design systems that acknowledge human fallibility, that anticipate and thus reduce or halt human errors before they become critical. Within this system design, the best way to manage human behaviour is to help practitioners to make safe choices, to learn from mistakes, and, based on these insights, to shift the focus from harm to the precursors of harm.

Recognizing that bad outcomes can and do occur, proponents of Just Culture maintain that the sources of these outcomes – from simple mistakes to at-risk, reckless, or intentionally harmful behaviours – demand different responses. Human errors that are a product of a combination of behavioural choices or decisions and system design are best addressed through changes in counseling or education related to the choices being made but also may demand changes in processes and procedures, structures and design. At-risk behaviours, the product of a decision by the individual based on a belief that the risk is insignificant or justified, are best managed by working to increase the individual's situational awareness and by changing the balance of incentives for risky versus safe behaviours. Reckless behaviour, stemming from a conscious disregard for what is a substantial and unjustifiable risk, requires timely and commensurate remedial or punitive action.

Right-touch Regulation

Linked to recognition of the limits of regulation and to evidence-informed decision-making, Right-touch regulation holds that the instruments applied to protect the public should be commensurate with the risks. Proponents of Right-touch counsel regulators to identify the problem before determining the solution, quantify the risks, get as close to the problem as possible, focus on the desired outcome, and use regulation only when necessary. When regulation is deemed appropriate it should be kept simple, regularly reviewed for impact — including unintended consequences - and modified accordingly. Seeking to be at once effective, appropriate, and proportionate, Right-touch regulation is the minimum regulatory force required to achieve a desired result. Right-touch regulation demands the regulator be aware of the environment in which it is operating, to foresee changes that will occur in a field, to anticipate risks, and to take timely action to mitigate those risks.

Regulation touches the point between the public and the personal. Over regulation is seen as an interference in personal conduct; under regulation is seen as an abdication of public responsibility. When harm happens we blame ineffective regulation but when we are stopped from doing something risky we say regulation is excessive. The public, media and politicians often face both ways, wanting more or less regulation depending on the moment and the mood. The rhetoric says 'cut red tape' but the practice is usually more regulation, whether it be for dangerous dogs, for bankers, for people who work with children or for medical research. We want to be free and we want to be safe. Nothing is wrong with either.

Here, in Right-touch regulation, we seek the balance between these extremes. We think regulation has an important public role but that it exists to protect people, not to control unduly how they chose to live their lives. We think that as individual citizens we should expect to look after ourselves and those we care about and those we have responsibility for. We should be helped to do so by laws, regulations and standards that restrain those who intend ill, those who are careless of the wellbeing of others and those whose greed or incompetence causes harm.

Right-touch regulation is the minimum regulatory force required to achieve the desired result.

Council for Healthcare Regulatory Excellence; Right-touch Regulation; August 2010

Collaborative Self-Regulation

Linked to the trend towards interprofessional practice is a push for collaborative self-regulation. As noted above, the current legal framework for interprofessional practice is seen to be deficient in several regards, lacking clear delineations of accountabilities, processes for the disposition of complaints lodged against a team of providers, mechanisms for addressing areas of overlapping scope of practice, and means of determining and assuring continuing competency of the team. Greater collaboration between the respective oversight and regulatory bodies is not only needed to address these deficiencies but could have the added benefit of reducing duplicated effort and, thereby, reducing resource demands and expenditures; providing opportunities for sharing regulatory "best practices"; harmonizing standards and codes as well as approaches to investigation and discipline across professions; and eliminating unjustifiable differences in processes and outcomes between professions and disciplines.

…collaborative self-regulation is a process of collaboration among self-regulating professions that respects the self-regulatory status of each regulated profession while seeking to identify and develop opportunities for collaborative effort that will strengthen the overall capacity of the system of health professional regulation to contribute to changes that are taking place and that need to take place in the broader health care system.

