Dalhousie Law Journal

Volume 44
Issue 1 *44:1 (2021) Special Issue: Purdy Crawford Workshop: The Role of Business Regulation in Advancing the Sustainable Development Goals*

Article 8

6-2021

Conflicts of Interest in Self-Regulating Health Professions Regulators

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Recommended Citation
Andrea MacGregor, "Conflicts of Interest in Self-Regulating Health Professions Regulators" (2021) 44:1 Dal LJ 339.

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Conflicts of Interest in Self-Regulating Health Professions Regulators

This article analyzes a set of related complaints and informal reports made to the Nova Scotia College of Chiropractors with respect to an alleged breach of the College's advertising policy. This analysis assessed situational elements of conflicts of interest in the complaint process, particularly dual roles and competing professional interests, against the Childress et al framework of ethical public health decision-making and the conflict-of-interest standards in the Nova Scotia Chiropractic Act and Regulations.

The analysis concludes that the legislative scheme fails to adequately regulate conflicts of interest and bias in the College's disciplinary decision-making processes through weak or unarticulated standards and high levels of discretion devolved to the College. Conflicts of interest within complaint processes threaten patients' health and well-being and diminish public trust in professional self-regulation. This case study identifies a need for legislative and policy reforms to better protect procedural justice and public accountability in health professional regulation.

Dans cet article, nous analysons un ensemble de plaintes et de rapports informels connexes adressés au Nova Scotia College of Chiropractors (collège des chiropraticiens de la Nouvelle Écosse) relativement à une violation présumée de la politique du collège en matière de publicité. Cette analyse évalue les éléments situationnels des conflits d'intérêts dans le processus de plainte, en particulier les doubles rôles et les intérêts professionnels concurrents, par rapport au cadre de prise de décision éthique en matière de santé publique élaboré par Childress et aux normes relatives aux conflits d'intérêts de la Chiropractic Act and Regulations de la Nouvelle Écosse.

L'analyse conclut que le régime législatif ne parvient pas à réglementer adéquatement les conflits d'intérêts et la partialité dans les processus de prise de décisions disciplinaires du collège, en raison de normes faibles ou non articulées et des niveaux élevés de discrétion dévolus au collège. Les conflits d'intérêts dans les processus de plainte menacent la santé et le bien-être des patients et diminuent la confiance du public dans l'autorégulation professionnelle. Cette étude de cas identifie un besoin de réformes législatives et politiques pour mieux protéger la justice procédurale et la responsabilité publique dans la réglementation des professionnels de la santé.

* I would like to express my special thanks to Rory Williams for sharing materials related to a set of regulatory complaints he made in 2018. These materials provided important support in the development of this article's thesis and analysis. This article's research was carried out, in part, with support from the Canadian Institutes of Health Research (CIHR PJT 156256). This paper was awarded first prize for the 2020 J.S.D. Tory Award for legal writing.

Part I

1. *Introduction*

A basic tenet of health professionals' work holds that practitioners should put the needs of patients and the public ahead of the practitioners' own interests.[1] A central idea that flows from this is that any interest that might conflict with this priority—that is, anything that might pose a professional conflict of interest—should be taken seriously and avoided wherever possible. The regulators of health professions frequently address conflicts of interest affecting their members, including by undertaking complaint and disciplinary proceedings. While much attention has traditionally been given to conflicts of interest in professional practice (e.g. in a hospital or a clinic), less has been given to conflicts that may involve the regulators themselves (that is, within the regulators' own administrative proceedings). To date, it appears that no detailed analysis has been undertaken of cases in which this type of conflict may be occurring, nor any comprehensive discussion of the nature, scope, and potential implications of these situations. However, instances of potential conflicts within regulators' complaint proceedings have recently arisen and in some cases garnered media coverage, investigation by regulators, and public concern.[2]

The analysis to follow initially arose from a set of advertising complaints I made to the Nova Scotia College of Chiropractors between late 2018 and early 2019. While chiropractors and other health professionals have lately gained scrutiny for misleading advertising related to COVID-19 treatment,[3] many other health conditions have also been the subject of advertising concerns. There has been a particular focus on advertising that references health benefits but which may not be substantiated by scientific evidence.[4] My complaints related to practitioners' online marketing on the topic of childhood health conditions—marketing that I was concerned might be misleading or harmful to patients or anyone else the advertising might reach.

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1. Health professions' legislation typically includes a reference to serving the public interest. See e.g. *Health Professions Act*, RSBC 1996, c 183, s 16(1)(b) [BCHPA]: "It is the duty of a College at all times to serve and protect the public, and to exercise its powers and discharge its responsibilities under all enactments in the public interest."

2. See e.g. Bethany Lindsay, "Vancouver Chiropractor Resigns from College Board over Anti-vaccine Video" (4 May 2018), online: *CBC* <www.cbc.ca/news/> [perma.cc/M4UE-W39T].

3. See Wallis Snowdon, "Cow Urine, Bleach, Oregano Oil: Medical COVID-19 Quackery Has Big Ramifications for Public Health" (3 April 2020), online: *CBC* <www.cbc.ca/> [perma.cc/4GFG-U4N4].

4. See e.g. Bethany Lindsay, "There's An Epidemic of Bogus Health Claims Online, and No Easy Cure" (9 June 2018), online: *CBC* <www.cbc.ca/news/> [perma.cc/C2YE-V4VW] [Lindsay Health Claims].

Box 1. List of Non-Musculoskeletal Health Conditions for which Chiropractic was Referenced as Beneficial in Children, Tallied from Web Advertising Complaints[5]

Health Condition	*# of Website References*
ADD/ADHD	3
Allergies	1
Asthma	2
Autism	1
Bedwetting	4
Colic	10
Depression	1
Difficulty Feeding	4
Infection (Ear, Cold, Other)	9
Irritable Bowel	1
Reflux	3
Sudden Infant Death Syndrome	1

My complaints went in, and the results came back several months later: all dismissed. This in itself was not necessarily a bad outcome. It is normally up to health professions regulatory College staff to make determinations about complaints as they see fit, regardless of whether the parties involved agree with the result. However, on reviewing the full written evidence I had collected by the end of the process, I noticed something interesting that had little to do with the substance of the complaints themselves. Based on the documents in front of me, it appeared as though many of the same parties: 1) had been complained against, 2) had some degree of influence over the complaint process, 3) had the ability to control and delete relevant evidence prior to adjudication, 4) in most cases did control and delete relevant evidence prior to adjudication, 5) were found not responsible for any misconduct, and 6) had written decisions issued stating that there was

5. While chiropractic has supporting evidence of efficacy for some musculoskeletal health conditions, its use for non-musculoskeletal conditions, especially in pediatric populations, is controversial and has generally been found to lack scientific support (see e.g. Canadian Pediatric Society, "Chiropractic Care for Children: Controversies and Issues" (2002) 7:2 Paediatric Child Health 85). Some regulators, such as the College of Chiropractors of British Columbia, have prohibited advertising that represents chiropractic care as beneficial for childhood health conditions on the grounds that there is not enough evidence to accurately support such claims (see College of Chiropractors of British Columbia, *Efficacy Claims* (Vancouver: CCBC, 2018) s 3, online (pdf): *CCBC* <www.chirobc.com/> [perma.cc/34X9-PRXJ]). I used the CCBC's policy and examples as a guide for assessing websites in Nova Scotia. Complaint documents are on file with the author.

no right of appeal to any of the findings. It also appeared that this was not the first time that something like this had occurred.

In this paper, I will seek to answer two questions about conflicts of interest in self-regulating health professions' complaint proceedings. First, when and how might these conflicts occur, and what are their implications for public health and for regulators' mandates? Second, what can be done to effectively address these conflicts? In order to answer these questions, this paper has two main purposes: to identify and describe the nature and scope of this type of conflict of interest, and to survey and evaluate possible actions that may address this kind of conflict, particularly options for reform.

In contrast to many jurisdictions, Canada's professional regulation happens mostly at the provincial level, using a model of self-regulation.[6] Canadian models of professional regulation typically include less involvement from independent parties (such as members of the public or government bodies). Because of the differences between the standard Canadian model and the regulatory models used elsewhere in the world, this paper's discussion will primarily be in the context of Canadian provincial jurisdiction. However, some reference will be made to models in other jurisdictions in order to compare policy responses and their potential consequences.

This analysis draws on a variety of sources, including legal literature and case law, as well as some sources from health disciplines and other areas. Due to the limited number of published sources dealing with the specific subject of administrative conflicts of interest within health professions regulators, I will also draw from unpublished complaints made to regulatory Colleges in Canada, including the ones I made, in order to discuss specific cases in more detail.

This paper includes three basic parts. In the first section, I provide background and legal context, including overviews of self-regulation and administrative conflicts of interest. In the second section, I outline the nature and scope of conflicts of interest in regulatory complaint processes, with reference to specific instances where potential conflicts appear to have arisen. I ultimately conclude that these conflicts appear not only to contradict commonly recognized ethical principles of public health decision-making, but also that they appear to run contrary to the purpose of the regulator's governing legislature. In the third section, I examine proposals for policy reforms that may help to address these issues.

6. See Tracey L Adams, "Self-regulating Professions: Past, Present, Future" (2017) 4 J Professions & Organization 70 at 71, 73.

2. *Background and regulatory context*

a. *Overview of self-regulation in Canada*

Professional regulation is intended to assure public health and safety.[7] In Canada, regulation is governed by the state, through a provincial, territorial, or federal government authority.[8] However, for most regulated occupations, including health professions, the direct work of regulation is delegated to a regulatory body, normally called a College, which is comprised mostly of members of that profession. The fact that the profession is regulated by its own members is what makes these professions "self-regulating." Canadian self-regulating health professions operate in a "closed" fashion: only people who meet certain education and competence standards may be part of the profession.[9]

Professional self-regulation has existed since the 19th century, but many professions have become self-regulating more recently within the 20th and 21st centuries.[10] Although the number of regulated professions is not consistent by region, provinces and territories regulate dozens of different health professions, and as a result, Canadian health care is mostly delivered by members of self-regulating professions.

