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Expanding Scope of Practice for Ontario Regulated Health Professionals during COVID-19

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Abstract

On 21 April 2021, the Ontario government issued a new order under the *Emergency Management and Civil Protection Act, 1990* that authorized regulated health professionals to practice beyond their regular scope of practice when working in hospital settings and providing pandemic-related care. This order required that professionals use their best judgement in practice and work within hospital-assigned duties and privileges. It also allowed health professionals licensed in other provinces or territories to practise without an Ontario licence. The goal of this temporary scope of practice expansion and suspension of licensure requirements was to expand health workforce capacity to care for COVID-19 patients. In place for just over a year, this pandemic workforce policy reform was instituted without warning to the health profession regulators in the province and raised questions about how concerns around competence to practise in these expanded roles would be resolved. While there is no clear evaluation plan for this temporary pandemic policy, restrictions and expansions to health professional scope of practice will continue to have broader implications given the worsening workforce crisis.

Le 21 avril 2021, le gouvernement de l'Ontario a émis une nouvelle ordonnance en vertu de la Loi de 1990 sur la protection civile et la gestion des situations d'urgence, qui autorise les professionnels de santé réglementés à exercer au-delà de leur champ d'exercice habituel lorsqu'ils travaillent en milieu hospitalier et fournissent des soins liés à une pandémie. Cette ordonnance exigeait que les professionnels fassent preuve de leur meilleur jugement dans leur pratique et qu'ils travaillent dans le cadre des fonctions et des privilèges assignés par l'hôpital. Elle permettait également aux professionnels de la santé titulaires d'un permis dans d'autres provinces ou territoires d'exercer sans permis de l'Ontario. L'objectif de cette ordonnance temporaire était d'accroître la capacité du personnel de santé à prendre en charge les patients atteints du syndrome COVID-19. En place depuis un peu plus d'un an, cette réforme de la politique a été instituée sans avoir averti au préalable les instances de régulation des professions de santé de la province et a soulevé des questions quant à la façon dont les préoccupations concernant la compétence à exercer dans ces rôles élargis seraient résolues. Bien qu'il n'y ait pas de plan d'évaluation clair pour cette politique temporaire, les restrictions et élargissements du champ d'exercice des professionnels de la santé continueront à avoir des implications plus larges étant donné l'aggravation de la crise des effectifs.

Key Messages

- On 21 April 2021, the Ontario Ministry of Health and Long-Term Care issued Ontario Regulation 305/21 under the *Emergency Management and Civil Protection Act, 1990* to respond to the COVID-19 pandemic.
- This order authorized regulated health professionals to practise beyond their regular scope of practice when working in hospital settings and did not require health professionals licensed in other Canadian jurisdictions who were engaged by Ontario hospitals to register with any Ontario regulatory body.
- This order was instituted without warning to health profession regulators in the province and raised questions about how concerns around competence to practice in these roles would be resolved.
- This order, meant to address hospital staff shortages and service capacity by enhancing the flexibility of the health workforce, devolved much responsibility to practitioners to make decisions about scope and competence in stressful work environments, thus raising liability concerns.
- Health workforce shortages have reached crisis levels in Ontario and may justify rethinking historical notions around restricted scopes of practice.

Messages-clés

- *Le 21 avril 2021, le ministère de la santé et des soins de longue durée de l'Ontario a publié le règlement de l'Ontario 305/21 en vertu de la Loi de 1990 sur la gestion des situations d'urgence et la protection civile afin de répondre à la pandémie de COVID-19.*
- *Cette ordonnance a autorisé les professionnels de santé réglementés à exercer au-delà de leur champ d'activité habituel lorsqu'ils travaillent en milieu hospitalier et n'a pas exigé des professionnels de santé agréés dans d'autres juridictions canadiennes qui ont été engagés par des hôpitaux de l'Ontario qu'ils s'inscrivent auprès d'un organisme de réglementation de l'Ontario.*
- *Cette ordonnance a été instituée sans avoir averti au préalable les instances de régulation des professions de santé de la province et a soulevé des questions sur la manière dont les préoccupations relatives à la compétence pour exercer dans ces rôles seraient résolues.*

