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Regulation of the Medical Profession in Nova Scotia

Duncan Beveridge

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I. Introduction

Consumerism has experienced fantastic growth over the last decade and as a result its influence is felt in almost every decision making process. Consumer groups have operated as potent pressure groups and have encouraged the reform of laws to protect the "little man". Federal and provincial legislative bodies have reacted and attempted to protect the consuming public from unfair or unconscionable business practices and established agencies to do research and co-coordinate consumer concerns.

Until recently, consumers have fixed their attention on business and have largely ignored services, particularly those provided by self-governing professions such as the medical profession.

The historical reasons for allowing self-government are complex. Basically it was (and is) thought that the public interest would best be served if professions governed themselves. To this end, the state has delegated authority to the professions.

The authority for the protection of the public has tended to have two main features:

1) setting of educational standards before admittance to the profession, ensuring technical competence; and
2) removal or discipline of members unfit to practice, ensuring integrity, high ethical standards and quality.

In other words, licensing and the power to withdraw the license.

Little quarrel can be had with regard to the medical profession's success in maintaining high educational standards but the general...
acceptance that the public purse should pay for health services, and
the growth of consumerism, and the escalating cost of those health
services⁶ has caused concern over the controls that exist to protect
the public interest, thus leading to numerous reports and
commissions.⁷

The focus of this comment will be on this area with emphasis on
the medical profession’s role in assuring quality.

II. Regulation in Nova Scotia

As mentioned, the privilege of self government was granted to serve
the public interest, yet the professional body has conflicting
interests in promoting and protecting the socio-economic and
professional interests of its members.⁸ The Castonguay Report⁹
recognized the incompatibility of the two roles and recommended
the roles be clearly separated.

In Nova Scotia the Medical Society of Nova Scotia has since
earliest times¹⁰ been separated from the licensing authority in Nova
Scotia.¹¹

Today the Provincial Medical Board has the responsibility of
maintaining a system of registers containing a list of practitioners
that have met or complied with the rules and regulations made by
the Board.¹² To be entitled to be entered in the Medical Register¹³
the applicant must pay the prescribed fee, be of the age of majority
and satisfy the Board that he has graduated from an approved
school; and produce satisfactory evidence of identity, experience,

⁶. J. McLeod, Health Security for British Columbians, B.C. Special Report on
Consumer Participation, Regulation of the Professions and Decentralization
(1974) at 2
⁷. See for example, J. W. Grove, Organized Medicine in Ontario — A Study for
the Committee on Healing Arts (Toronto: Queen’s Printer, 1970); Ont. Report of
Professions and Occupations,” (Toronto: Queen’s Printer, 1968); Que. Report of
Professions and Society,” (Quebec: Quebec Official Publisher, 1970) — Castonguay Report
17
⁹. Id. at 18
¹⁰. Medical Society of Nova Scotia Act, S.N.S. 1861, c. 69 as am. by S.N.S.
1970, c. 140
¹¹. See for example, R.S.N.S. 1858, c. 57 or R.S.N.S. 1964, c. 56
¹². Medical Act, S.N.S. 1969, c. 15 as am. by S.N.S. 1973, c. 66
¹³. s. 14 of the Medical Act also provides for a Temporary Medical Register for
certain classes of practitioners, which need not be mentioned here.
good professional conduct, and good character as a citizen.

Section 40 (1) (a) of the Medical Act prohibits the practice of medicine unless the physician is registered under the Act. Section 41 provides that on violation of s.40 every person is liable to a penalty not exceeding $500.00 for a first offence and a penalty of $500.00 and imprisonment for not less than seven days for a second and subsequent offence. Thus, a monopoly is granted to physicians licensed under the Act. Because it is a monopoly, there must be safeguards for the public interest.

Although there is a separation between the Medical Society and the Board, all members of the Board must be a member of the Medical Society. Section 2 (1) of the Medical Act provides:

There shall be a Provincial Medical Board consisting of fourteen qualified medical practitioners, each of whom has been fully registered with the Provincial Medical Board and in good standing for at least seven years and is a member of the Society.