Just like the professions themselves, discussions of the advantages and disadvantages of self-regulation are not new. There are several main arguments in favour of self-regulation, including arguments relating to administrative efficiency, necessity, economics, and health. For example, it may be argued that self-regulation benefits governments through increased efficiency and cost-effectiveness, and decreased administrative burdens.[11] Arguments about necessity, economic benefits, and public health arise from the idea of a knowledge gap between the public and health professionals. This gap, which exists due to the complexity of the service being provided, is termed "information asymmetry."[12] The idea is essentially that non-experts do not have enough knowledge to evaluate the quality of health care for safety, effectiveness, or efficiency, and so

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7. See Government of Canada, "Regulated Professions and Trades" (11 January 2015), online: *GC* <canadabusiness.ca> [perma.cc/T2QZ-ZADC].
8. *Ibid.*
9. See Adams, *supra* note 6 at 74.
10. *Ibid*; see also *Naturopathy Act*, 2007, SO 2007, c 10, Sched P.
11. See Amy Zarzeczny, "The Role of Regulation in Health Care—Professional and Institutional Oversight" in Joanna Erdman, Vanessa Gruben & Erin Nelson, eds, *Canadian Health Law and Policy*, 5th ed (Toronto: LexisNexis, 2017) at 171.
12. Canada, Competition Bureau, *Self-Regulated Professions: Balancing Regulation and Competition*, (Gatineau: Competition Bureau Canada, 2007) at 18, online (pdf): *Competition Bureau* <www.competitionbureau.gc.ca> [perma.cc/DN6M-FKSF].

health professionals, as experts, should be responsible for ensuring quality standards on the public's behalf.[13]

Just as Canada's model of self-regulation has been defended, it has also been criticized for decades. Concerns include bias (particularly in terms of practitioners putting their interests ahead of the public interest), insufficient transparency, and inadequate monitoring and enforcement of professional standards.[14] There is also an economic argument that self-regulation restrains trade, sometimes in an unnecessary fashion. Additionally, health-based arguments focus on concerns that where regulators fail to enforce standards and the public is not protected from misconduct, members of the public may be subjected to a range of harms.

b. *Public health implications of Canadian professional regulation model*

Professional regulation can influence public health outcomes in several ways, both through policy-based "input" regulation practices and enforcement-based "output" practices.

The "input" based public health influence is based around professions' ability to dictate care quality and manner of delivery. Health professions define many of the actions and decisions available to their members, from education and entry-to-practice standards to ethical obligations and care standards.[15] As a result, the delivery of health interventions is effectively filtered through professional bodies by way of the standards they create and impose on members. In this sense, professional bodies are an important component of public health, because when the public accesses health care, the quality and manner of delivery of that care is mediated by the professional body that sets the standards for that care and determines who may deliver that care.

The "output" based public health influence is based in the function of regulators as an accountability mechanism for professionals. Regulators have the ability to safeguard quality using several means, including handling complaints, conducting investigations, and making disciplinary decisions.[16] Regulators are particularly instrumental in regulating professional conduct by way of issuing orders and imposing penalties, including fines, practice conditions, and the suspension or revocation of

13. See Roger Collier, "Professionalism: The Privilege and Burden of Self-regulation" (2012) 14 Canadian Medical Association Journal 1559 at 1559, online: <www.ncbi.nlm.nih.gov> [perma.cc/D2YV-LLKT]; Competition Bureau, *supra* note 12 at 19.
14. See Zarzeczny, *supra* note 11 at 172.
15. See *ibid.*
16. See *ibid.*

professional registration to practice. The system is intended to protect the public from harm or abuse by professionals. However, if it fails to effectively monitor and regulate members' activities, the public may be at risk of many kinds of harm: some reports of repeat behaviours by self-regulated professionals include improperly performed procedures, abuse, and even homicide.[17] Because of the extensive role that regulators have in health care quality and safety assurance, and the range of health implications that their effectiveness can have for the public, it is important that regulators serve their functions effectively.

c. *Self-regulating health professions legislation and governance*

As previously noted, health professions' self-regulating bodies exist by delegation from a provincial government authority. This is enabled through provincial legislation and accompanying regulations, which typically define each profession and its respective scope of practice,[18] dictate the structure of the self-regulating body,[19] and grant the self-regulating body specific governance powers and obligations.[20] The structure of a self-regulating body generally includes a governing Board composed mostly or entirely of professional members (sometimes with a minority of non-members appointed by government),[21] and a series of professional committees to which the Board sub-delegates its powers of practice standard creation and enforcement. Often, the Board or Board Chair may also appoint and remove professional committee members and Chairs.[22]

d. *Professional complaints processes*

One of the main functions of a self-regulating body is to investigate professional complaints against members of the profession. This is normally undertaken by committees composed of professional and lay members who receive and process complaints, gather evidence and conduct interviews, and make determinations about whether a member has engaged in misconduct or failed to adhere to a standard of professional practice. In

17. See e.g. Adams, *supra* note 6 at 78; see also Bethany Lindsay, "Parents 'Infuriated' to Learn of Past Complaints Against BC Psychologist" (26 October 2019), online: *CBC* <www.cbc.ca/> [perma.cc/37UE-ZNKZ].

18. See e.g. BCHPA, *supra* note 1, ss 12(1), 12(2)(a)-(h) (designating titles that may be held and health services that may be performed).

19. *Ibid*, ss 15(1), 15(2)(a)-(b) (establishing the College and its basic structure).

20. *Ibid*, ss 16(1)(a)-(b), (2)(a)-(j), 19(1)(a)-(z) (outlining the College's obligation and power to establish education requirements, standards of practice, and enforcement).

21. See e.g. *Chiropractic Act*, SNS 1999, c 4, s 7(1) [*Chiropractic Act*].

22. *Ibid,* s 46(1), 46(5)*;* see also Nova Scotia College of Chiropractors*, Board Regulations* (Halifax: NSCC, 2017), ss 7.1, 7.5, online: <www.chiropractors.ns.ca/> [perma.cc/L8ZD-LVQ2] [*Board Regulations*].

some cases, there may be a complaint investigator who receives complaints directly; in others, complaints may be forwarded to the relevant committee by another party such as the Registrar. Regulatory bodies (and the relevant committees) must normally investigate any complaint brought forward by any professional or member of the public. They may also initiate their own investigations based on information about professional conduct that is brought to their attention, even if it is not formally complained about. Once an investigation is complete, a complaint may be dismissed or referred to a disciplinary committee, which may in turn impose warnings or penalties to members who are found to have contravened a professional standard.[23]

A central feature of self-regulating professions' governance is that most professional members of each regulator are also practicing members of the profession—that is, they provide health care to patients, and they also work within the regulatory body to create or enforce professional standards. A critical implication of this, for the purpose of this paper's discussion, is that any professional member of any regulatory body may potentially be subject to a professional complaint, in addition to having an ongoing role in the complaint management process. This can lead to professionals having a dual role, acting both as a potential enforcer of standards and as a party against whom standards may potentially be enforced.

3. *Conflicts of interest in the context of professional self-regulation*

The legal and health care fields have each developed their own conceptions of conflicts of interest. The approaches are similar and overlap in some respects, and both are relevant to a health professions regulator, which functions as part of the legal system and as part of the health care system.

a. *Conflicts of interest in the context of health professions ethics*

In the context of health care, a conflict of interest has been defined as "a set of conditions in which professional judgment concerning a primary interest (such as a patient's welfare...) tends to be unduly influenced by a secondary interest (such as financial gain)."[24] One of the specific health implications of a conflict of interest is that it may have a negative impact on patient care.[25]

23. See e.g. Ontario College of Pharmacists, "Complaints Process," online: *OCP* <www.ocpinfo.com/> [perma.cc/5Z5W-DK3Y].
24. Dennis F Thompson, "Understanding Financial Conflicts of Interest" (1993) 329 N Engl J Med 573 at 575, online: *NEJM* <www.nejm.org> [perma.cc/8DQH-HC46].
25. *Ibid* at 574.

Canadian self-regulating bodies have generally adopted similar conflict of interest definitions in their own College rules, often making reference to the best interests of patients. Colleges typically recognize conflicts of interest within a clinical setting as a form of professional misconduct.[26] Regulatory Colleges' conflict of interest rules often apply to a range of situations, including business referrals, product sales, or matters involving monetary or personal interests. Some College Boards also have specific guidelines outlining procedures for addressing conflicts of interest affecting Board and committee members carrying out College functions.[27] The governing legislation of self-regulators sometimes references conflicts of interest as well, typically with a focus on conflicts that may directly affect patient care.[28]

b. *Conflicts of interest in the common law context*

In instances where a conflict of interest occurs within an administrative body like a health professions regulator, common law principles of procedural fairness that address conflicts of interest and bias are engaged. These principles are well-recognized and ordinarily apply to any administrative decisions made by staff within a regulator, unless a statute clearly provides otherwise.

One main issue that arises where registrants have influence over complaint processes in which they also have a professional interest is the potential for financial conflicts of interest. It has been recognized that where an adjudicator (or someone connected to the adjudicator) may benefit or suffer financially from a decision, bias is presumed,[29] and the adjudicator should typically be disqualified from taking part in the decision.[30] This is directly relevant to regulatory complaints processes, where complaints against registrants may have consequences that affect registrants' finances directly (via monetary penalties) or indirectly (via impacts on professional reputation or ability to practice). Given the range of possible disciplinary

26. See Debra LC Zelisko, *Managing Conflict Of Interest In Healthcare: The Roles Of Professionalism And Regulatory Colleges* (PhD Dissertation, University of Toronto, 2015) at 72-73 [unpublished], online: *U of T* <tspace.library.utoronto.ca> [https://perma.cc/HTZ5-HGMY] (noting several Ontario Colleges defining COIs as professional misconduct).

27. See e.g. College of Physicians and Surgeons of Saskatchewan, "Governance Policy: GP-10 Conflict of Interest" (19 January 2018), online: *CPSS* <www.cps.sk.ca/> [https://perma.cc/G66U-4Z9N].

28. See e.g. College of Registered Nurses of Alberta, *Bylaws* (revised September 2019) s 36.5, online (pdf): *CARNA* <nurses.ab.ca/> [perma.cc/PS62-ZUKY].

29. See Sara Blake, "Discretion and Bias" in *Administrative Law in Canada*, 6th Ed (Toronto: LexisNexis, 2017) at 121.

30. See David J Mullan, *Administrative Law*, 3rd Ed, (Toronto: Carswell, 1996) at 293.

sanctions, from fines to de-registration,[31] and the possibility of decisions against registrants being made public,[32] a registrant's livelihood may be affected by the outcome of a complaint, resulting in a financial conflict.

As a result, any practising registrant with influence over any part of their own complaint process will presumably have a financial stake in the outcome of that process, and as a result would presumably be unable to participate as an impartial decision-maker. This conflict would most clearly affect registrants serving on complaints or disciplinary committees, who have direct power to determine the outcome of a complaint. However, it could also affect other members of the regulatory body, including executive and Board members who have complaints made against them. This is because some of these members may potentially serve on the committees at the time the complaints are made, and these registrants often have the ability to decide whether to proceed with the complaint, make disciplinary decisions regarding the complaint, or control which members serve on committees that process complaints.