> Charter of the Nova Scotia Health Professions Regulatory Network as quoted in William Lahey; Collaborative Self-Regulation and Professional Accountability in Nova Scotia's health Care System; 2009

Collaborative self-regulation does not supplant but, instead, complements and enhances the effect of self-regulation of individual professions. Nova Scotia initiated work in this area in 2009 and the effort has expanded to include other jurisdictions interested in exploring ways to create a more effective legal framework for interprofessional practice. Asking "what are the enabling conditions for regulation more oriented to the facilitation of interprofessional practice", a leading figure in this effort, Bill Lahey and his colleague Robert Currie, conclude:

… they must include the creation of institutions that not only provide the opportunity for regulatory collaboration but make it clear that such collaboration is a condition for professional self-regulation. This means institutions that ensure meaningful dialogue, planning and action across professional boundaries. It means institutions that by their very existence communicate and enforce a shared accountability for making interprofessional practice happen through the exercise of profession-specific regulatory powers in ways that respect, accommodate and enhance the contribution that can be made by each profession.

> Lahey W, Currie R. Regulatory and medico-legal barriers to interprofessional practice. J Interprof Care 2005 May; Suppl 1:197-223

Tim Porter-O'Grady, a strong supporter of collaborative self-regulation, agrees. He suggests that:

We need to think in terms of the interfaces rather than the boundaries between professions. We need more dialogue and less opportunity for maintaining arbitrary and capricious differences between professions.

> Porter-O'Grady, Tim; Personal Communication; November 21 2011.

A Principle-Based Approach

Suffering a set-back in the wake of the international economic crisis, affection for a principle-based approach to oversight and regulation has remained high in some circles. Linked closely to the concepts of evidence-informed practice, Right-touch regulation, and Just Culture, a principle-based approach in healthcare would favour the achievement of an outcome, a "value", by whatever means needed that does not inflict a "corollary harm" (more harm than the problem it seeks to address), over ritual compliance with a set of detailed instructions, protocols or rules.

An ardent proponent of the approach, Tim Porter-O'Grady contends that statutory and rules-based approaches to self-regulation are too narrow, rigid and inflexible to meet the needs of a rapidly changing and complex healthcare system. As noted above, modern information and communication technologies make it possible for people to get real-time feedback on their performance and the outcomes of their decisions and actions, raising the moral imperative that, where harm is an observed outcome, they make changes to their practice

before waiting for rules and regulations to be brought into force. Standards should reflect, not the practices that conform to policies and rules, but the principles that guide the use of evidence. Those principles, in turn, should reflect societal values, not yield to the constraints of settings, professional providers, or institutions.

Porter-O'Grady submits that the application of a principle-based approach goes to the very core of what it means to be a healthcare professional.

When people look for "rules" to guide them they are looking for advice on "what is risky" and "what is risk free". They want to know firmly where there is danger or lack of it and they look to the rules to tell them this. But this presents a bit of a conundrum. If there is no risk, then there is no need to protect an "act" under a licensed profession. You are a professional because you're in a place where there's risk. The question is, how capable are you at managing the risk that is attendant to your role?

Porter-O'Grady, Tim; Personal Communication; November 21 2011.

He instructs decision-makers:

Ask the question "what is the value of what we do", where "value" can be a moral or an actual good, something that is important to us and something to which we are prepared to commit resources and effort. Ask what are the best choices we can make to obtain or sustain that value? How can we eliminate choices that will not obtain value?

Porter-O'Grady, Tim; Personal Communication; November 21 2011.

and, thus, he warns them

Do not set the objective of being "safe". You can be safe but still worthless; safety is the floor. Most people want to regulate behaviour but structure trumps or extinguishes the impact of desired behaviour

Porter-O'Grady, Tim; Personal Communication; November 21 2011.

Like proponents of a Just Culture, Porter-O'Grady submits that there is no way to completely eliminate risk, it will always be present. The question for the professional is "how capable am I at managing the risk that is attendant to my role". And, the question for the overseer or regulator should therefore be "did the individual apply the right priority to the scenario? Did he/she demonstrate prudential judgment, applying the right kind of judgment that fit the circumstances?".

Moving from "rules-based processes" to "principle-based dynamics" requires regulators to shift from "performance evaluation systems" to "performance demonstration systems" that situate measurement and accountability for excellence at the point of practice and at the level of the individual practitioner.

Continuing Professional Development

Entirely consistent with the concepts of evidence-informed practice, initiatives to establish Just Culture and principle-based regulation that are simultaneously gaining traction, increasing attention is being afforded to continuing professional development or CPD. Though not new, in the dynamic of continuous learning and

improvement envisioned under principle-based regulation, practice and education become inseparable and, so, CPD is essential. CPD extends beyond learning for practice improvement and includes learning for:

systematic maintenance, development and broadening of knowledge, skills and attitudes, to ensure continuing competence as a professional throughout their careers.