- *Cette ordonnance, censée remédier à la pénurie de personnel hospitalier et à la capacité des services en améliorant la flexibilité de la main d'œuvre sanitaire, a transféré une grande partie des responsabilités aux praticiens, qui doivent prendre des décisions sur le champ d'application et la compétence dans des environnements de travail stressants, ce qui soulève des problèmes de responsabilité.*
- *Les pénuries de personnel de santé ont atteint des niveaux de crise en Ontario et peuvent justifier une remise en question des notions historiques concernant les champs d'application restreints de la pratique.*

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1 BRIEF DESCRIPTION OF THE HEALTH POLICY REFORM

On 21 April 2021, the Ontario Ministry of Health and Long-Term Care (MOHLTC) issued Ontario Regulation 305/21 under the *Emergency Management and Civil Protection Act, 1990 (EMCPA)* as part of the COVID-19 pandemic response. This order authorized regulated health professionals to practise beyond their regular scope of practice when working in hospital settings as part of hospital responses to COVID-19. Additionally, health professionals licensed in other Canadian jurisdictions who were engaged by Ontario hospitals did not have to register with any Ontario regulatory body (Government of Ontario 2021). This order applied notwithstanding any statute (e.g., any health profession act); regulation, order, or policy; collective agreement; and regulatory instrument (i.e., practice standard, guideline) made by a regulatory college (Government of Ontario 2021).

This scope of practice expansion and relaxation of licensure requirements was temporarily authorized specifically "to respond to, prevent or alleviate" the effects of COVID-19 (Government of Ontario 2021). The goal of the emergency order was to facilitate the redeployment of health care workers, ensuring adequate staffing and access to services in hospitals, specifically to address the urgent and unprecedented surge capacity requirements. In the first year of the pandemic, the Ontario government passed several individual orders altering the scopes of practice of particular professionals doing particular tasks (Canadian Institute for Health Information 2022a). Ontario Regulation 305/21 was different as it permitted regulated health professionals to practise beyond their professional scope by their own authority (as opposed to under delegation) as long as the services provided were consistent with the duties that had been assigned or the privileges that had been granted by the hospital (College of Medical Radiation and Imaging Technologists of Ontario 2021; College of Midwives of Ontario 2021; College of Naturopaths of Ontario 2021). Communications to practitioners from regulators at the time of this order noted that registrants were still required to use their best professional judgement to provide services and treatments for which they had the requisite skills and knowledge (College of Medical Radiation and Imaging Technologists of Ontario 2021; College of Naturopaths of Ontario 2021; College of Nurses of Ontario 2021a).

This pandemic policy and health workforce reform was instituted by the government without consultation with health professions regulators in the province (College of Midwives of Ontario 2021; College of Naturopaths of Ontario 2021; College of Nurses of Ontario 2021a). At the time of enactment, the implications of the order were unclear; for example, it was uncertain how to determine which practitioners were competent to perform which tasks or how practitioner competence would be ensured (Ontario Council of Hospital Unions 2021a). There were risks to practitioners, as the order made clear that members of regulatory colleges would continue to be liable to the regulator where they were registered for any incompetence that occurred while providing services (Government of Ontario

2021). While health workers remained liable to regulators in their home province, it was uncertain who (e.g., Ontario regulator, hospital/employer) was responsible for determining practitioner incompetence, as well as how or if complaints for practice conduct occurring in Ontario would be handled in other provinces. Ontario Regulation 305/21 was in place for just over one year and was revoked on 27 April 2022.

2 HISTORY AND CONTEXT

In legislation and professional policy statements, scopes of practice refer to roles, functions, tasks, and competencies (Baranek 2005) that are authorized to be performed within specific occupations (Bae and Timmons 2022). Professionals may lack the experience and training to practice competently outside their legislated scope of practice. While health professions tend to describe their scope of practice as broadly as possible (Visocan and Switt 2006) and broader scopes of practice may afford more clinical independence, concerns about the breadth and maintenance of professional competencies have been raised by the medical community (Baker et al. 2010). For example, individual practitioners may not have sufficient knowledge and skills to perform all aspects of their profession's scope of practice (McCauley and Hager 2009). Tension arises between the need for clarity and precision regarding scope of practice, and the need for flexibility to account for jurisdictionally specific realities and potential health system stresses such as a pandemic.