Section 2 (2) of the Act further provides:

Seven members of the Board shall be appointed by Governor in Council, six members shall be elected by the Society, and one member shall be appointed by Dalhousie University from the Faculty of Medicine.

So, even though the Governor in Council appoints half of the members (for variable terms), all must be qualified medical practitioners and members of the Medical Society of Nova Scotia. This can lead to conflict because of the comprehensive definition of practicing medicine contained in s.40(2):

In this section "practice medicine" includes:

(a) to allege by advertisement, sign or statement of any kind of ability or willingness to diagnose or treat any human disease, defect, deformity or injury;

(b) to advertise or claim ability or willingness to prescribe or administer any drug, medicine or treatment, or to perform any operation or manipulation, or to apply any apparatus or appliance for the cure or treatment of any human disease, defect, deformity or injury. 14

Through this comprehensive definition the Board, comprised entirely of physicians, could restrict developments that may compete with their notions about treatment of disease. In fact this has already happened with regard to acupuncture. The Board on February 21, 1976 made it an official policy that acupuncture be

14. Subject to certain exceptions, e.g. dentists.
deemed to be a medical procedure and/or treatment modality within the above definition.\textsuperscript{15}

Thus the scope of initial regulation is extremely wide and could involve subjugation of the public interest by unduly restricting entry to the profession. Further possibilities for conflict arise when the Board exercises its function of ensuring the fitness to practice of licensed physicians. First it is convenient to discuss the existing external controls over quality.

III. \textit{Mechanisms of Quality Control}

A. \textit{Litigation.}

Actions against physicians for negligence have not yet reached the epidemic proportions of the United States. However, they have increased.\textsuperscript{16} Some have expressed fear of the negative effect of malpractice suits\textsuperscript{17} attendant with the consequences of practicing "defensive medicine" which increases costs and restricts innovations. This may be true in the United States but the available evidence shows the negligence action in Canada has a positive role to play besides compensating victims of medical negligence.

Kretzman identifies its role in asserting social control over the medical profession\textsuperscript{18} which can lead to revealing questionable practices not of just a few practitioners but those accepted by the profession as a whole.\textsuperscript{19} The most blatant example of this being that of \textit{Anderson v. Chasney}.\textsuperscript{20}

A sponge had been left in the child's nose during an operation and the child died as a result. Even though it was an accepted practice not to carry out sponge counts in such operations, the action was successful and the profession changed its "accepted practice".

A more recent example is the case of an anaesthetist using a machine which had the valves reversed from the kind he was accustomed to. During the operation he adjusted the flow of nitrous oxide and oxygen without looking at the control valves. Due to the reversal of controls, the patient suffered a cardiac arrest and

\textsuperscript{15} \textit{Report} of the Provincial Medical Board of Nova Scotia (1975) at 26
\textsuperscript{16} \textit{Seventy-Sixth Annual Report} of The Canadian Medical Protective Association (June 1977) at 24
\textsuperscript{17} D. Kretzman, \textit{The Malpractice Suit: Is it needed?} (1973), 11 Osgoode Hall L.J. 55 at 62
\textsuperscript{18} \textit{Id.} at 87
\textsuperscript{19} \textit{Id.} at 67
permanent brain damage resulted. The report of the Canadian Medical Protective Association, from which the incident is taken, also reported that as a result standardization of all gas machines was being carried out.  

It would be safe to conclude that litigation has a role to play in improving the quality of care available to consumers. Particularly since in contrast to other areas of consumer problems the damages actually caused are large enough to warrant legal action. Controls such as these are important because although consumer legislation is designed to protect the consumer from unfair business practices and hazardous substances, none of these directly stipulates a minimum quality. Rather, quality is left to be regulated by the market economy. Monopolies such as the medical profession, being an essential service, have no controls over quality of service other than by their professional colleagues. However, even monopolies must be paid and this is the next area of control or potential quality control.

B. Health Services and Insurance Commission

It is not within the scope or purpose of this paper to examine the complex arrangement of financing provided by the Health Services and Insurance Act. However, basically the Commission pays for hospital costs and fees claimed by the physician.

This is one time when the old adage of "he who pays the piper also calls the tune" does not hold true. Largely, no real quality control exists although s. 12 of the Health Services and Insurance Act provides for regulations which are broad enough to allow the imposition of controls governing medical care in the hospital and the physician's office.