The second issue underlying potential conflicts is the dual role that can arise where parties subjected to complaints also have decision-making roles connected to the complaint process. One type of dual role that may undermine procedural fairness is when a party can be both a defendant and a formal adjudicator (or investigator) in a complaint process. Where regulatory tribunals are concerned, it has been recognized that members should not judge complaints against themselves or preside over hearings if they have been involved in the matter being heard.[33] Such a dual function is normally treated as an inherent conflict of interest. An exception to this is cases where dual roles have been authorized by statute.[34] However, statutes generally authorize an overlap between investigatory and adjudicatory roles, and not an overlap between being a party and being an investigator or a judge. Such an overlap would also be contrary to longstanding, fundamental procedural fairness principles: for example, an early Quebec Court of Appeal case regarding the province's College of Dental Surgeons stated that the possibility of a dual plaintiff-judge or defendant-judge role was "not even open for discussion."[35] This is particularly relevant to formal investigations undertaken by a regulator, where an Investigation

31. See e.g. *Chiropractic Act, supra* note 21, s 60(2)(e)(i).
32. *Ibid*, s 88(1), (2).
33. See Blake, *supra* note 29 at 121, citing *Great Atlantic and Pacific Co of Canada Ltd v Ontario (Human Rights Commission),* [1993] 13 OR (3d) 824, 109 DLR (4th) 214 (ONSC); *Griffin v Summerside (City) Director of Police Services*, [1998] PEIJ No 30 at para 34, 159 DLR (4th) 698 (PEISC).
34. See Blake, *supra* note 29 at 121.
35. *Maillet v College of Dental Surgeons* (1921), 58 DLR 210 at 211, 34 CCC 138 (Que CA).

Committee may have at least two practising registrants and one member who is not a member of the profession—a situation that may allow for a majority of Committee members to potentially be in a dual-role if a complaint is ever made against them.[36]

Another type of dual role can arise from less formal administrative roles, i.e. decisions that fall outside the formal complaint process. Beyond formal hearings or investigations, decision-making roles within any stage of the complaint process may give rise to a conflict affecting procedural fairness in cases where a decision-maker has a competing personal or professional interest. This can include the stage of deciding whether to forward a complaint for investigation, or whether and how to gather and handle evidence. In *Baker v Canada*, a leading decision regarding procedural fairness, the Supreme Court of Canada recognized that the level of importance of a decision on the lives of those affected is a significant factor in determining a duty of procedural fairness.[37] Where the level of importance is higher, the level of fairness required will also increase. Administrative decisions that may ultimately start, finish, or affect the course of a complaint would seem to have a high level of importance. This is in part because they may lead to significant professional consequences, which the court in *Baker* used as an example of a situation in which a high standard of fairness is required (specifically referencing a professional disciplinary decision, in the form of a suspension).[38] At the same time, decisions about investigations may also affect the lives of complainants and the public, as concerns about health professionals will often be related to health or safety. Both sets of impacts would probably have a high level of personal importance for affected individuals, one that attracts a significant duty of procedural fairness that a dual-role conflict would undermine.

Part II

1. *Scope and description of conflicts within regulators*

This section provides a basic account of the nature and potential implications of cases in which members of self-regulating bodies appear to have control over, or involvement in, the decision-making processes regarding complaints against themselves. It begins with an overview of instances in which these types of conflicts appear to have arisen. Following

36. *Chiropractic Act, supra* note 21, s 46(1)–(3).
37. See *Baker v Canada (Minister of Citizenship and Immigration)*, 1999 CanLII 699 (SCC) at para 25, [1999] 2 SCR 817.
38. *Ibid* at para 25, citing *Kane v Board of Governors of the University of British Columbia*, 1980 CanLII 10 (SCC), [1980] 1 SCR 1105 at 1113.

this will be a discussion of the ethical and legal considerations that may apply to such cases.

a. *Sources suggesting extent of conflicts within regulators*

The existing evidence around possible conflicts of interest affecting health professions regulators has largely been centered around practitioners' advertising practices, possibly because these practices are more publicly visible (and therefore more likely to be reported). Canada's health professions regulators typically have advertising policies requiring that all information contained in their registrants' marketing should be accurate and verifiable.[39] However, research suggests that in self-regulating professions across many provinces, a large percentage of practitioners (or even a majority in some cases) may be making factually unsupported health claims online,[40] potentially in violation of their regulatory Colleges' advertising policies.

There has been a particularly large number of reports of this issue occurring in professions associated with Complementary and Alternative Medicine (CAM). Some experts have cited the lack of a strong evidentiary basis behind many CAM practices, as well as the common use of CAM by those who are distrustful of conventional medical practices, as reasons why factually unsupported health in this area may be more common.[41] However, concerns about misleading advertising also exist across more mainstream health professions.[42]

Because it is common for professional Board and committee members (i.e. governing members) to be actively practising members of their profession, and because most practising members advertise their services, it is perhaps unsurprising that governing members of Colleges have sometimes been implicated in advertising complaints. For example, one governing member of the College of Chiropractors of Ontario

39. See e.g. Nova Scotia College of Chiropractors, *Board Policy: Advertising* (Halifax: NSCC, 2019) s 4, online (pdf): *NSCC* <drive.google.com/> [perma.cc/7ELX-L8ZN] [NSCC Ad Policy]; see also College of Physiotherapists of Ontario, *Advertising Standard* (Toronto: CPTO, 2019), online: *CPTO* <www.collegept.org/> [perma.cc/ER3Q-CUY9]; College of Dietitians of Alberta, *Code of Ethics* (Edmonton: CDA, 2008) ss 3.5, 3.7, online (pdf): *CDA* <collegeofdietitians.ab.ca/> [perma.cc/2HDW-R82D].

40. See e.g. Blake Murdoch, Stuart Carr & Timothy Caulfield, "Selling Falsehoods? A Cross-Sectional Study of Canadian Naturopathy, Homeopathy, Chiropractic and Acupuncture Clinic Website Claims Relating to Allergy and Asthma" (2016) 6:12 BMJ, online: *BMJ* <bmjopen.bmj.com/> [perma.cc/7AJM-R8DT]; see also Timothy Caulfield & Christen Rachul, "Supported by Science?: What Canadian Naturopaths Advertise to the Public" (2011) 7:14 AACI 7 at 7, online: *NCBI* <www.ncbi.nlm.nih.gov/pubmed/> [perma.cc/6UY2-VPWM].

41. See e.g. Lindsay Health Claims, *supra* note 4.

42. *Ibid*; see also Leanne Loranger, "Good Practice: Are you Selling Snake Oil?" (30 April 2015), online: *CPTA* <www.physiotherapyalberta.ca/> [perma.cc/29WJ-FXD6].

was subject to a complaint about anti-vaccination statements in 2019. Although she lost her seat on the College council in an election shortly afterward, multiple other members of the College who had also made anti-vaccination statements remained on the council,[43] and as of July 2020, no disciplinary action regarding the complaint has been reported.[44] A similar issue of potential conflicts of interest arose when I made a set of informal reports to the College of Naturopaths of British Columbia (CNBC) about practitioners advertising alternative therapies for cancer.[45] At the time the reports were sent, four of the College members I reported were listed as being on the CNBC Board, and one member was listed as serving on the College's Discipline Committee.[46] In some cases, it is professionals themselves who come forward with allegations that their regulatory Colleges are not adequately enforcing advertising standards, or that governing members of Colleges may not be following the standards. For example, members of the British Columbia Chiropractic Association, a voluntary professional body, reportedly complained to the College of Chiropractors of British Columbia over a two-year period about anti-vaccine content posted by their fellow registrants online, including postings by one registrant who was the College's Vice Chair at the time.[47]

The high prevalence of misleading advertising among practising members of health professions, in combination with the high prevalence of governing members being practising members, suggests that there may be potential for widespread conflicts of interest within many self-regulatory bodies across Canada, since many professionals may be engaging in at least one practice (misleading advertising) that may contravene the same policies the professionals are responsible for enforcing. If Colleges are charged with enforcing policies against members, but governing members

43. National Post, "As One Anti-Vaccination Sympathizer is Voted off Ontario's Chiropractic Regulatory Body, Another is Voted on" (16 April 2019), online: *National Post* <nationalpost.com/> [perma.cc/V7HW-T8FG].

44. See College of Chiropractors of Ontario, "Discipline Hearings and Decisions," online: <www.cco.on.ca/> [perma.cc/3PN4-GUZ2].

45. See Letter from Andrea MacGregor to the College of Naturopathic Physicians of British Columbia (5 February 2019), titled "Advertising Concerns: Online Claims Regarding Cancer Treatment and Screening" [unpublished].

46. See College of Naturopathic Physicians of British Columbia, *Board,* online: *Wayback Machine* <web.archive.org/>; College of Naturopathic Physicians of British Columbia, *Committees,* online: *Wayback Machine* <web.archive.org/> (showing the members of the Board and the Discipline Committee in February 2019).

47. See Bethany Lindsay, "Ministry Considered Options for Handling 'Dysfunctional' Chiropractors College after CBC Report, FOI Shows" (18 March 2019), online: *CBC* <www.cbc.ca/> [perma.cc/D76Y-7FZ3].

of the College are violating those same policies, the College's interest in policy enforcement may be substantially undermined.

b. *Overview of specific instances of potential conflicts: N.S. College of Chiropractors*

In November 2018, the Nova Scotia College of Chiropractors President and Board Chair were named in a set of complaints alleging that some College members were contravening advertising policies by sharing anti-vaccine content online. According to the complainant, the College had not taken any disciplinary action as of December 2018, and no notice of any decision has been published on the College's disciplinary webpage as of the date of this paper's submission.[48]

My own complaints were also in relation to registrants' advertising practices. After hearing of the initial anti-vaccine advertising complaints, I compiled a survey of College registrants' online advertising practices in relation to childhood health conditions. This survey revealed that nearly 25% of practitioners registered with the College had a website that contained at least one reference to chiropractic being beneficial to non-musculoskeletal childhood health conditions (such as ADHD, colic, autism, or ear infections). The wording of these references was often similar or identical across multiple practitioners' websites. According to health experts, there is insufficient scientific evidence to support these statements about childhood conditions,[49] and chiropractic regulators in other jurisdictions, including British Columbia, have made explicit policies prohibiting the use of these representations in their practitioners' advertising.[50] However, the Nova Scotia Chiropractic College has not adopted this rule (although the College does have an advertising policy requiring that advertising claims be accurate and verifiable).[51] In addition to the practitioners whose websites contained childhood conditions references, another 15% of practitioners claimed to perform treatments for babies or infants. This claim itself is not misleading, but it has been described by medical experts as potentially unsafe and also unlikely to be

48. See Letter from Rory Williams to the Nova Scotia Minister of Health (9 December 2018) [unpublished]; Nova Scotia College of Chiropractors, *Disciplinary Findings*, online: *NSCC* <www.chiropractors.ns.ca/> [perma.cc/Q26Y-YDTZ].