In 2014, a Canadian Academy of Health Sciences expert panel convened to examine collaborative care models and optimal scopes of practice for health care providers (Nelson et al. 2014). A fundamental problem with health service delivery models, they determined, was the organization of health professional scopes of practice and models of care based on political considerations and tradition. Changing legal and regulatory frameworks from siloed to a more collaborative, patient-centric health system to better meet population health needs was among their recommended reforms (Nelson et al. 2014). Most recently, a report of the House of Commons Standing Committee on Health articulated a need for flexible scopes of practice and recommended optimizing primary care professionals' scope of practice (Canada, Parliament, House of Commons 2023). The report also suggested that jurisdictional variations in scope of practice between provinces and territories can result in care access inequities depending on the composition and skill mix of providers, especially if they are the sole point of care for patients. Furthermore, the report argues that national scopes of practice might permit providers to practise to the full extent of their expertise, which would be especially valuable in traditionally underserviced areas (Canada, Parliament, House of Commons 2023).

Scarce resources (e.g., human, infrastructural, technological) curtail the health care system's ability to meet patient needs and deliver quality care. Responding to increasingly constrained resources in Canadian health care, the Commission on the Future of Health Care of Canada (Romanow 2002), the Standing Senate Committee on Social Affairs, Science and

Technology (Kirby and LeBreton 2002), and the MOHLTC (2010) all suggested that health professional scopes of practice, as defined by legislation and regulation, be reviewed and expanded to increase access to services. Scopes of practice have important health workforce implications, and altering professional scopes of practice has also been recently discussed in Nova Scotia (Government of Nova Scotia 2023) and Québec (Conseil interprofessional du Québec 2022).

Over the last century, Ontario health professional scopes of practice have been detailed in legislation, with strict regulations about which professionals can do which tasks. Several Canadian provinces adopted umbrella legislation, a common legislative framework for regulated health professions within the jurisdiction (Lahey, Currie, and Lafferty 2014). These frameworks were designed to specify overlapping professional scopes of practice to enhance health workforce flexibility, beginning in the 1990s (Health Profession Regulators of Ontario 2022; O'Reilly 2000); that is, different practitioner groups may have the same tasks in their scope of practice. Ontario's *Regulated Health Professions Act, 1991 (RHPA)* was one of the first of these regulatory models in Canada. It currently governs twenty-nine health professions and twenty-six professional colleges (Health Profession Regulators of Ontario 2022; Government of Ontario 1991).

The controlled act model in Ontario's *RHPA* establishes performance standards for individual professions, protects the activities that comprise the scope of practice of the twenty-nine professions, and regulates fourteen controlled activities considered to be potentially harmful if performed by unqualified persons. No regulated profession has access to all fourteen controlled acts (Government of Ontario 1991). Gaps may exist between the clinical abilities of health professionals acquired through education and training, and the legal authority granted to perform specific tasks (White et al. 2008). These gaps may exacerbate health workforce shortages by reducing health resource efficiency and cost-effectiveness (Gatrell and Elliott 2009).

While Ontario's framework was innovative in the early 1990s in establishing overlapping scopes of practice, the more recent trend in regions like Australia and the United Kingdom has been to remove scopes from legislation (Leslie et al. 2021a). When the COVID-19 pandemic hit, these countries appear to have had more flexibility to respond to the crisis (Adams and Wannamaker 2022). In contrast, provincial governments and public health authorities in Canada scrambled to issue a number of temporary orders to expand specific professions' ability to perform specific tasks, through what appeared to be a cumbersome process (Canadian Institute for Health Information 2022a; Adams and Wannamaker 2022). Early in the pandemic, British Columbia considered temporarily suspending all health care professional scopes of practice and suspending liability for those professionals who may have struggled to fulfill expanded roles (Adams and Wannamaker 2022); however, this initiative never came to pass. Internationally, health profession regulators incorporated scope of practice expansions as well as continuing competency and other educational offerings to support capacity building, task and scope of practice shifts beyond practice limits as a pandemic response strategy (Stralen et al. 2022) to address pressing skills demands (Coates et al.

2021). The expansion of scopes of practice during the pandemic was positive in expanding workforce flexibility and providing opportunities for expanded practice to health care practitioners. At the same time, there were risks for practitioners who were informed they would be responsible for any errors or mistakes in practice, even when directed to work beyond their scope by their employers (Adams and Wannamaker 2022). Indeed, practitioners were made responsible for refusing such work. Scope of practice guidance, for which they received differing levels of support from regulators (Professional Standards Authority for Health and Social Care 2021), emphasized exercising their professional judgement (General Pharmacy Council 2020; National Health Service England 2020) to determine what fell within their professional scope in pandemic conditions (Health and Care Professions Council 2021).