C. The Role of the Hospital

As primary medical care moves from the office setting to

21. Supra, note 16 at 17-18
22. See for example, M.I. Roemer, Controlling and Promoting Quality in Medical Care (1970), 35 Law and Contemporary Problems 284 at 297
23. Supra, note 1
25. S.N.S. 1973, c.8 as am. by 1974, c. 31; 1977, c. 2
26. Id., s. 8
27. Id., s. 19
28. Id., s. 12 (1) and (2)
hospitals, their potential for assuming a more prominent role in ensuring consumers receive quality care at reasonable cost also increases.

The hospital was identified by Grove to be one of the major control factors in not only protecting against incompetence but also quality control in the sense of aiming at ensuring the best possible standards of care.

In order to admit and treat patients in a hospital the physician must be a member of the medical staff of the hospital. The hospital does not itself usually employ the physicians who work there but merely grants privileges. The hospital’s Board of Trustees has the ultimate authority and responsibility for what goes on inside the hospital. The medical care system, however, is actively run by the Medical Advisory Committee (MAC) and its network of committees such as the Clinical Appraisal Committee which has such duties as:

(a) evaluate and review the professional work of each member of the medical staff.

(b) cause the head of each department to evaluate the medical care provided by each member having privileges in the department.

The department head also has the duty and responsibility for the supervision over any matter affecting the treatment of patients within his department and, given a serious problem, may remove the physician in charge after discussing the case with him.

30. Although not elaborated on, most hospitals have or should have Utilization Committees overseeing efficient use of the hospital facilities e.g. Prototype Hospital By-Laws (3rd draft), s. 100, published by the N.S. Association of Hospital Organizations.
31. Grove, supra, note 7 at 175
32. See for example, Regulations of the Board of Commissioners, Victoria General Hospital, Reg. 22
33. Granted on recommendation of the Credentials Committee through which the Board receives and acts, e.g. id., Reg. 29. The Credentials Committee recommends to the Executive Committee which recommends to the Board.
34. Prototype Hospital By-Laws, s.97 (2), supra, note 30. Also see, V.G. Regs. Reg. 30.02, supra, note 32
35. Id. Prototype s. 72 and V. G. Regs, Reg. 23.18. This active duty is also helpful in so far as the Credentials Committee is composed of departmental heads (Reg. 29.01, V.G. Regs.) so that even if the extreme action contemplated by Reg. 23.18 is not used, the department head will at least be aware of any deficiencies in a physician's competence.
The potential for effective and comprehensive quality control certainly exists. However, some doubt has been expressed as to the degree of confidence to be placed in the hospital's role.

The machinery is aimed at securing that, so far as possible, the doctor in the hospital has privileges in keeping with his competence, but in practice it is acknowledged to be far from infallible; the supervision of quality of care by medical advisory committees often leaves much to be desired: the effectiveness of medical audit and tissue procedures [included in duties of the Clinical Appraisal Committee] is conditioned by pressure of work and staff shortages . . . .36

Add to these the problems involved with the natural reluctance to offend professional colleagues in small community hospitals and real doubt may be felt as to the effectiveness of the hospital's role.

In the future hospitals may be forced to ensure that their channels of quality control are functioning properly. L. E. Rozovsky presents an interesting case that hospitals are the only existing institution that can effectively reduce the incidents of poor medical practice. Speaking of this favourable goal he states:

The only system which exists that can conceivably accomplish this is the hospital.37

and,

. . . an increase in the hospital's responsibility would benefit the majority of physicians and patients.38

This increased responsibility, he theorizes, may well be imposed on the hospitals by the common law. He argues that since hospitals have the ultimate control over physicians (that is, removal of privileges) and liability is founded upon public expectation, and the public expects the hospital to screen staff, then failure to have a proper system of control or failure to use it will constitute negligence.39

Although the arguments sound very academic, Rozovsky notes that several states have imposed liability on these or similar bases.40

The developments identified may very well be desirable but this

36. Grove, supra, note 7 at 201
37. Supra, note 29 at 135
38. Id.
39. Id. at 134-135
40. Id. at 134. Mitchell Co. Hosp. v. Joiner (1972), 189 S.E. (2d) 412 (Ga.); Gonzales v. Nark and Mercy Hospitals of Sacramento No. 228566 (1973), (Sup. Ct. of Calif.)
writer feels it likely that changes could only come about through legislative action and not judicial reform.