> Winslade, Nancy E. et al; Integrating Performance Assessment, Maintenance of Competence, and Continuing Professional Development of Community Pharmacists; 2007

While demonstration of competence is required for entry to practice, competence is fundamentally different from performance. As stated by Nancy Winslade et al.,

Competence is defined as what health professionals are able to do in artificial, testing situations; performance is defined as what health professionals do during daily practice [which is not possible to assess until they enter practice].

> Winslade, Nancy E. et al; Integrating Performance Assessment, Maintenance of Competence, and Continuing Professional Development of Community Pharmacists; 2007

Assuring quality and safety requires assessment of outcomes which, in turn, demands assessments of practitioners' daily performance, rather than their underlying competence. Some professional regulatory bodies have not only made CPD and comprehensive annual performance appraisals mandatory, but are also requiring health professionals to formally "revalidate" their knowledge, skills, and abilities. The need for ongoing assessment of performance to assure quality and safety implies a role for regulatory bodies that may be more extensive than it has been historically.

V Considerations for CRNBC

The impact of social and economic trends and the rapid changes in healthcare itself suggest that, to be effective and relevant, the contemporary regulatory body must be firmly situated within, aware of, and engaged with its environment. The imperative to "see and be seen" has already profoundly affected the way many US State Boards of Nursing, the counterparts to Canadian "Colleges" of nursing, focus their time and resources. The top priority of the regulatory body remains ensuring the public is protected, but the execution of this role is multidimensional. Key informants identified a number of roles and functions that are now considered central to the role of an effective regulator. The regulator must:

- be transparent in its processes and outcomes. This is essential to reassuring the public of the regulator's priorities and demonstrating its competence in the exercise of its duties. Explaining why and how regulatory instruments are developed and applied is key to developing a better understanding and appreciation of the role, and the challenges and limitations, of the regulator.
- educate the public and its licensees on its role and function. This is critical to raising awareness of when and how they should call upon the regulator. It is also key to inspiring licensees to see their regulatory body as critical to the quality and coherence of their profession, to value the regulator's role in "protecting the RN brand".
- learn about and engage with other regulatory, oversight and policy-making bodies. This is key to ensuring a complementary, consistent, comprehensive, efficient and effective integration of roles and functions. It is essential to ensuring the wealth of knowledge that resides with the regulator effectively informs policy- and decision-making processes.

To these we might add some of the recurring recommendations from other key informants, that the regulator must:

- be evidence-informed in all that it does. Linked to transparency in the execution of its role and function, the regulator must be clear on the rationale for new regulatory instruments and mechanisms, must carefully plan their deployment, evaluate their effectiveness in achieving desired ends, and be prepared to make modifications as needed based on the evidence.
- be collaborative. Professional regulatory bodies must engage with a wide range of other professional groups, agencies and organizations in needed dialogue about healthcare system aims and interprofessional and inter-sectoral action needed to improve quality and safety. In addition to serving to improve the *system* of healthcare, this engagement with other bodies ensures the regulatory body is "situated", remains current, and is able to anticipate new demands and challenges.
- help to ensure "good things happen". Engagement with other key players in collaborative efforts to improve quality and safety is an important new focus for regulatory bodies but they must also expand their efforts within the profession of nursing, ensuring not only that "bad things don't happen" but also that "good things" do. This means playing a significant role in performance assessment and a greater role in continuing professional development.
- be seen as accessible to registrants. Overcoming an image of the regulatory body as inaccessible and "Big Brotherish" is essential. A climate of trepidation and fear of reprisal leads to suppression of information, failure to seek help when needed, under-reporting of near misses and AEs and, thus,

unfulfilled potential for learning and improvement among nursing professionals and unfulfilled potential for significant contributions to system quality and safety for the regulatory body.

- work with other provincial nursing organizations, the unions and associations, in its efforts to educate the public and its registrants. These organizations play distinct but critical, and often complementary roles, for the profession of nursing. Though it could appear counterintuitive, visible collaboration - and continual clarification of roles and functions - among nursing bodies can help to delineate, and reinforce awareness of, the respective roles of each body.