This order expanding scopes of practice for Ontario regulated health professionals, the implications of which are the focus of this analysis, also applied to out-of-province practitioners, who, as part of this order, were not required to register with the relevant Ontario regulator. Suspended registration requirements are part of a broader occupational licensure discussion. While this latter component of the order is beyond the scope of this analysis, we would be remiss if we did not briefly mention it here, as it was part of this order and had the same policy goal. Moreover, labour mobility continues to be raised in recent national conversations to address health system and resource needs (Wright 2023; Picard 2023).

Occupational licensing reforms (e.g., licensure compacts, national licensure) to promote mobility and cross-jurisdictional licensure for health professionals have been discussed in Canada in the context of the pandemic (Sweatman, McDonald, and Grewal 2022; Canadian Medical Association 2022), presumably because the labour mobility provisions within the *Canadian Free Trade Agreement, 2017 (CFTA)* did not address provincially specific registration requirements which slowed down the process of deploying health human resources during this public health crisis. Moving towards pan-Canadian registration would lay the groundwork for greater responsiveness to the *CFTA* (Leslie et al. 2022). The COVID-19 pandemic challenged Canadian health systems and hospitals to balance treating patients presenting to them with COVID-19 and other health issues, and in doing so, make difficult decisions about medical necessity (i.e., care that could or could not be delayed). Between March 2020 and June 2021 roughly 560,000 fewer surgeries were performed, 11% fewer in-patients were admitted, and an average increase of 3,000 additional in-patients per month were admitted for respiratory conditions compared to the pre-pandemic period of January to December 2019 (Canadian Institute for Health Information 2021). Between April 2021 and March 2022, there were more than 101,000 hospital stays in Canada for patients diagnosed with COVID-19 (excluding Québec) and more than 262,700 reported emergency department visits for COVID-19 (Canadian Institute for Health Information 2022b).

Ontario Regulation 305/21 devolved much responsibility to individual hospitals and practitioners, potentially creating confusion and inconsistencies, and leading to questions to regulators from registrants (e.g., can midwives assist with or perform a Caesarean section or neonatal resuscitation in an emergency?). Unlike the proposed British Columbia order, Ontario practitioners would be liable for errors made when practising outside their usual

scope, and health professionals were individually responsible for determining and assessing their competence to perform tasks (Mann et al. 2011). There is no indication that health profession educators, training institutions, or bodies were involved or approached prior to the regulation's enactment to facilitate continuing competency education or training to support safe, effective scope of practice expansions in hospital settings. In a demanding, high-stress environment, practitioners may have experienced pressure to practise outside their scope, and they may have had to make decisions about whether they would agree to do so, with inadequate time to reflect on regulatory guidance, consider their potential liability, and make an informed decision (Adams and Wannamaker 2022). Regulators and employers may also have been confused or uncertain about the suspension of licensure requirements and how this might impact accountability and data sharing for typical hiring practices.

3 THE POLICY-MAKING PROCESS

In steady state, scope of practice is determined by numerous national, provincial, and territorial stakeholders (Ontario Hospital Association 2003), which have different objectives and do not often collaborate to devise or define health professions' scopes of practice and associated competencies (Baranek 2005). Regulatory collaboration may be legislated, as is the case in Ontario, where regulators must collaborate on standards where controlled acts are shared among their professions (Leslie et al. 2021b; Regan et al. 2015). Creating or changing scopes of practice can cause tensions within and between professions that are exacerbated by union contracts with health care payers (Tomblin Murphy and O'Brien-Pallas 2002). Overlapping scopes of practice among health professions can result in professional turf wars, role confusion, a lack of trust among professions, and inefficient use of health professional resources (Nelson et al. 2014; Moat, Waddell, and Lavis 2016). For example, highly paid professionals are providing services that lower-paid professionals have the knowledge and skills to provide, thereby impeding the best usage of the health human workforce and potentially limiting access to services.

3.1 Factors that influenced how and why: ideas, interests, institutions

The COVID-19 pandemic provided a critical juncture for this policy change to occur (Kingdon 2003). In what follows, the structured policy analysis 3I framework of ideas, interests, and institutions will be used to identify factors influencing a particular policy decision (Lavis et al. 2012).