IV. *Regulation by the Provincial Medical Board*

The maintenance of a register of qualified practitioners has already been mentioned.

Any such register, if it is not to be a fraud on the public, must list only those having a certain standard of competence. The body responsible for maintaining the register has therefore two duties to discharge. First it will have to assure itself that those admitted to the register are competent. Secondly it will have to remove those practitioners unfit to practice.\[41\]

Thus, the efficacy of the procedures of the Provincial Medical Board in securing compliance with the acceptable standards of competence and ethics and the removal of those unfit to practice is of vital importance to the consumer. It will be necessary to first outline briefly the structure and mechanisms available to the Board.

Section 27 of the Medical Act, gives the power to the Board to appoint a Discipline Committee consisting of seven members of the Board. The Board may investigate by such means as it sees fit any complaint received against a qualified medical practitioner (s.28).

Complaints may be initiated by:

(a) the Board  
(b) the Discipline Committee  
(c) the Society  
(d) any official corporate body  
(e) any registered medical practitioner  
(f) any other person (s. 28(2))

Thus the Board has wide power to receive and investigate a complaint. What may be complained of is not defined. Rather, the controlling facts would appear to be the Board’s jurisdiction to take action.

The Board has several avenues of approach to a complaint divided by subject matter.

Section 29 of the Medical Act governs complaints alleging that a qualified medical practitioner is not using adequate skill and knowledge in his practice. In this case the Board may require him to undergo such an examination as they may direct and may, as a result thereof, erase his name from the Medical Register or erasure and

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entry into the temporary Medical Register subject to terms or conditions or suspend the imposition of punishment and place the qualified medical practitioner on probation on whatever terms the Board may prescribe.

Section 30 of the Act governs complaints alleging professional misconduct in which case the Discipline Committee may appoint an Inquiry Committee\textsuperscript{42} to hear the complaints. The Inquiry Committee then reports to the Discipline Committee which may order a formal hearing (s.30c). Following an investigation the Board shall receive the Discipline Committee's written findings and recommendations and if the Board considers that a qualified medical practitioner has been guilty of 'professional misconduct' or that the complaints have proved him unfit or incapable to practice the Board may:

(a) erase the name from the medical register
(b) suspend the practitioner for a specified period
(c) erase the name and enter it upon the temporary medical register subject to terms
(d) issue a reprimand\textsuperscript{43}
(e) suspend punishment and place the practitioner on probation on whatever terms the Board may prescribe s. 30 (a)

Section 30(f) of the Act in addition allows the Board to take disciplinary action for conviction of an indictable offence.

It should be noted that the Medical Act has an expanded definition of professional misconduct. Section 1(i) defines professional misconduct as meaning:

\ldots a qualified medical practitioner who has

(A) had his rights or privileges under the Narcotic Control Act (Canada) or the Food and Drugs Act (Canada) or the regulations under either Act restricted or withdrawn; or

(B) been guilty, in the opinion of the Board, of misconduct in a professional respect or of conduct unbecoming a medical practitioner, or of incompetence; or

(C) engaged in advertising other than to announce the formation or change of a medical partnership, or \ldots

The definition retains the advantage of leaving open what activities the Board will not accept\textsuperscript{44} as proper and provides the

\textsuperscript{42} The members of which need not be members of the Board.
\textsuperscript{43} s. 30(d) also allows the Discipline Committee to reprimand where the complaint is not sufficiently serious to appoint an Inquiry Committee or hold a formal inquiry.
\textsuperscript{44} Traditionally such nebulous phrases were approved by the Courts and findings
profession and the public with some basic guide as to the meaning of the term.\textsuperscript{45}

In summary, the Medical Act differentiates between complaints of lack of skill and complaints of misconduct. Although the two may overlap since incompetence implies a lack of ability or fitness, the attempt is there to provide a non-punitive effective control over competence.\textsuperscript{46}