49. See e.g. Sharon Kirkey, "Pediatricians Alarmed by Chiropractic Treatments for Babies That 'Border on the Fraudulent'" (8 May 2018), online: *National Post* <nationalpost.com/> [perma.cc/4T49-XV4M]; see also Samuel Homola, "Pediatric Chiropractic Care: The Subluxation Question and Referral Risk" (2016) 30:2 Bioethics 63 at 63, online: *Wiley* <onlinelibrary.wiley.com/> [perma.cc/FWY7-TZ8F].

50. See College of Chiropractors of British Columbia, *Efficacy Claims* (Vancouver: CCBC 2018) s 3, online (pdf): *CCBC* <www.chirobc.com/> [perma.cc/34X9-PRXJ].

51. See NSCC Ad Policy, *supra* note 39.

of medical benefit, and as such, it may engage concerns about safety and about the promotion of unnecessary treatment, even if it is not explicitly addressed in College standards.[52]

In total, 41 practitioners had websites with representations about childhood health conditions, and 26 additional practitioners did not reference childhood conditions but claimed to treat babies or infants. Initially, all practitioners and websites were reported to the College informally in December of 2018.[53] The College's original response was to decline to investigate.[54] The College did not give any reasons for its decision not to begin an investigation or otherwise act on the reports, stating that it was under no duty to give reasons. However, the College did state that to have the complaints investigated, each complaint would need to be filed formally using a standardized complaint template. The template requires a complainant to state their full name, address, and other contact information, and to provide a description of the nature of the complaint (which can include any written or visual evidence the complainant would like to rely on). The form states that all of this information is forwarded to every party who is complained against.[55] The College confirmed that this is the case even for the complaints at hand, which were based entirely on publicly available website information, where the complainant would not be needed for the purpose of testimony, and where the complainant's personal information would not be relevant to the outcome of the decision.[56]

Following this response, any websites that still contained childhood condition references were formally reported in March of 2019 (for a total of 19 formal complaints against 18 practitioners, as some practitioners shared a single website and other websites had since been modified to remove the references).[57] The practitioners whose websites were formally complained against included three of eight professional members of the College Board (including the Board Chair), as well as one of two members who served as Chairs of the Investigative Committee during the time the complaints were active.[58]

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52. See Kirkey, *supra* note 49; *Homola, supra* note 49 at 63.
53. See Letter from Andrea MacGregor to the Nova Scotia College of Chiropractors (12 December 2018) titled "Online Advertising Complaint" [unpublished] [Ad Complaint].
54. See Letter from the Nova Scotia College of Chiropractors to Andrea MacGregor (3 January 2019) titled "Complaint N SCC 4.6.59 Andrea McGregor" [sic] [unpublished].
55. See Nova Scotia College of Chiropractors, "Complaint Form/Authorization and Consent to Investigate" at 4, online (pdf): *NSCC* <drive.google.com/> [perma.cc/T4PG-PZCS].
56. See Letter from the Nova Scotia College of Chiropractors to Andrea MacGregor (4 March 2019) titled "Complaint NSCC 4.6.59 Andrea McGregor" [sic] [unpublished].
57. See Message from Andrea MacGregor to the Nova Scotia College of Chiropractors (27 March 2019) reply to "Complaint N SCC 4.6.59 Andrea McGregor" [sic] [unpublished].
58. See Nova Scotia College of Chiropractors, *The Board of the Nova Scotia College of*

Importantly, the Board Chair has the ability to appoint, grant powers to, and repeal the Chairs of the Investigative Committee (which investigates complaints) and the Hearing Committee (which carries out hearings and disciplinary decisions).[59] An additional Board member and Investigative Committee Chair had also originally been named in the informal reports that were not investigated.[60] The Board collectively has the power to appoint the members of the Investigation Committee, and a majority of people on the Investigative and Hearing Committees may also be current or former Board members.[61] In total, seven of ten governing members of the College who were known to have a connection to the complaint process had a website that was subject to a formal complaint or an informal report. Of particular note is that six of the ten governing members had websites that were subject to complaints or informal reports about the same subject matter (advertising references about childhood conditions). This means that most of the College's governing members who were known either to be involved in the complaints process,[62] or to have the power to decide who could be involved in the complaints process, had their own websites subjected to a formal complaint or informal report about the same subject matter as one another.

Each registrant who received a complaint responded in writing in April of 2019. In June and July of 2019, the College issued decisions for each formal complaint, opting to dismiss all of them. In a majority of cases,[63] according to the College, the online material in question had been removed from the websites by the time investigators attempted to review it, resulting in the College being unable to review the material. The College then found insufficient evidence for any finding of professional misconduct or adjudication by a Hearing Committee. (This was notwithstanding that

Chiropractors, online: *NSCC* <www.chiropractors.ns.ca/> [perma.cc/96GP-K5LP] (listing the College Board members) [*NSCC Board*]; NSCC, *Cover Letter and Decision 4.6.68; 4.6.70; 4.6.75; 4.6.77* [unpublished] (noting the reported websites with which the members and Investigation Committee Chairs were associated); Chiropractic Nova Scotia, *Directory* [a collection of Directory weblinks is on file with the author] (showing that the same members listed on the *Board* page are the operators of the websites listed in decision numbers 68, 70, 75, and 77, respectively).

59. See *Board Regulations, supra* note 22, ss 7.1, 7.2, 7.4, 7.5.

60. See Ad Complaint, *supra* note 53 (included reports against websites associated with Investigative Committee Chair and Board member); Chiropractic Nova Scotia, *Directory* [a collection of Directory weblinks is on file with the author] (showing that the members are the operators of the websites listed in the reports).

61. *Chiropractic Act, supra* note 21, ss 46(1)–(3), 52(3).

62. See *NSCC Board, supra* note 58 ("The Board governs, controls and administers the regulatory and administrative affairs of the College... The Board's functions include... complaints and investigation").

63. Thirteen of nineteen cases contained similar statements: NSCC, C*over Letter and Decision 4.6.62; 4.6.63; 4.6.65; 4.6.66; 4.6.67; 4.6.68; 4.6.73; 4.6.74; 4.6.75; 4.6.76; 4.6.77; 4.6.78; 4.6.80* (2019) [unpublished] [NSCC Decisions].

dated screenshots from the websites had been provided in the complaints, and that in some instances, the original webpages are still visible in public web archives.)[64] Two follow-up surveys in August and October of 2019 found that most references captured in the original complaint screenshots were no longer displayed on the websites. However, 15 practitioners whose advertising was reported had not removed the original references, and another seven practitioners had removed material that had been captured in reported screenshots but still had other online content referencing childhood conditions. As of the time of this paper's submission, approximately 10% of the province's practitioners still appear to be representing on their websites that chiropractic may benefit childhood conditions.[65]

Following the final outcomes of the reports and complaints, the College and Investigative Committee did not at any point state that registrants should not represent that chiropractic may be beneficial for childhood health conditions, although some decisions stated that registrants should not expressly claim to treat or cure childhood health conditions.

2. *Discussion of issues raised*

a. Childress framework and ethical concerns relating to the public interest

Professional ethics is an important aspect of health professions generally, but it is particularly relevant to discuss here because ethical considerations are often a feature of health professions legislation, with conflicts of interest being a common kind of ethical concern within health professions. The *Chiropractic Act* includes several mentions of ethics generally, and conflicts of interest specifically. Section 4(3) of the *Act* states that "In order that the public interest may be served and protected, the objects of the College are to... establish, maintain and develop standards of professional ethics among its members."[66] Section 3(a) of the *Regulations* further notes that "professional misconduct" includes "a breach of the *Act*, regulations or by-laws of the Council,"[67] which can include ethical standards. The *Regulations*, By-laws, and College standards include a Regulation addressing corporation conflicts of interest and undertakings contrary to ethical practice,[68] a By-law regarding Board conflicts of interest,[69] and a

64. Example weblinks are on file with the author.
65. A survey and collection of weblinks are on file with the author.
66. See *Chiropractic Act, supra* note 21, s 4(3)(a).
67. NS Reg 130/2001, s 3(a).
68. NS Reg 130/2001, s 32.
69. See NSCC, *Board Policy: Conflict of Interest* (Halifax: NSCC, 2009), online (pdf): *NSCC* <www.chiropractors.ns.ca/> [perma.cc/8XUM-VZUS].

professional Code of Ethics (which has previously been treated as a source of misconduct findings by the College).[70] These examples show that ethics and conflicts of interest are an important concern embedded within the College's governing statutes and practices, and the decisions of its staff must be considered in light of this.

Accordingly, this section discusses the ethical implications of the College's decisions, with reference to the public health decision-making framework outlined by James Childress et al,[71] which has been described by other ethics scholars as "the state of the art in the field."[72] The framework generally looks first to the moral concerns raised in a particular situation, and then to any justificatory considerations that may apply where moral concerns appear to be infringed.[73] This section looks at the possible moral concerns and justifications relevant to the cases at hand, including any potential justificatory problems.

A central idea underpinning the Childress framework is that of public trust and accountability. According to the authors, "Public accountability requires an openness to public deliberation and imposes an obligation on decision-makers to provide honest information and justifications for their decisions."[74] Public accountability should, at a minimum, involve transparently seeking information from affected parties and disclosing relevant information publicly in order to maintain public trust.[75]

i. *Moral concerns raised*

The cases set out above raise several moral concerns outlined in the framework. The first is a privacy concern. The only manner in which members of the public could ensure their concerns are investigated would be to have their full names and contact information be automatically forwarded to all parties complained against. This would result in the disclosure of their personal information to numerous adverse parties, potentially infringing the complainants' information privacy. The second concern engaged is harm avoidance. Since the concerns in question involved potential misconduct, the cases involve a risk of misconduct going unchecked if the concerns are not acted upon by the College, potentially

70. See *Nova Scotia College of Chiropractors and Dena Churchill (Notice of Hearing)* (1 Nov 2018) (NSCC), online (pdf): *NSCC* <www.chiropractors.ns.ca/> [perma.cc/XWA8-HWKP].