Some Actions to Consider

The role of the regulator in the healthcare system is, clearly, no longer seen as limited to the oversight and rectification of individual behaviour. Opportunities for improvement in quality and safety in healthcare abound. The question for CRNBC is how it could and should contribute meaningfully to these efforts. Some actions may hold considerable merit, including.

Create a table — or tables — for discussion

Many key informants welcomed the idea of a "table" for discussion, not only among health professional regulatory bodies, but also among regulators in general. Consistent with the "natural" convening and collaboratory role of nurses, CRNBC was seen as the ideal "host" for a table of health professional regulators. Not only could this table be a forum for developing a better understanding among the respective bodies, it could be a locus for initiating discussion on collaborative regulation with all of its attendant benefits.

The creation of, or participation in, a broader table of policy- and decision-makers in healthcare could provide a locus for exploring opportunities for collaboration on system improvements and for the application of new approaches to regulation such as Just Culture or principle-based regulation.

Engage the public

As a servant to the public, it is critical that British Columbians from all parts of the province understand the role and function of the College. A "road trip" featuring "town hall" sessions in communities across the province would provide forums for knowledge exchange. Engaging the other nursing bodies, the BC Nurses Union and the nascent Association of Registered Nurses of BC, in a dialogue with the public about the respective roles and functions and seeking the public's views on how these could and should be exercised could help to increase and enrich the effectiveness and perceived relevance of the College.

Engage registrants

Similarly, registrants need to better understand the critical role played by their regulatory body. They need to view the College as a key resource in ensuring the quality and safety of nursing practice, in reinforcing the distinction between a vocation and a profession and helping them to protect the integrity of the professional brand. Registrants need to feel safe and welcome to approach the College for advice, support, and remediation when needed. The College needs to engage registrants to both better understand the current state and to seek input into how it can be more effective in the eyes of registrants.

Make greater use of social media

The proliferation of social media presents both a challenge and an opportunity to CRNBC. On the one hand, the ubiquity of social media demands that this resource be tapped if the College is to remain relevant and connect with the public and with registrants. But, as many governmental and quasi-governmental bodies have found, it is difficult to keep up with the pace of social media, especially given the presence of definitive protocols for communication and the need for "sign-offs" on all messaging. "Social media" is not a communication method that can be harnessed. On the other hand, if used to deploy relevant messages and facilitate communication, social media could play a vital role in increasing awareness of the role and function of the College; and enabling engagement, interactive dialogue and learning (thereby, increasing its perceived relevance to the public and to registrants). The benefits of deploying social media would appear to outweigh the risks.

VI Conclusions

As noted at the outset, the engagement exercise that led to the production of this document was much appreciated by those who had an opportunity to participate. Clearly, people have "things to say" and welcome the opportunity to share their thoughts as well as to hear what others have said. A "first next step" for consideration by the College is to share this document with others and to seek opportunities for further dialogue.

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APPENDIX B: Key Informants

Andrews, Joan
Apple, Kathy
Araujo, Paula
Beckett, Daryl
Bethune, Darrell
Black, Joyce
Blizzard, Kim
Buchanan, Janice
Burki, Jane
Byres, David
Cairns, Lynn
Calnan, Robert
Canitz, Brenda
Coghlan, Anne
Commons, Kathy
Cotter, Cathy
Covington, Patricia
CRNBC Board
Dhillon, Margaret
Du Charme, Catherine
Ducharme, Debra
Duncan, Susan
English, Tom
Ewing, Kate
Fulton, Tom
Gauthier, Margaret
George, Julie
Grant, Lorraine
Guengerich, Lynn
Habib, Sharon
Hamilton, Linda
Hamilton, Sherry
Harrington, Ginny
Harwood, Gillian
Heldman, Margaret
Herman, Carina
Howe, Caroline
Jiang, Hua
Johnson, Catherine
Johnston, Suzanne
Johnstone, Bob
Keath, Jacqollyne
Lahey, Bill
Logie, Anne
MacLeod, Hugh
Maloney-White, Eileen
Massey, Christine
McGee, Tim
McPherson, Deborah
Meeuwissen, Irene
Mei-Po Tung, Mabel
Midgley, Jamie
Murphy, Donna
Nickerson, Veronica
Nicolson-Church, Jean
North, Catherine
Oetter, Heidi
Paterson, Dr. Barbara
"Patient Voices" (8 participants)
Porter O'Grady, Tim
Powrie, Robert
Ratner, Pam
Reed, Diane
Rees, Richard
Regehr, Colleen
Ridenour, Joey
Robinson, Mary-Anne
Robinson, Jan
Rodney, Paddy
Skinner, Michael
Smith, Lorraine
Smith, Sandra
Stevenson, Dr. Lynn
Steward, Karen
Taylor, Carla
Thorne, Sally
Trombley, Adam
Van Neste-Kenny, Jocelyne
Wannamaker, Susan
Wearing, Jo
Weir, Katie
Wichmann, Laurel
Winder, Jane
Winslow, Wendy
Wood, Mike