\textbf{V. Evaluation of Licensure}

Licensure as a system has been criticized as a once in a lifetime deal\textsuperscript{47} with the licensing board having little or no jurisdiction after initial licensure except in extreme cases.\textsuperscript{48} The Medical Act amendments in 1969\textsuperscript{49} at least attempted to overcome this criticism by s. 29. However, a study of the annual reports of the Provincial Medical Board since 1969 reveals not a single case of proceedings by way of Section 29.\textsuperscript{50}

It should be noted however that in an interview with Dr. MacDonald, Registrar of the Provincial Medical Board,\textsuperscript{51} it appeared that a Rehabilitation Committee was able to intervene before the Discipline Committee became involved and procedures instituted that included retraining programmes, thereby partly replacing the s.29 procedure in the context of non-punitive corrective measures.\textsuperscript{52}

Proposals for remedying this lack of control until problems have

\textsuperscript{45} This type of development was recommended by McCner. Ont. Royal Commission Report, supra, note 7. Also note that the Provincial Medical Board publishes outlines of the disciplinary cases in its annual reports, which provide further guidance. See particularly (1973) Report at 31.

\textsuperscript{46} Since s. 29 (c) would allow probation on terms, the terms imposed may include retraining of some kind such as continuing medical education

\textsuperscript{47} s. 24 of the Medical Act, supra, note 12 only requires an annual licensing fee to be paid after initial registration.

\textsuperscript{48} Ludlam, "Medical Staff Privileges: Legal Snares for the Hospital" in Readings in Hospital Law of the Amer. Hosp. Assoc., Chicago, Ill. at 160

\textsuperscript{49} R.S.N.S. 1967, c. 179 repealed by S.N.S. 1969, c. 15

\textsuperscript{50} This may be partly due to the overlap in definition noted earlier between incompetence and lack of skill.

\textsuperscript{51} Interview conducted on February 17, 1978.

\textsuperscript{52} Analogous to the voluntary undertakings in the B.C. Trade Practices Act, S.B.C. 1974, c. 46
arisen have gained prominence in many jurisdictions. Some of the more common proposals are systems of periodic relicensure alone, or in conjunction with compulsory participation in continuing education programmes as a prerequisite to relicensure.\textsuperscript{53}

The Nova Scotia Council of Health also recognized the benefits of continuing medical education (C.M.E.) in its 1972 report and recommended the acceptance of such a system:

The continued upgrading and renewing of knowledge and skills by professionals is essential to maintain and improve the quality of care. We have recommended that regular continuing education eventually become a prerequisite to continued professional practice licensing in Nova Scotia.\textsuperscript{54}

The Registrar of the P.M.B. writing in the 1969 Report of the P.M.B., after noting the increasing pace of medical advances and the development of C.M.E. operated by Dalhousie, commented:

With such a program it should never be necessary in Nova Scotia for the Government or a Medical Licensing body to make it a condition of relicensure that a physician keep himself informed.\textsuperscript{55}

and commended the individual physician to keep himself well informed.\textsuperscript{56}

Experience, however, shows the opposite. The Nova Scotia Council of Health reported a participation level of less than 15\% of the potential doctors for the province and that generally it is the same doctors using the programme on a regular basis.\textsuperscript{57}

A further criticism of the licensing system with regard to quality control is that although s. 28(2) of the Medical Act provides a wide list of who may lodge a complaint with the Board,\textsuperscript{58} in fact the system depends to a large degree on physicians reporting physicians.

\textsuperscript{53} R. D. Greene, Assuring Quality in Medical Care (Cambridge, Mass.: Ballinger Publishing Co., 1976) at 197
\textsuperscript{54} N.S. Report of the Nova Scotia Council of Health — Health Care in Nova Scotia: A New Direction for the Seventies (1972) at 110. Note same conclusion in supra, note 41 at 47
\textsuperscript{55} N.S. Report of the Provincial Medical Board of Nova Scotia (Dec. 31, 1969) at 28
\textsuperscript{56} Id.
\textsuperscript{57} Supra, note 54 at 111-112
While professional misconduct may be obvious to the layman it is entirely conceivable that he would be unaware of deficiencies in the degree of skill or competence of a physician.\textsuperscript{59}