71. See James E Childress et al, "Public Health Ethics: Mapping the Terrain" (2002) 30:2 JL Med & Ethics 170.

72. See Kalle Grill & Angus Dawson, "Ethical Frameworks in Public Health Decision-Making: Defending a Value-Based and Pluralist Approach" (2015) 25:4 Health Care Analysis 291 at 291, online: *Springer* <link.springer.com/article/> [perma.cc/MCY2-YLZU].

73. See Childress, *supra* note 71 at 173.

74. See *ibid* at 175.

75. See *ibid.*

resulting in public harm. The third major concern is one of distributive justice, which entails a fair distribution of benefits and burdens among affected parties. This concern may be infringed if a member of the public must commit time, resources, and personal information to bringing an already publicly visible matter forward to the College. This process may be intimidating and burdensome for complainants.

ii. *Justificatory conditions*

Having identified concerns that may be have been infringed by the decisions underlying the College investigation process, the discussion will now move to a consideration of the possible justifications for potentially infringing decisions, both in terms of the formal complaints and informal concerns involved. The justifications put forward by Childress et al, which will be discussed in turn, include considerations of a decision's effectiveness, proportionality, necessity, least infringement, transparency, and public accountability.

Effectiveness and proportionality

According to the Childress framework, decisions must be assessed for effectiveness, and "it is essential to show that infringing one or more general moral considerations will probably protect public health."[76] Additionally, the positive effects of the decision should outweigh the negative effects.

Relevance to formal complaints

The concern of harm reduction is relevant here, since the complaints revolved around an activity that was alleged to be harmful to the public by way of deception. The College's apparent action of not gathering its own evidence from the websites before informing the website owners of the investigation (resulting in the deletion of text evidence) raises questions of effectiveness. The College suggested in some of its final decisions that the complainant's evidence alone was insufficient for a full assessment of the online communications as they appeared prior to removal,[77] but the College appeared to preserve no other evidence in these cases. From the College's perspective, there may be a reasonable argument that these decisions were effective because any potentially harmful online text is no longer visible to the public, and the risk of harm that may come from a lack of determination about the original text is outweighed by the conservation of College resources that may also be needed for other public-interest activities. However, these positive effects may not outweigh the level

76. See *ibid* at 173.
77. See e.g. NSCC, *Cover Letter and Decision 4.6.62; 4.6.65* [unpublished].

of harm that could ensue if the text was indeed harmful and might be reposted due to a lack of disciplinary action or other intervention, as well as the fact that the investigation may not appear to have been thorough from the public's perspective.

Relevance to informal concerns

In terms of harm reduction concerns, it is not clear how declining to investigate without issuing reasons was beneficial to the public. This is especially true in light of the fact that some of the text the College initially declined to investigate was eventually found to be problematic by the College following a subsequent formal investigation. It could be argued that the decision not to investigate the concerns was again based on a consideration of resource efficiency. However, without reasons being issued, it is unclear how the potential costs and benefits of declining to investigate were evaluated. As a result, the effectiveness and proportionality of the decision with respect to public health appears doubtful.

Necessity and least infringement

Where a decision infringes a moral consideration, it is important to be able to show that the decision was necessary, and that there was no less-infringing alternative available.

Relevance to formal complaints

With respect to privacy and distributive justice concerns, it is unclear why a complainant's personal information would need to be forwarded to all parties complained against and why repeatedly submitting the College's complaint form against each individual practitioner would be the only acceptable format. This is especially the case given that forwarding personal contact information to defendant registrants is not required under the Nova Scotia *Chiropractic Act*, and regulatory Colleges in other provinces have accepted confidential reports that were written in various formats and did not require a complainant's contact information to be disclosed to every potential defendant.[78] This alternative would seemingly be less infringing of a complainant's personal privacy, and potentially a more efficient means of accepting reported concerns.

Relevance to informal reports

Without reasons being issued, it is unclear whether the College considered any alternatives to disregarding the informal concerns. The College noted that the *Chiropractic Act* does not enumerate any factors that must be

78. See e.g. Letter from the College of Chiropractors of British Columbia to Andrea MacGregor (30 November 2018) [unpublished].

considered when the Registrar or Investigative Committee are deciding on a discretionary basis about whether to investigate an informal report. Despite this lack of guidance, some alternative strategies may have been possible. The College of Chiropractors of British Columbia acted on informally reported concerns regarding its own registrants, ultimately giving some practitioners informal warnings about their content without carrying out a full investigation.[79] This alternative strategy would seem to strike a balance between resource constraint considerations and the need to ensure that practitioners are following professional standards. It is unclear why this, or another alternative, was not chosen.

Public accountability and transparency

Where public accountability may be employed to justify a decision, the importance of honest information and justification is heightened.[80] Transparency as an aspect of accountability is highly relevant in this situation, where a College has decided to decline first to investigate, and then to discipline, its own members.

Relevance to formal complaints

In the case of the formal complaints, the College's written decisions could arguably be considered appropriately transparent in a situation where possible harm to the public is being considered. However, the reasons did not address any potential conflicts among staff who acted on the complaints. As a result, it is unclear how conflicts were addressed and whether they were addressed effectively. In particular, it is unclear whether the complaint-processing members' advance knowledge of the complaints against themselves had any bearing on the decision to allow members to delete textual evidence before the evidence was reviewed. Without a transparent explanation for these decisions, it may appear that members were allowed to act on "inside knowledge" about the complaints by deleting evidence and avoiding potential penalties that might ensue from a later investigation.

Relevance to informal reports

In the case of the informal reports, there was no written explanation for the decision not to investigate. The College's position was that the choice to take no action did not constitute a decision at all, and so no written justification was needed. Given that the reports were informal, the choice

79. See e.g. Bethany Lindsay, "College Registrar Says 'I won't Hesitate' to File Complaints on Chiropractors' False Claims" (10 November 2018), online: *CBC* <www.cbc.ca/> [perma.cc/F4HL-YD67].

80. See Childress, *supra* note 71 at 175.

not to investigate may indeed be considered an informal choice, rather than a formal decision in the traditional sense. However, the fact that there was concern about public harm, and that a formal report would not give the College any additional relevant information, and that there were possible conflicts of interest that could later be discovered, supports a higher level of transparency. Without written reasons and the ability to appeal, the situation could give the impression that the College could reject a report without any clear rationale.

b. *Statutory interpretation concerns relating to the public interest*

In addition to the ethical concerns outlined above, these cases raise further issues regarding whether the College's decisions were carried out in accordance with the purpose of the *Chiropractic Act*. The *Act* ultimately governs all of the College's duties and activities, including those related to complaint investigation decisions, oversight decisions, recusal and evidence-handling decisions, and informal report handling decisions. This section turns to a purposive interpretation of the *Act* and a discussion of whether the College's interpretation of its duties and abilities under the *Act* were in accord with the *Act*'s ultimate purpose as it relates to the public interest.

i. *Purposive interpretation of the NS* Chiropractic Act*: The public interest and the avoidance of onflicts among governing members*

The accepted starting point for interpreting statutes is the modern approach set out by E. A. Driedger and adopted in Rizzo & Rizzo Shoes:

> Today there is only one principle or approach, namely, the words of an Act are to be read in their entire context and in their grammatical and ordinary sense harmoniously with the scheme of the Act, the object of the Act, and the intention of Parliament.[81]

The decisions of the College were based in the College's understanding of the text of the *Act*. Those same decisions, however, also appear to have led to significant conflicts within the complaint process. A purposive reading of the *Act* leads to the conclusion that the College's interpretation, one that allows for extensive conflicts within the regulator, cannot be in accordance with the *Act*'s purpose of protecting and serving the public interest.

81. *Rizzo & Rizzo Shoes Ltd (Re)*, [1998] 1 SCR 27 at para 21, 36 OR (3d) 418 [*Rizzo*].

The object of the Act

The *Chiropractic Act*, like most health professions legislation, has a written purpose that explicitly focuses on the public interest: as previously mentioned, section 4(3) of the *Act* states that the objects of the *Act* exist "[i]n order that the public interest may be served and protected."[82] Regulation of chiropractors in a manner that serves the public interest is evidently the central purpose of the *Act*, and all parts of the legislative scheme should be read with this central goal in mind.

The scheme of the Act

The public interest is not defined within the *Chiropractic Act* or *Regulations*. However, several parts of the scheme outline practices that serve to reduce the potential for conflicts of interest, which suggests that a consideration of conflicts is an important aspect of considering the public interest. The relevant aspects of the legislative scheme include the creation of multiple branches of the College which are given separate governance functions, as well as a regulation restricting chiropractors from engaging in conflicted business practices.[83] These will be discussed in more detail shortly, within the context of the *Act*'s legislative history. These aspects of the scheme illustrate that the need for conflict avoidance is written into the scheme of the *Act*, denoting that conflict avoidance is connected to the central purpose that the *Act* exists to enable: serving and protecting the public interest.

The intention of the Legislature

The Nova Scotia Legislature's concern with conflicts of interest in the regulation of chiropractic is made clear by a set of 1999 legislative amendments, the preceding debates regarding the amendments, and the most recent guidance document created by the provincial government to provide information on the process of granting new professions self-regulating status. All of these factors support an understanding that the Legislature intended for conflicts to be prevented in the College's regulatory functions.

The 1999 amendments to the *Act* and *Regulations* specifically addressed conflicts of interest within the College and among registrants. The *Act* was amended to create two bodies within the regulator: a Board, charged with functions related to regulating registrants, and a Council, charged with functions relating to the development of the profession

82. *Chiropractic Act, supra* note 21, s 4(3).
83. *Ibid*, ss 6(1), 6(2), 89, 90; NS Reg 130/2001, s 32 [NS Reg 130/2001].

itself. Essentially, the amendment served to separate roles and interests within the College that might otherwise conflict (i.e. those of professional promotion versus those of professional oversight). The amendments to the *Regulations* added a conflict of interest clause prohibiting chiropractors from having professional corporations that engaged in any conflicts of interest or unethical practices.[84] This served to ensure that chiropractors would not engage in unethical or conflicted practices through their businesses, in addition to not engaging in these practices personally.

The debates recorded in Hansard further illustrate that the Legislature's purpose in enacting the 1999 amendments was to prevent conflicts of interest within the College and among practising registrants. Members in the debates state that the *Act*'s amendments are intended to address conflicts of interest and confusion of roles within the regulator by separating the functions of professional regulation from those of professional promotion.[85] There is also an explanation that this separation is important for public confidence and for the protection of people who use regulated health services.[86] The debates additionally mention that the *Regulations* amendments are intended to address conflicts and "would ensure that practitioners are not inappropriately shielded against the liability claims of patients."[87]

Of further note is that the debates make specific reference to past advertising representations by chiropractors purporting to treat cancer with chiropractic (a claim that, like childhood conditions representations, lacks supporting scientific evidence).[88] These advertisements are described as being "morally wrong and unethical," but the debate speaker explains that "we don't see that sort of thing anymore," and that the profession has "truly come together" since the time these advertisements had been published.[89] Taken together, the statements from the debates support the idea that the Legislature intended for chiropractors to avoid conflicts of interest in their regulatory and clinical practices, and that additionally, the Legislature had a specific expectation that chiropractors would not engage in misleading advertising about health conditions.