APPENDIX C: Interview Guide

Developing a Regulatory Philosophy and Framework for CRNBC Discussion Guide

June 2011

Developing a Regulatory Philosophy and Framework for CRNBC: Discussion Guide

Background

The regulatory philosophy and framework developed by CRNBC will need to take account of several factors, including

- current trends, contemporary approaches, and related philosophical frameworks for regulatory practice among health and other professions
- perceptions of "best practices" in regulation
- the views of key stakeholders including the CRNBC Board, Leadership Team, and staff; nursing and other health professional leaders from BC, Canada, and elsewhere; College registrants; the Ministry of Health and other relevant government officers; nursing educators; employers; and the lay public.

A variety of sources and methods will be needed to acquire the information required to develop a regulatory philosophy and framework, including:

- Review of the grey and published literature;
- Review of relevant CRNBC documents;
- Review of relevant documents from other professional Colleges;
- Structured interviews with expert informants;
- Internet-based surveying; and
- Focus groups with key informant groups.

Published literature on the subject of regulatory philosophy for nursing is sparse. Key informant interviews will likely yield more sources, including access to (a) relevant frameworks from other professional regulatory bodies, including those outside the health disciplines; (b) published literature used as sources by others; (c) grey literature used as sources by others.

Focus groups will be used to assess the views of collectives such as "CRNBC Board members", "CRNBC Leadership Team", "CRNBC Staff", "HA nurse leaders", and "nurse educators". Participants will be asked to reflect on the questions contained in this discussion guide. One-on-one interviews will be conducted using the same discussion guide.

Although some of the commentary made may be captured verbatim and "quoted" in a final report of the findings, nothing said in focus groups or one-on-one interviews will be for attribution to an identifiable individual.

For Consideration

A. Some Trends

Some trends that are having an impact on nursing and other professional regulation include the following:

- "Just Culture"
- principle-based approach
- evidence-based orientation to practice improvement; and
- continuing quality improvement through continuing education and continuing professional development.

These are elaborated in greater detail in Exhibit 1 below.

Exhibit 1: Some Trends Influencing Professional Regulation

'Just Culture', including…. shared commitment to learn from adverse events and emphasis on correcting the problem vs. individual blame

In a just culture of safety, the leaders and all staff are committed to providing the safest possible care to patients. There is a shared commitment to learn from adverse events and close calls, and to make improvement. The interests of both patients and providers are protected.
(Just culture of safety: Why protecting quality improvement reviews is important for everyone; CMPA; 2010.)

principles vs. rules-based approach

In an effort to remain consistent and establish a sound foundation for regulation, national regulatory boards have established principles that guide their work nationally and advise the individual states regarding independence, regulation, and standards-setting practices. At the state level, the challenge is to translate these principles into practice in an industrial framework of rules-based regulatory processes. The result is a conflict between the dynamics of principle-driven behaviours and rule-based practices.

- Porter-O'Grady, Tim; *Confronting the Realities of Regulation in a New Age of Practice;* Journal of Nursing Regulation; Volume 1, Issues 2; pp4-7.