The fact that the system is essentially dependent on physicians reporting their professional colleagues does not in itself make the licensing system in Nova Scotia useless. It does, however, raise at least a doubt in this writer's mind that the individual members are good watchdogs of the public interest. The Merrison Report recognized the problems of professional loyalty and noted:

Taken too far, such reluctance may represent a considerable inhibition on the effective control of fitness to practice.\textsuperscript{60}

Dr. MacDonald, Registrar of the Board, also recognized the unsurprising possibility that physicians might be a bit slow to report a fellow colleague but also commented that he felt that they were less reluctant today than in previous years.\textsuperscript{61} In the same context, the control power of the P.M.B. may have increased in importance\textsuperscript{62} because of the same problems associated with small hospitals in Nova Scotia, where staff shortages increase reluctance by physicians to criticize colleagues and make staffing the hospital's review committees a problem. Dr. MacDonald identified the process that occurs in such a situation. A physician informs the hospital administration of a deviation in acceptable standards and he then brings the matter to the attention of the P.M.B. for action.\textsuperscript{63}

A further criticism often voiced against the present type of licensing system is that it is a system based on the control of doctors by doctors alone. This is also true of the hospital control mechanisms but a distinction must be made between the two. In the latter the hospital is not entrusted with looking after the public interest while in the former it is.

The only assurance in the present system of the primacy of the public interest is the appointment by the Governor in Council of half of the Board members\textsuperscript{64} and the Board's recognition of their responsibility.

The possibility of conflict still exists between professional self interests and the public interest. J. T. MacLeod re-emphasizes this:

\textsuperscript{59} Supra, note 41 at 82
\textsuperscript{60} Id.
\textsuperscript{61} Supra, note 51
\textsuperscript{62} The 1969 amendments to the Medical Act and the stress on non-punitive measures has probably helped account for this.
\textsuperscript{63} Supra, note 51
\textsuperscript{64} Supra, note 12 at s. 2
Professions often tend to assume that, because the object of professional regulation is to maintain quality and to protect the public, the interest of the profession must necessarily be identical with the best interests of society. This sweeping assumption is by no means valid. Indeed it will be argued below that in some respects the interests of a profession and public interest may be sharply divergent and in conflict.65

Perhaps the most striking example of this is the pressing need for drastic change from the health care system described by the Nova Scotia Council of Health, “In short, a flawed and awkward system is demanding more money than we can afford and providing too little in return.”66

The Council felt the key to reform to be “. . . acceptance of sweeping changes, both by the public and by the people working within the system.”67 The drastic changes may well involve a redefinition of concern from the medical to total health care and thus the medical profession may well feel threatened and resist change.

To correct this, consumer participation has been suggested as a solution by many inquiries and commissions68 not only for this purpose of easing change69 but also to ensure professional bodies such as the P.M.B. remain aware of their responsibility to the public and act as a safeguard against injury to the public interest.70

VI. Consumer Participation

Where consumer participation has been incorporated into the system, the effects of having lay participation have not yet been assessed. Reforms in Ontario with the Health Discipline Act71 and in Quebec with the Medical Act72 and the Professional Code73 create systems involving substantial lay participation. Both recognize the fundamental principle behind professional

66. Supra, note 54 at i
67. Id. at ii
69. Supra, note 6 at 29
70. Ont. Royal Commission Report, supra, note 7 at 1166
71. S.O. 1974, c. 47 as am. by S.O. 1975, c. 63
72. S.Q. 1973, c. 46
73. S.Q. 1973, c. 43 as am. by S.Q. 1974, c. 65
self-government;\textsuperscript{74} that only a professional peer or equal who partakes of the same body of knowledge can judge adequately the skill or competence of another practitioner.\textsuperscript{75} What benefits then are really reaped by having consumer participation?