Ideas for this order were likely generated from existing evidence for this type of reform. As was highlighted above, previous commissions and reports have advocated for more flexible and expanded scopes of practice to enhance health service access in response to constrained resources in Canada prior to the pandemic. Health professions regulators internationally incorporated scope of practice expansions to reduce barriers to practice (Leslie

et al. 2023), increase health workforce capacity and bolster health system responses during the pandemic (Myles et al. 2023).

Interests for this order include health professions regulators in Ontario, and home jurisdictions throughout Canada if professionals were not licensed in Ontario, who had to field questions they may not know how to answer (about scope of practice, liability, accountability). Employers also had an interest in this order. Larger employers (i.e., hospitals) may have been better equipped to manage and benefit from this change because of their human resource departments' capacity to conduct personnel screening and determine appropriate background checks compared to smaller employers. Patients represent an additional interest, since there might be confusion on the part of Ontarians about where or how to lodge complaints about health services received from out-of-province providers during the time this order was in force. Health professions regulators in Ontario have a statutory mandate to protect the public interest (Government of Ontario 1991). Moreover, health systems in other provinces and territories might have experienced a loss of their health care providers to Ontario for a period of time, thus depleting their home jurisdiction of urgently needed services and resources. While scope of practice interests generally involve professional associations who advocate on behalf of their members and trade unions who negotiate contracts and other employment conditions with health care funders and employers, there was surprisingly little indication of professional associations or unions taking a public position on this temporary pandemic policy change beyond communicating where and to whom this order applied, what it permitted, and encouraging communication with employers for clarity regarding practice implications (Ontario Council of Hospital Unions 2021b). However, professional associations mentioned the order in submissions to the House of Commons Standing Committee on Health in June 2021 (Society of Rural Physicians of Canada 2021).

Institutions related to this order include the framework for health professions regulation in the province (i.e., the *RHPA* and regulatory college requirements for registration), which was impacted because they were effectively suspended by the emergency legislation. Another institution related to this order is the emergency legislation framework, which grants federal and provincial governments extraordinary powers during a declared emergency. For the COVID-19 response in Ontario, this mainly includes emergency planning provisions in the *EMCPA*, and the *Reopening Ontario (A Flexible Response to COVID-19) Act, 2020*. An additional institution is the interplay and relationship between governments, health professions regulators, professional associations, and other stakeholders when changes to controlled acts and professional scopes of practice are being considered. In Ontario, this is usually a consultative process where relevant regulators work with government and as part of public consultations and MOHLTC referrals for scope of practice reviews to the former Health Professions Regulatory Advisory Council (e.g., registered nurse prescribing, psychotherapy-controlled act) (2013; 2014; 2017; 2018; Registered Nurses Association of Ontario 2009; College of Nurses of Ontario 2021b). However, it was clear from regulators' statements that this policy change came without warning (e.g., that they received a memo from the MOHLTC about the directive as the order came into force) (College of

Midwives of Ontario 2021; College of Naturopaths of Ontario 2021; College of Nurses of Ontario 2021a; College of Occupational Therapists of Ontario 2021). Professional regulators typically work collaboratively with the government to regulate professions effectively. This government decision to implement Ontario Regulation 305/21 overrode that partnership. In this sense, the institutionalized relationship between professional regulators and the government is another institution impacted by this policy reform.

4 IMPLEMENTING THE REFORM

Federal and provincial governments are granted extraordinary powers by law in emergencies, which have evolved to include pandemics such as COVID-19 (Sheppard 2021). In Ontario, the main emergency response legislation is the *EMCPA*, which contains several emergency planning provisions, the most significant of which pertain to emergency declarations made and powers exercised during that time. Since the onset of the COVID-19 pandemic in March 2020, the Ontario government extensively used these and other regulatory powers, tabling and enacting additional legislation (Sheppard 2021). On 24 July 2020, the Ontario government enacted the *Reopening Ontario (A Flexible Response to COVID-19) Act, 2020*, under which most *EMCPA* orders related to COVID-19 were moved including Ontario Regulation 74/20 (Work Redeployment for Certain Health Providers) (Sheppard 2021). Ontario Regulation 305/21 required professionals to conduct themselves in accordance with Ontario Regulation 74/20 (Government of Ontario 2021).