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84. NS Reg 130/2001, *supra* note 83.
85. See Nova Scotia, Legislative Assembly, *Hansard*, 58th Leg, 2nd Sess (16 November 1999) at 2134 (Hon J Muir).
86. See Nova Scotia, Legislative Assembly, *Hansard*, 58th Leg, 2nd Sess (19 November 1999) at 2408 (Hon Dr J Smith).
87. Muir, *supra* note 85 at 2134.
88. See e.g. Cancer Research UK, "Chiropractic" (18 Jan 2019), online: <www.cancerresearchuk.org/> [perma.cc/K8TE-LAVC].
89. Nova Scotia, Legislative Assembly, *Hansard*, 58th Leg, 2nd Sess (16 November 1999) at 2140 (Hon Dr J Smith).

In addition to past amendments and debates concerning the *Chiropractic Act*, more recent actions from the provincial government indicate continued concern about conflicts of interest within health professions regulators. A 2016 department guide on self-regulation, intended for use by "staff responsible for examining proposals for new or amended legislation respecting self-regulated professions" states that "[p]ersons with personal or professional conflicts of interest should be expressly prohibited from appointment as public representatives"[90] who would sit on the Board alongside elected chiropractic professionals. This is consistent with a legislative intention that anyone carrying out duties within the College should not be in a position of conflict when carrying out those duties.

The legislative scheme of the *Chiropractic Act* does not contain a definition of a conflict of interest. In the absence of any specific definition within the governing statute, the common law conceptions described earlier in this paper would apply to the decisions of anyone working within the College and would guide a determination of whether a particular situation within the College constitutes a conflict.

ii. *The College's decisions in light of a purposive reading of the* Act: *Conflicts and potential conflicts arising from decisions*

(a) *Investigative conflicts and recusal issues*

With the exception of the Investigative Committee Chairs, it is unclear which College staff participated in investigating each complaint. However, many governing members of the College were implicated in the complaints, and the College made no mention of having enlisted outside, independent actors in the complaint-handling process. Registrants judging their own complaints would be a direct conflict of interest, one which the *Chiropractic Act* does not explicitly authorize, and which would run contrary to the Legislature's interest in conflict avoidance. If no additional parties replaced the Board or Investigative Committee members in handling the complaints, this would effectively have left staff with two possibilities. One is that the staff whose websites were complained against could each recuse themselves from any individual complaint made against their website. This would leave members to potentially investigate and judge complaints about the same subject matter as their own reported or complained-against advertising. The other option is that all of the

90. See Nova Scotia, Advisory Committee on Self-Regulation, "Self-Regulation in Nova Scotia: A Guide for Nova Scotia Government Departments" (Nova Scotia: ACSR, 2016) at 15, online (pdf): *Gov NS* <novascotia.ca/> [perma.cc/U4SD-45J9].

complained-against or reported staff could all recuse themselves from investigating every complaint that was similar or related to their own case. This would potentially leave only a small minority of peers to investigate and judge all of the complaints.

Based on the signatures visible on the complaint decisions, it appears that there were at least some individual complaint recusals. One Investigative Committee Chair was the signatory of all complaints except for the complaint against her own website.[91] Her website's complaint was instead signed by a second Investigative Committee Chair.[92] However, both of the Investigative Committee Chairs were the signatories of complaint decisions involving the same subject matter as the complaint made against one of their websites, and the reports made against both of their websites. This indicates that the Chairs did not recuse themselves from all complaints related to their own website's complaint or report. Based on this, it appears that the College, at least to some extent, chose the first recusal option, that of individual recusals, rather than the second option, that of collective recusals from all similar or related complaints.

This choice raises conflict of interest concerns, despite members apparently having recused themselves from investigating their own complaints directly. Individual recusals would result in members investigating whether statements about childhood conditions may constitute grounds for misconduct—despite the fact that their own advertising contained such statements. It could be argued that because not all of the advertising statements were identical, it may have been reasonable for members to judge one another's cases, as long as they did not judge their own advertisement. However, all of the advertising had a common theme (childhood conditions), and the text across advertisements frequently contained much of the same vocabulary and phrasing and referenced many of the same ailments. Due to the similarities shared by the advertisements, a finding of misconduct against a fellow recused practitioner would most likely have the practical effect of setting a precedent for misconduct against the practitioner reviewing the complaint. Since misconduct can have implications on one's professional reputation and ability to practice, any party potentially facing a misconduct investigation would presumably have a personal interest in the matter, particularly a financial one, as reputation and practicing status affect one's financial viability as a

91. See NSCC Complaint Decisions, *supra* note 63.
92. See NSCC, C*over Letter and Decision 4.6.75* [unpublished].

professional. Such an interest would likely give rise to a financial conflict resulting in a presumption of bias.[93]

This interest is most clearly applicable to the Chair whose website was formally complained against, and who in turn investigated other formal complaints. However, it is also a concern with respect to the Investigative Committee Chair whose website was only informally reported. If the second Chair was judging complaints similar to their own report, then the fact that the second Chair had engaged in similar practices, coupled with the potential risk of being reported again for past or future advertising, could have a reputational impact on the second Chair if they were to find that the first Chair's similar advertising constituted misconduct. In both cases, there would be a conflict grounded in the practitioners' professional interest in their advertising practices.

(b) *Oversight conflicts and lack of recusals*

In addition to the issue of conflicts affecting members in complaint-handling positions, there was also a more fundamental issue of conflicts affecting members in supervisory positions. The Board members and Board Chair were the parties who chose the members of their own Disciplinary Committees, which in turn handled the complaints. This means that even if all of the complained-against parties on the Committees had recused themselves from their investigative or adjudicative positions in all cases (including all complaints on the same subject matter as their own complaints), the Board still oversaw the process that the complaint-handlers undertook, having also personally appointed these parties to undertake the process. The Board members and Chair having an oversight position with respect to these same complaints would create an additional conflict of interest in the complaint process, by way of these parties having a pecuniary interest in their own complained-against website content. As discussed previously, this is a recognized form of administrative conflict at common law. Since there was no evidence offered by the College that the Board members affected by the complaints were not involved in their ordinary function of overseeing the process, it appears that this conflict was in play when the complaints were handled.

(c) *Evidence handling issues*

When a complaint is received by a regulatory College, it is normally forwarded to the registrant to provide an opportunity to respond before the complaint is reviewed. Registrants made responses to the College in April,

93. See Blake, *supra* note 29 at 121.

a number of weeks before the College issued its decisions in June and July.[94] In many cases, respondents removed material from their websites before the review, having been notified that the material might contravene College policy. That is, staff within the College had notified respondents about the online material before the Investigative Committee reviewed the material, apparently without anyone in the College taking any measures to retain the original material as evidence before it could be taken down. It is unclear which members of the College were responsible for these actions. However, the fact that a majority of governing members had connections to the complaints raises the possibility that the governing members' involvement in the matter influenced the decision not to secure the online material prior to review, which in turn resulted in a determination that there was insufficient evidence for a finding of professional misconduct.

Decisions to notify parties of a complaint against them, and of when and how to gather evidence within a complaint process, are administrative actions that appear to attract a significant duty of fairness, given their importance for professionals and their implications for the public. The fact that so many registrants who were affected by the complaints may potentially have been involved in these initial administrative actions raises the possibility of conflicts in these administrative decision-making processes. The particular concern in this situation is that registrants could notify other registrants about each complaint, including some of the direct evidence to be relied on (by way of the complaint forms requiring a description of all relevant information), in a situation in which many of the defendant registrants might have direct control over that evidence (by way of the ability to edit their own complained-against websites). This could have a bearing on availability of evidence to be considered, which could in turn have a significant impact on the outcome of the decision. An appearance of a conflict, or possibly an actual conflict, could have resulted from potential decision-makers in the complaint process having the ability to notify one another of the online evidence to be used against them, and then being given the time and ability to alter or destroy that evidence before it was reviewed.

(d) *Initial decline to forward concerns for investigation or to give reasons*

In the case of the informal reports, only one governing member of the College (the Registrar) had a formal ability to make a decision about whether to pursue the reports as complaints (one which would seem to

94. See NSCC Decisions, *supra* note 63.

attract a high standard of procedural fairness). The Registrar was not named or otherwise connected to any of the informal reports and did not have any apparent connection to the matters involved. To this extent, there was no apparent dual role-based conflict of interest, as the Registrar would have only been in an administrative role, and not a defendant role, if the reports were pursued as complaints.

However, an indirect conflict could have arisen from the Registrar's own administrative position relative to those of direct peers who were named in the reports. The Registrar, like other registrant Board members, is elected by a body of peers and may potentially serve for several terms at a time. If the Registrar (or any elected Board member) has an interest in maintaining their position (for example, for reasons related to professional reputation), this would potentially conflict with a decision to take regulatory action against other members of the Board, or against a large number of non-governing registrants of the College. Given that approximately 40% of province's practitioners were named in the informal reports, a decision to take action on the reports could significantly undermine the probability of later re-election (and perhaps cause more general reputational damage in the eyes of one's peers). This would constitute a personal interest, and potentially a financial one, as reputational stakes can impact one's career. Both of these interests would also form the basis of an administrative conflict as described earlier.

In addition to this, one party who was named in the informal reports was the current President of the College, and another party was a past President. Although the President is not part of the Board, the position of President is a highly senior position within the College. Seniority has been recognized as a source of bias where it may influence the regulatory decisions of peers within a self-regulating body, specifically where a senior professional has a known interest in the outcome of a regulatory decision. In a Manitoba Queen's Bench case that resulted in this determination, bias was found by way of interested senior professionals who were part of the formal decision-making process, as well as by way of an interested senior professional who was not part of the decision-making committee but who later served as a complainant.[95] The role of the College President as a potential defendant to one of the informal reports may be analogous to the role of the senior official who acted as a complainant: in both situations, a named senior professional's potential interest in the case may put pressure or influence on a peer who is charged with making an independent decision about the case. This issue raises a potential concern about an appearance

95. See *Fong v Winnipeg Regional Health Authority*, 2004 MBQB 182 at para 17.

of biasing the Registrar, a party to whom the President may be considered senior in a professional context, despite the President serving in a separate branch of the College.