There are basically two benefits:\textsuperscript{76}

1) the benefits that may be gained by having consumers become more aware and involved in the health problems\textsuperscript{77}(and conversely, the profession become more aware of the consumer's views and problems in medical care); and

2) the esoteric satisfaction of removing the anamoly of a non democratic institution wielding enormous power in a democratic society.\textsuperscript{78}

This writer has no intention to belittle these benefits of consumer participation and the attempts to make the system more consumer-oriented \textit{(i.e.,} assert the public interest without, it should be noted, another cumbersome government bureaucracy of department) and at the same time maintain a high degree of professional autonomy and pride.\textsuperscript{79} However, the main benefits of acts such as those passed in Ontario and Quebec are sometimes lost in the discussion of lay participation.

The \textit{Health Disciplines Act}, for example, establishes a review by the Minister of the activities of the Council\textsuperscript{80} and allows for an active input, thereby protecting the public interest to a significant extent since the Minister can be questioned in the Legislative Assembly.\textsuperscript{81}

The Council is given extended powers to make regulations, subject to the approval of the Lieutenant-Governor in Council to \textit{inter alia}:

\begin{itemize}
\item providing for a program of continuing education of members
\end{itemize}

\textsuperscript{74.} Peer review is maintained in both systems with only minor lay participation in disciplinary matters. See supra, note 71 at s. 57 and s. 58 and Id. at s. 114

\textsuperscript{75.} Supra, note 65 at 61

\textsuperscript{76.} There are many more benefits included in the 2 basic ones given, such as control of the medical profession's immense influence in areas of physician assistantship or simply allowing justice to be seen to be done.

\textsuperscript{77.} Supra, note 6 at 29

\textsuperscript{78.} Id.

\textsuperscript{79.} Report of the Committee on Healing Arts, vol. 3, c. 25 at 29 noted the importance of professional pride and the folly it would be to minimize the benefits of professional pride.

\textsuperscript{80.} The Council is created by s. 48 and is similar in function to the P.M.B. but with non health profession representation.

\textsuperscript{81.} S.O. 1974, c. 47, ss. 49, 50
to maintain their standard of competence and requiring members to participate in such continuing education. 82

Thus setting up machinery that can effectively upgrade the quality of care that consumers can reasonably expect to receive.

This type of development may very well have lasting significance whereas the role of lay participation may go the same route of hospital Boards of Trustees, which although legally responsible for standards in the hospital, have abdicated this responsibility to the physicians in the hospital. 83

This is not to minimize the case for consumer participation which has many advantages and at least no readily apparent disadvantages.

VII. Conclusions

It is safe to say that generally the quality of medical care in Nova Scotia is quite high and is due primarily to the efforts of the medical profession itself. There is, however, room for improvement in the manner of regulation. Consumer participation of at least some level seems inevitable. 84 Furthermore, the P.M.B. should take a more active role in effectively promoting excellence in its efforts to establish a minimum level of competence through such measures as enforced continuing medical education.

The Board has made progress through attempts to remove the punitive aspects of quality control recognized to be inimical to encouraging the self-policing role of the physician. 85

There are limits to every system, and the licensure system cannot possibly ensure that all physicians will at any given time be providing an adequate quality of medical care. To fill this gap the other control mechanisms step in. The hospital can provide the type of active day to day supervision impossible with a licensing authority. 86

The malpractice action also has a role to play in a traditional sense of providing compensation to victims of medical negligence and also as a form of social control over the standards of the

82. Id. s. 50 (n)
83. Grove, supra, note 7 at 177
84. e.g. Report of the Committee on Health Professional Licensing, supra, note 68, recommended lay participation in an overseer capacity rather than in the licensure body.
85. Supra, note 83 and, supra, note 41 at 81
86. It should also be noted that hospital regulation may be important because of the greater risk of activities carried on in a hospital such as major surgery.
profession. Although the extent of these roles can be affected by the efficacy of the other controls, it must be realized that no licensing authority or hospital supervision can eradicate the existence of malpractice. 87

In summary, the delegation made to the medical profession has warranted our trust only in the last decade when the Provincial Medical Board has actively undertaken its responsibility to ensure the competence of physicians entered in the medical register. The trend in the future points to the hospital undertaking increased responsibilities in protecting the consumer, perhaps in conjunction with the Health Services and Insurance Commission.

If fulfilled, these institutional controls can hopefully provide a better system of protection to the consumer than the highly touted competitive market has provided with respect to other services.