Comparing Characteristics of Statutory Regulation with Principle-Driven Regulation	
Statutory Regulation	**Principle-Driven Regulation**
Prescriptive statute or law	Alignment with health outcomes
Risk based	Evidence driven
Fixed	Defined by outcome standards
Externally directed	Product value related
Punitive power	Expectation grounded
Functional elements	Control by profession
Task enumerated	Reflective practice principles
Process driven	Impact value focused
Institutional discipline	Demonstration of impact value
Control for judgment	Grounded in good judgment

- Porter-O'Grady, Tim; *Confronting the Realities of Regulation in a New Age of Practice;* Journal of Nursing Regulation; Volume 1, Issues 2; pp4-7.

regulation vs. evidence-based practice

In the evidentiary dynamic, practice should reflect the aggregation of data and application, not the fixed standards or protocols that are more directive than responsive to the requisites of practice. When standards are applied they should reflect principles guiding the use of evidence, not practices reflecting the demands of fixed policy.

- Porter-O'Grady, Tim; *Confronting the Realities of Regulation in a New Age of Practice;* Journal of Nursing Regulation; Volume 1, Issues 2; pp4-7

We stopped using 'foreign' language for regulation and started to talk about it as evidence-based practice.

- Jeanette Salmon, Dean University of Washington School of Nursing, as quoted in: Saver, Cynthia; *Trends and Challenges in Regulating Nursing Practice Today*; Journal of Nursing Regulation; Volume 1 Issues 1; pp4-8

continuous improvement through continuing professional education vs. credentialed entry to practice

The central themes of the Continuing Professional Development (CPD) concept are teaching health professionals how to identify problems and apply solutions; tailoring the learning process, settings and Continuing Education (CE) curriculum to enable individual clinicians to be architects of their own learning; and stretching health professionals' learning opportunities from the classroom to the point of care.

- Dobson, Christina L. and Robert G. Hess; *Pursuing Competence Through Continuing Education*; Journal of Nursing Regulation; Volume 1 Issue 2; pp8-13

(1) What are your thoughts on these trends — do they resonate with you?
(2) What other trends do you think are important/worth noting?

B. Impact on Work of CRNBC

The CRNBC organizing framework identifies four areas of foundational work for the organization

- Registration and Renewal Standards;
- Standards of Practice;
- Support to Registrants to meet Standards; and
- Governance

Another way of thinking about the role of the professional regulatory body is described in Exhibit 2 below.

Exhibit 2: Three Pillars of Professional Standards Regulation

- Entry standards
  - Set and develop standards of competency and conduct and using these as criteria for admittance or regulation
- Complaints and Discipline
  - Accept and investigate complaints, hold hearings based on investigations and punish those found guilty possibly by suspension or expulsion. Run and appeals process.
- Continuing Professional Development (CPD)/Continuing Education (CE) and positive supports for ethical competence.
  - Set ethics content and provide other forms of guidance and publicity on ethics

Friedman, Andy; Presentation for Professional Bodies at Professional Engineers Ontario; Toronto, November 2010

Thinking about the operation of the four areas of foundational work

- Registration and renewal standards;
- Standards of Practice
- Support to Registrants to meet Standards; and
- Governance

and/or the three pillars of professional standards regulation presented above…

(3) How do you think the identified trends will affect these areas?
(4) What imperatives or needs for change will arise?

C. The Continuum of Regulatory Practice

It is possible to think about regulation in general along a continuum from one end that is more protection oriented, seeking to minimize if not eliminate all possible risks, to the other end which is more laissez-faire, relying on the parties to any given encounter to assess the risks and benefits and act accordingly. The regulation of professional practice has evolved over time, influenced by societal expectations and factors such as new technologies and modalities of care. Thinking about the following continuum…

	Laissez-Faire	CRNBC	Zero Tolerance
	←		→
Dominant Thinking:	"Buyer knows best" and "caveat emptor"		"Small benefits that are certain are better than large benefits that are uncertain or carry risks"
Attributes:	Tolerance		Discipline/punitive action
Methods of Promoting:	De-regulation		Rules and regulations
Needed to Work:	Market-like structures		Extensive system of codified rules, monitoring and intervention
Engenders in Parties:	Self-interest		Punishment and defensiveness
Other Comments/ or Keywords			

(5) Where do you think the profession of nursing as practiced and regulated in BC, "fits" along the continuum at present?
(6) Where should CRNBC fit?
(7) What are the keywords that would define where CRNBC should be positioned on the continuum?

D. Parting Thoughts

(8) Do you have any additional thoughts about content or process, or any references or resources to share that will assist with the work of developing a regulatory philosophy and framework for CRNBC?

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Pub. No. 783