3. *Conclusions on conflicts of interest in self-regulation complaint processes*

The overlapping roles and interests that were at play in the College's complaint investigation decisions appear to have involved potential perceived or real conflicts involving the members who handled the advertising concerns. Given that conflicts of interest are a potential threat to the public interest—one that the Legislature appears to have been concerned with avoiding—the College's decisions to allow for potential conflicts are unlikely to accord with the purpose of the legislation.

In addition to the Legislature's concern with conflict avoidance, there is a further reason why the Legislature could not have realistically intended for the College to interpret its powers in a way that would allow for conflicts to occur: such an interpretation would undermine the College's own mandate. In health professions conflicts, one of the interests at the root of the conflict is the public interest, and the public interest is an express part of the statutory mandate of the regulator. Because of this, a conflicting interest that undermines the public interest would effectively frustrate the College's ability to carry out its statutory mandate. It is a recognized principle of procedural fairness that an administrative decision-maker "may not thwart the intention of the stature by failing to carry out the statutory mandate."[96] Interpreting the *Chiropractic Act*'s legislative scheme in a way that allows for the purpose of serving the public interest to be thwarted by conflicted interests would be an absurd result: if this approach were correct, then the legislation would allow for its own purpose to be defeated. The presumption against absurdity in accepted statutory interpretation would lead to the conclusion that the legislature could not have intended that the College should read its power in this way.[97]

There are several alternative actions the College could have taken to address the advertising concerns in a way that would be more in line with its statutory purpose and its need to prevent and mitigate conflicts of interest. These options include requesting the assistance of an independent investigator, disclosing the possibility of conflicts among members in

96. See Blake, *supra* note 29 at 111, citing *Greenisle Environmental Inc v Prince Edward Island*, [2005] 248 Nfld & PEIR 39, 2005 PESCTD 33 at para 42.

97. See e.g. Ruth Sullivan, *Driedger on the Construction of Statutes*, 3rd ed (Toronto: Butterworths, 1994) at 88 (discussing the presumption against absurdity); see also *Rizzo, supra* note 81 at para 27 (endorsing Sullivan's view on the presumption against absurdity).

advance of the advertising concerns being handled, and having any reported or complained-against College members step down from their complaint-handling or oversight positions (whether temporarily or permanently).[98] The College of Chiropractors of British Columbia did all of these things when one of their Board and complaint inquiry members faced concerns over anti-vaccine content that he had posted online in 2018. The College's response was to allow the member to resign from his College positions. The College then sought an independent investigator to look into the concerns, rather than having College members handle the concerns directly.[99] This kind of response can allow a regulator to exercise its mandate, including its complaint and discipline functions, while distancing defendant members from having control over or involvement in the complaint process in a way that might create a conflict of interest.

While the alternative courses of action available to the College may appear straightforward (in that another regulator was able to act on them in a recent case), the current lack of external guidance available to College members who may face conflicts of interest, combined with the number of overlapping roles and obligations among members, may make for an uphill battle for College members who may wish to organize alternative courses of action when potential conflicts arise. It should be acknowledged that in many cases, a governing member of a College who faces a conflict may be in a very difficult situation because of their position relative to other College members.

An Investigative Committee Chair, for example, may understandably be reluctant to thoroughly investigate a Board Chair, given that the Board Chair is responsible for appointing and removing Committee Chairs.[100] A Board member may be reluctant to take disciplinary action against a senior College member, such as a president, or against peer Board members, particularly if this would require a minority of Board members to take action against a majority of their peers. Any governing member may be wary of taking action on complaints that might implicate a large percentage of a province's registrants, as this could undermine a governing member's chances of re-election to the College. Permitting dual roles of practice and governance can put many actors in these challenging and conflicted positions, perhaps suddenly and unexpectedly. Without external guidance on how to handle these potential conflicts, this

98. *Chiropractic Act, supra* note 21, s 42 (power to employ assistance in investigating any disciplinary matter).
99. See Lindsay Health Claims, *supra* note 4.
100. See *Board Regulations, supra* note 22, ss 7.1, 7.5.

situation may discourage investigatory and disciplinary actions, by pitting both professional interests and institutional hierarchy against the need to regulate professional conduct. If the possibility of seeing disciplinary action taken against registrants in favour of the public interest may also raise the possibility of damage to one's professional, social, or institutional position, actors within the College will have less of a realistic chance of working in the public interest.

The fact that College members may face challenging circumstances in addressing administrative conflicts of interest does not absolve the College of responsibility in properly carrying out its mandate. However, given the extent and potential prevalence and repeat nature of administrative conflicts within the regulator, further intervention from the Legislature in the form of more specific guidance could help to clarify to members that conflicts should be avoided, and also to outline which procedures College members should undertake to reduce conflicts. This clarification could take the form of specific guidance for regulators that may face conflict issues. More fundamentally, clarification could be supported by way of reforms to the legislation itself.

Part III

Health professions governance has been undergoing substantial change in many jurisdictions within the last several decades, with increasing layers of independent oversight being added into regulatory schemes. This section surveys recent and proposed regulatory reforms within health professions regulators, both outside and within Canada, and evaluates the extent to which these reforms may address conflicts of interest within health professions regulators.

1. *International examples of reforms to health professions regulation*

a. *UK: Repeal of self-regulation, replacement with professional regulation*

The reforms undertaken in the United Kingdom with respect to the medical profession are probably the most radical reforms discussed in this section. The reform process began in the early 2000s, when a physician who was allowed to keep practising in the face of professional complaints went on to be found responsible for killing more than 200 patients. A national scandal ensued, with heavy public criticism that the medical profession's regulator, the General Medical Council (GMC), had been overly self-interested and protective of practitioner interests in its operations. Following this, the GMC was significantly reformed. Two of the biggest changes to the GMC itself were altering the council's membership to 50% lay membership,

rather than a professional majority, and having government-appointments of professional members, rather than peer-based elections.[101] Additionally, a new independent body was created to oversee the GMC and other health professions regulators. This new body, the Professional Standards Authority for Health and Social Care (originally called the Council for the Regulation of Healthcare Professionals),[102] has several main functions: reviewing regulators' final disciplinary decisions, conducting performance reviews of regulators, and reviewing council appointment processes.[103] This system of oversight functions has effectively changed the UK model from a self-regulation model to a model of professional regulation by an external body.

Although the initial reforms have now been in place for more than 15 years, there is limited research evaluating their full effects. Allegations of the GMC catering to the interests of practitioners appear to have waned (potentially indicating a positive change), but some research has found potential negative effects of the new GMC reforms on practitioners themselves. In particular, there are claims that the GMC may now be overly punitive toward doctors.[104] However, there are some indications that overall public trust in UK health professions and professional regulation is favourable,[105] and the reforms do not appear to have had a negative impact on the regulatory system's performance. The strategies of moving certain regulatory functions to an independent body, increasing lay membership in regulatory bodies, and making professional membership for regulators appointment-based, appear to be promising structural changes in terms of their potential for building the public interest into the regulatory system to a greater degree. These strategies may be particularly relevant in Canada because these ideas already have support from some Canadian health professionals, as will be discussed shortly.

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101. See General Medical Council, "Our History," online: *GMC* <www.gmc-uk.org/> [https://perma.cc/YL23-KJM3].

102. See Patrick Butler, "National Body to Oversee Healthcare Professionals" (9 August 2001), online: *The Guardian* <www.theguardian.com/> [perma.cc/8PMF-BYZT].

103. See United Kingdom Professional Standards Authority, *Our Work with Regulators,* online: <www.professionalstandards.org.uk/> [perma.cc/T7WF-M6MS].

104. See United Kingdom, Civitas Doctor's Policy Research Group, *The General Medical Council: Fit to Practise?* (London: Civitas, 2014) (Hilarie Williams, Christoph Lees & Magnus Boyd), online (pdf): *Civitas* <www.civitas.org.uk/> [perma.cc/WT93-QFY6].

105. See UK, Nursing and Midwifery Council, *Building Trust and Confidence: What our Audiences Say about the Key to Better, Safer Care* (London: NMC, 2019) at 4, online (pdf): <www.nmc.org.uk/> [https://perma.cc/83FT-NV9F]; General Medical Council, *Promoting and Maintaining Public Confidence in the Medical Profession: Full Research Report* (GMC, 2019) at 19, online (pdf): <www.gmc-uk.org/> [https://perma.cc/3C9X-VJ6T].

b. *Australia: Setting specific standards using a separate authority*

Australia's approach to regulatory standard-setting is notable for its specificity. Australian health professions are regulated nationally, and in 2010, the National Registration and Accreditation Scheme came into force, effectively standardizing the manner in which health professions are regulated. The Australian Health Practitioner Regulation Agency (AHPRA) was charged with working alongside each individual professional regulator (called a Board) to implement the standardized legislation. Importantly, AHPRA is independent from the regulators, and it has issued its own guidelines that the regulators are expected to follow. In some cases, the guidelines are highly specific, as in the case of AHPRA's acceptable evidence guideline.[106]

These guidelines are notable for their relative objectivity, as no single profession has control over their creation. This may potentially prevent professionals from crafting standards in their own interest. The guidelines are also highly specific and contain numerous concrete examples for acceptable and unacceptable conduct, which may help to prevent regulators from making arbitrary or self-interested decisions in cases where the guidelines would apply. The existence of independently created guidelines is not a be-all, end-all improvement to regulation, however. For example, although the acceptable evidence guideline targets the accuracy of advertising claims, research has found that inaccurate advertising is still common in Australia, and there have been calls for further reforms to the enforcement aspects of Australia's regulatory framework to improve compliance.[107]

Despite these limitations, independently created guidelines for regulators can potentially be a useful tool in other jurisdictions, including Canada. To better ensure compliance, guidelines could be clearly labelled as formal standards (that is, labelling them as standards to denote that they are mandatory, rather than guidelines which may be treated as permissive). At least one Canadian regulator appears to agree with the approach of independently-created standards: the College of Chiropractors of British Columbia has directly adopted the AHPRA evidence guideline.[108] Given that professions are regulated provincially and not nationally in Canada,

106. See Australian Health Practitioner Regulation Agency, *Factors for Assessing if Evidence is Acceptable* (10 August 2019), online: *AHRPA* <www.ahpra.gov.au/> [perma.cc/56TQ-T3V2].

107. See Ian Freckleton, "Misplaced Hope: Misleading Health Service Practitioner Representations and Consumer Protection" (2012) 20:1 J L & Med 7 at 7, online: *ProQuest* <search.proquest.com/> [perma.cc/MP4L-2WM7].