When an emergency declaration is made under s. 7.0.2(1) of the *EMCPA*, Ontario's cabinet may make emergency orders to promote the public good by protecting health, safety, and welfare in accordance with the *Canadian Charter of Rights and Freedoms*. Under the *EMCPA*, cabinet can make orders to use or make available services or resources located in Ontario, procure services or resources, and authorize persons to render services they are reasonably qualified to provide. Terms or conditions may be stipulated for persons providing the services in question, and individuals providing services in accordance with such orders may not be terminated for doing so (Government of Ontario 1990, ss. 7.0.2(4)-(6)). Ontario Regulation 305/21 is consistent with orders cabinet may make to "respond to alleviate the effects of an emergency" (Sheppard 2021; Government of Ontario 1990, s. 7.0.2(4)14), the intention, in this case, was to enable more health care system flexibility to manage and treat "COVID-19 cases, including those requiring hospitalization" (Emond Harnden 2021). To make this order, cabinet had to deem it essential under the circumstances to lessen and attenuate serious harm to persons, and that it was a reasonable alternative to other potential courses of action (Government of Ontario 1990, s. 7.0.2(2)). While it was not explicitly stated why this order was put in place in April 2021 (versus when the COVID-19 emergency was initially declared over a year earlier), it corresponded with the third wave of the pandemic which was accompanied by much higher levels of hospitalization presumably due to COVID-19 variants (Favaro, St. Philip, and Jones 2021; Aziz 2021); a

partially vaccinated population due to eligibility and vaccine availability; concerns about hospital capacity (Detsky and Bogoch 2021); a lockdown policy and stay-at-home order implemented in Ontario on 3 April 2021 and 7 April 2021 respectively (Navazi, Yuan, and Archer 2022). As this order prevailed, other instruments (e.g., statutes, regulations, rules, bylaws) (Government of Ontario 1990, s. 7.2(4)) were not considered necessary from the provincial government's standpoint.

5 EVALUATION

At the time of writing, we are not aware of any publicly articulated plan by the Ontario government to formally evaluate the impact of this order. Opportunities to learn and generate evidence-informed best practices are limited by a lack of evaluation. It can be argued that it is important to evaluate implemented measures to deploy health professionals to deliver care and overcome regulatory barriers to enable effective and coordinated health system pandemic responses (Basky 2020; Marks 2021). These evaluations can explore questions such as: how were issues related to practitioner liability and competence addressed? How did the implementation of this order work in practice? Did all hospitals in Ontario implement it, and if so, in what way(s)? Did members of the health workforce feel pressure to work outside their competency, or was it a positive experience enabling them to exercise the full breadth of their skills? How can governments and health professions regulators justify being flexible regarding professional practice boundaries such as scope of practice during a crisis but not during steady state? For example, was access improved and staffing ensured as the order intended? Did health care delivery, quality, and patient safety suffer under the expanded scopes of practice during the pandemic compared to usual scopes of practice, as suggested by Lai, Skillman, and Frogner (2020)? What are the implications for restricting this order to hospitals and to COVID-related care (compared to other settings/sectors such as home and community care which were not impacted by the health workforce deployment this order facilitated, or COVID patients in long-term care in instances where they were not transferred to hospital)?

Expanding the health workforce and service capacity is in the public interest, particularly during severe workforce shortages that potentially constitute a greater public safety risk than regulatory standard changes (Professional Standards Authority for Health and Social Care 2022). Beyond the pandemic emergency, health workforce shortages have reached crisis levels in Ontario (Al Mallees 2022; Goodyear 2022; Guerriero 2022; Karpenchuk 2022; Smith Cross 2023), illustrated by temporary emergency department closures and a record number of complaints to the province's Ombudsman Office focused on a lack of adequate staffing, access to, and quality of care (Casey 2023). This predicament may justify rethinking historical notions around restricted scopes of practice. Internationally, there have been calls advocating to make permanent emergency policies expanding "health workforce supply by removing" jurisdictional barriers (Frogner 2022); temporary scope of practice

changes for advanced practice nurses and nurse practitioners (Stucky, Brown, and Stucky 2021), and to adopt more flexible mechanisms for recognizing skills and specializations (e.g., emergency, intensive care) to quickly identify practitioners during emergencies (Panteli and Maier 2021). In rapidly changing environments, it is unclear why health professional tasks are inflexible and "rigidly defined;" in addition to preventing practitioners from using the full extent of their skills and training, strict scope of practice regulations may contribute to care access deficits (Bae and Timmons 2022).

All orders issued under the *EMCPA* are valid for two weeks unless revoked or renewed in accordance with the statute (Sojourner-Campbell 2021). This order was meant to change scopes of practice temporarily and was in place for just over a year, until April 2022. Presumably, this order was rescinded when the state of emergency declaration in the province ended. On 19 January 2023, the Ontario government announced the introduction of "As of Right" rules, legislation aimed to attract more health workers to Ontario. Under these rules, the province would automatically recognize the credentials of health workers registered in other provinces and territories and allow them to start working in Ontario without registering with the relevant professional regulator if they provided safe, ethical, and competent care in their home jurisdiction (Government of Ontario 2023). In February 2023, Bill 60, extending to physicians, nurses, respiratory therapists, and medical laboratory technologists was introduced (Government of Ontario 2023b). Similar to Ontario Regulation 305/21, Bill 60 raises important scope of practice, competence, and liability considerations surrounding potential scope of practice differences between the home jurisdiction and Ontario such as: practising a broader scope of practice in Ontario if training in particular areas was not received by a practitioner; potential limitations beyond what a practitioner can normally do in practice if the scope of practice in Ontario is narrower, and the appropriate entity to monitor this if a practitioner is not registered with the Ontario regulator, even if on an interim basis (Maciura and Durcan 2023).

That provincial health workforce shortage and capacity issues have intensified as the pandemic is abating make scope of practice changes crucial to examine and implement. As health care systems continue to adjust to health system challenges amplified by the pandemic, health professionals may not wish to return to pre-pandemic scope of practice limits (Lai, Skillman, and Frogner 2020). Reversals of scope of practice expansions during pandemic recovery should be carefully considered and evidence based. Such reversals could harm relationships with and among segments of the health workforce, registrants, and employees; foster feelings of unfair treatment and job dissatisfaction, as well as a lack of appreciation or resentment after risking personal health and needs (Lai, Skillman, and Frogner 2020).

6 STRENGTHS, WEAKNESSES, OPPORTUNITIES AND THREATS

A SWOT analysis of the implementation of Ontario Regulation 305/21 under the *Emergency Management and Civil Protection Act, 1990* is presented in Table 1.

Table 1: SWOT Analysis

Strengths	Weaknesses
• Aligns with government responsibility to ensure access to needed health services for its citizens and facilitate a coordinated health workforce response during a global public health emergency. • Provides a way to facilitate deployment of health resources and enhance workforce capacity intraprovincially. • Can be quickly enacted due to the structure of Ontario's emergency legislation framework. • Provides flexibility in how health providers work during a time of incredible strain on the health care system and providers.	• Regulators did not have sufficient time to prepare communications or internally work through implications to immediately provide clear guidance to employers and registrants. • Evaluating the reform may be difficult since it was temporary, no formal evaluation plan has been created, and it was issued during the pandemic as regulators and employers were experiencing other pressing challenges. • The swift enactment of the reform did not permit sufficient time for linkages with professional training to facilitate scope of practice expansion.

Opportunities	Threats
• Opportunity to reconsider historical ideas around scope of practice to determine if greater flexibility enhances or promotes team-based care. • Chance to consider occupational licensure reforms to facilitate labour mobility and deploy the health workforce. • Chance to revisit continuing competency and other continuing professional development options to build workforce capacity and support shifts in scope of practice beyond typical practice boundaries. • Opportunity for stakeholders (e.g., government, employers/hospitals, regulators, health providers) to learn from this experience for future emergencies.	• Potential practitioner and patient protection to be compromised with changing guidance/directives and insufficient time for practitioners to consider competence to make informed scope choices. • Potential threat to patients if practitioners practised outside their usual scope of practice. • Uncertainty surrounding the autonomy of self-regulated professions as part of the social contract between health professions and society; this may adversely impact state-profession relations. • Potential confusion and inconsistency among practitioners and hospitals regarding how the order was enacted in practice. • Lack of clarity and additional stress on practitioners about possible liability for scope of practice decisions in stressful practice environments.

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