108. CCBC, "College of Chiropractors of British Columbia Professional Conduct Handbook" (30 November 2017) at 50, online (pdf): *CCBC* <www.chirobc.com/> [perma.cc/J6R3-KAZ2].

provincial arms-length regulatory bodies could be created to help set fair and specific professional standards for regulators to follow.

2. *Canada: Themes from current and proposed reforms*

a. *Increased independent oversight of regulators*

i. *Creation of a separate oversight body, changes to scope of powers*

Perhaps the most major recent proposals for regulatory reform in Canada are those that came out of British Columbia in late 2018. Following a great deal of public concern over the practices of the College of Dental Surgeons of British Columbia, which largely revolved around allegations of professional self-interest similar to those seen in the UK,[109] the provincial government commissioned an inquiry led by UK-based regulation expert Harry Cayton. The final report from the inquiry, called the "Cayton Report," contained sweeping recommendations for a new regulatory structure for health professionals. A primary recommendation was for the province to create an independent oversight body above all health professions, and to transfer certain functions from the Colleges to that independent body. The body would have similar functions to the UK's independent regulator, taking on the tasks of disciplinary decision reviews, appointment oversight, College performance reviews, and investigations. However, the responsibilities of professional standards creation, licensing, and complaint investigation would remain with the Colleges.[110] Health professionals, research experts, and members of the public have expressed support for more independent oversight in the form of a separate governing body, with the rationale being that the body could serve as a check against potential professional self-interest and reduce conflicts within health regulators.[111]

ii. *Separation of bodies and functions*

The Cayton Report noted that "Separation of investigation from adjudication is a common principle of law which currently does not apply under the [current *Health Professions Act* of British Columbia]."[112] This

109. See Bethany Lindsay, "How BC's System for Regulating Health-care Workers is Failing Patients" (13 April 2019), online: *CBC* <www.cbc.ca/> [perma.cc/DNN5-RN53].

110. See Canada, The Professional Standards Authority for Health and Social Care, *An Inquiry into the Performance of the College of Dental Surgeons of British Columbia and the Health Professions Act* (London, UK: Professional Standards Authority, 2018) (Harry Cayton) at 91, online (pdf): *Government of British Columbia* <www2.gov.bc.ca/> [perma.cc/3Z5S-D36P].

111. See e.g. Paul Bendetti & Wayne MacPhail, "Calls Grow for Outside Regulation of Chiropractors" *Globe and Mail* (30 December 2018), online: <www.theglobeandmail.com/> [perma.cc/3N47-ZANG].

112. See Cayton, *supra* note 110 at 87.

lack of separation was viewed as a factor in the creation of regulatory conflicts of interest. In his proposal to create an independent and separate professional oversight body, Cayton recommended that a new body should be responsible for complaint inquiries and disciplinary functions, as this would "create a proper independence from the licencing and investigatory functions of the colleges and remove conflicts of interest from the membership of the committees and panels."[113]

This step of separation between the investigation stage (largely conducted by the College) and the adjudication stage (conducted by a separate adjudication body) would make it impossible for the same party to have any immediate influence over both the investigation and adjudication of a complaint against them. One problem that may remain in such a system is defendants potentially influencing their own complaint investigations, if the power to investigate still remains with actively practising members of Colleges. However, moving both investigative and adjudicative functions to the new body would replicate the problem of a lack of separation. As a result, leaving the investigative power with the College may be justified based on this procedural concern, while still allowing for the benefit of adjudication through a more independent body.

iii. *Changing accountability structures*

Current structures of support and accountability in self-regulating bodies can create problematic incentives for members. In his study of self-regulating bodies' current roles, Robert Mysicka notes that "self-regulators derive a sizable portion of their support from current members and can be driven more by the immediate interests of such members instead of the broader interests of the public."[114] This support may be in part collegial, but it is also structural, in the form of member elections, a process in which all professionals can participate as voters.

Many professionals themselves are concerned about regulatory conflicts of interest and support the idea of a change away from peer-based selection of governing members. For example, a 2018 survey conducted by the College of Chiropractors of Ontario found that a majority of the College's own surveyed members felt that the College's provisions did not address conflict of interest concerns sufficiently to allow the College to regulate in the public interest.[115] A separate 2018 regulatory conference

113. *Ibid* at 86-87.

114. Robert Mysicka, "Who Watches the Watchmen? The Role of the Self-Regulator" (Toronto: CD Howe Institute, 2014) (CD Howe Institute Commentary 416) at 3, online: *SSRN* <papers.ssrn.com/> [https://perma.cc/JBL8-EENE].

115. See College of Chiropractors of Ontario, "Conflict of Interest Considerations and Request for

survey found that 92% of surveyed attendees supported merit-based selection of regulators, instead of election-based selection.[116] The College of Nurses of Ontario is taking direct action on this issue, with plans to change its governance structure to an appointment-based membership system that is focused around competencies, rather than peer-based elections.[117] An appointment-based structure for professional members would help to remove pressure from regulators to act in favour of their peers' interests when professional and public interests conflict, as there would not be a risk of peer reprisal by way of removal from one's regulatory post.

In addition to considering professional membership in regulatory governance, public membership is also an important aspect of a regulator's functions. Currently, many Canadian regulators require only a small minority of decision-makers to be non-professionals. Although there is a reasonable rationale that professional regulators are needed to evaluate complaints from an expert perspective, public members can bring an added degree of independence to the process. If too few investigators or adjudicators are non-professionals, their views can potentially be crowded out by a professional majority. As noted above, the UK's reforms involved increasing lay representation on the GMC to 50% of the membership. In Canada, some regulators are now taking similar steps. The College of Dental Surgeons of British Columbia has increased its Board's public membership through appointments by the province's Minister of Health, and the College of Nurses of Ontario in Canada now intends to do the same with its own governance Board.[118] This suggests that the use of more lay membership in governance to bolster independent decision-making holds at least some support and potential within Canada.

b. *Collaborative regulation*

Many professional activities can fall within the purview of multiple regulators. Practitioners who operate multidisciplinary clinics or engage in shared marketing, for example, may be responsible for adhering to clinic and marketing standards overseen by multiple regulatory Colleges, as well as competition law standards overseen by the Competition Bureau. This means that when issues arise from professional activities, there are

Feedback" (29 October 2018) at 291, online (Council Public Package): *CCO* <www.cco.on.ca/>.

116. See Julie Maciura, "92%" (October 2018), online (newsletter): *SML Law* <www.sml-law.com/> [perma.cc/6C4S-39YD].

117. See College of Nurses of Ontario, "Governance Vision 2020," online: *CNO* <www.cno.org/> [perma.cc/ZRE5-JC5Y].

118. *Ibid*; British Columbia Ministry of Health, News Release, "Board Appointments Help Dental College Put Public First" (8 March 2018), online: *Gov BC* <news.gov.bc.ca/> [perma.cc/6DSS-AM9Y].

sometimes multiple regulators that may take action, whether separately or in collaboration with one another. Encouraging input from multiple regulators, where possible, may reduce the likelihood of self-regulating bodies encountering conflicts of interest in their activities.

Collaboration could occur between regulatory Colleges and independent bodies like the Competition Bureau or other consumer protection bodies. Given that many of the same professional activities might fall within the oversight of self-regulators and the Competition Bureau, Mysicka proposes that "Canadian governments can further enhance oversight by consulting with the Competition Bureau and consumer advocacy groups when administering or surveying self-regulatory powers."[119] Increased input from bodies like the Bureau may help to put greater emphasis on consumer protection, rather than professional interests, when governments are reviewing self-regulatory powers or when self-regulatory bodies are creating their own policies or reviewing enforcement practices.[120]

Collaboration could also occur between different health professions' regulatory Colleges. Two provinces, Nova Scotia and Ontario, have already created legislation to support collaborative regulation among health professions, and in general there has been an increased interest in collaborative health professions regulation in Canada.[121] Current legislation in Nova Scotia allows for several actions that may help to avoid conflicts in complaint processes, such as the ability for different health professions to investigate on one another's behalf, and the ability for professions to assign investigative tasks to appointed investigative professionals (rather than the elected professionals of a College).[122] Professional Colleges can also develop collaborative policies, tools and resources, and communicate with government and other bodies regarding improvements to regulation,[123] which could help with developing policies and practices that prevent investigative or disciplinary conflicts.

Nova Scotia's legislation is permissive in nature; professions are not required to collaborate but may do so voluntarily.[124] While this legislation may work well for enabling professional autonomy and initiatives, it may be justifiable to treat the prevention of conflicts as an exceptional situation

119. Mysicka, *supra* note 114 at 4.
120. *Ibid* at 20-21.
121. See William Lahey & Katherine Fierlbeck, "Legislating Collaborative Self-regulation in Canada: A Comparative Policy Analysis" (2016) 30:2 J Interprof Care 211.
122. *Regulated Health Professions Network Act*, SNS 2012, c 48, ss 19(5)(a), (e).
123. *Ibid*, ss 16(3)(b), (f).
124. See Lahey & Fierlbeck, *supra* note 121.

in which collaboration should be made mandatory by government, as the public interest arguably outweighs an interest in professional autonomy. For similar reasons, other Canadian jurisdictions without collaborative legislation could benefit from creating rules that would require health professions to collaborate in ways that help to reduce regulatory conflicts of interest.

3. *Conclusion on proposals for reform*

Taken together, the proposals and reforms made to health professions self-regulators within and outside Canada would represent a significant overhaul of the current system. Changes like creating independent oversight and rule-making bodies, increasing the separation of regulatory functions, altering College membership composition, and using new processes for determining who can govern a College all represent a different way of approaching almost every facet of the current system. Some of these changes, like changing governance composition, may be simpler to effect than other changes, like creating entirely new bodies. Each change has its own set of potential limitations, and little is known about whether one approach may be the most effective.

However, most of the outlined proposals have been implemented somewhere, and most have been endorsed by at least some regulators or their professional members within Canada, without any indication of the changes being a misstep. More fundamentally, any one of these changes would decrease the propensity for governing members of Colleges to be in conflicted positions that may lead to decisions that are harmful to the public. The more duties, roles, and expectations a professional carries within the same system, the more likely it is that some of these interests will conflict. Any change that decreases the number of overlapping regulatory and professional roles and expectations for health professionals can help to solve this problem. Regulatory reform for Canadian health professions is already receiving attention for a variety of reasons, in the hope of addressing a variety of concerns related to public health, safety, and trust. Conflicts of interest within self-regulating governance structures should be included on the list of important considerations that can be readily targeted by reform.