

2012

Monash University Centre for Ambulance and Paramedic Studies (MUCAPS) Submission to the Department of Human Services (DHS), in response to the DHS Discussion Paper examining the regulation of the Health Professions in Victoria

Stephen Burgess et al.
stephen.burgess@med.monash.edu.au

Recommended Citation

Burgess et al., S. (2003). Monash University Centre for Ambulance and Paramedic Studies (MUCAPS) Submission to the Department of Human Services (DHS), in response to the DHS Discussion Paper examining the regulation of the Health Professions in Victoria. *Australasian Journal of Paramedicine*, 1(3).
Retrieved from <http://ro.ecu.edu.au/jephc/vol1/iss3/5>

This Journal Article is posted at Research Online.
<http://ro.ecu.edu.au/jephc/vol1/iss3/5>

Journal of Emergency Primary Health Care

An International eJournal of Prehospital Care Research, Education, Clinical Practice, Policy and Service Delivery

PROFESSIONALISM

Monash University Centre for Ambulance and Paramedic Studies (MUCAPS)
Submission to the Department of Human Services (DHS), in response to the DHS Discussion Paper
examining the regulation of the Health Professions in Victoria
Article No. 990066

Mal Boyle, Steve Burgess et al.

PARAMEDIC CONTRIBUTORS

Mal Boyle, ADHS(AmbOfficer), MICACert, BInfoTech(Info Sys), MCLinEpi,
ADipBus(GenAdmin), AACCS, (PhD Candidate)

Stephen Burgess, BHthSc(VU), MICACert, MPH (Monash), MACAP.

Mark Chilton, BParamedStud, MICACert, MHLthAdmin(LaT), MACAP, AFACHSE, CHE

Ben Ellis, ADHS(AmbOfficer)

Brian Fallows, BParamedStuds, BA(SocialSciences), MICACert, DipFrontlineMgt,
CertIVAssessment&WorkplaceTraining, AssocDipGenAdmin(GIT)

Bill Lord, BHSc(Pre Hospital Care)(CSU), AdvCertPersonnelMangt(TAFE NSW),
GradDipComputerBasedLearning(UTS), MEdAdultEd(UTS), (PhD Candidate)

David Shugg, PSM, BEd(HIE), MICA Cert, GradDipStdWelf(HIE), GradDipBusAdmin(RMIT),
MEdStds, LMACAP, AFAIM.

Brett Williams, BAd&VocEd(UTas), BHthSc(VU), ParamedicCert(Tas), MICACert,
GradCertIntensiveCareParamedic(VU), GradCertAeromedicine(VU), APLS (Aust)

Andrea Wyatt, BParamedStud(Monash), BSc(Melb), MICACert,
GradDipEd&Tng(Melb), MEd(Melb), (PhD Candidate)

INTRODUCTION

The following submission is made on behalf of the Monash University Centre for Ambulance and Paramedic Studies (MUCAPS), an academic Centre within the School of Primary Health Care. The School of Primary Health Care is one of several schools that comprise the Faculty of Medicine, Nursing and Health Sciences at Monash University.

This submission will primarily address the regulation of the health professions from the perspective of an education institution, and is made in response to the [Discussion paper](#) examining regulation of the health professions in Victoria, dated October 2003 which was issued by the Policy and Strategic Projects Division of the Victorian Department of Human Services, Melbourne, Victoria.

SUMMARY OF THE MAJOR ISSUES ARISING FROM THE SUBMISSION

MUCAPS contends that:

1. In relation to regulation of practice, paramedics are anomalous amongst kindred acute health practitioners in having no regulation of professional practice despite the consequences of their practice posing a clear threat to the health, safety and well being of the public.
2. The absence of regulation of paramedic practice poses a clear threat to the health, safety and well being of the public.
3. Paramedic practice meets all of the criteria for consideration of statutory regulation of practice as defined by the Australian Health Minister's Advisory Council in 1995 (p.12).
4. The lack of a regulatory framework means that there is no external body that can accredit the paramedic education programs offered by Monash University, or any other education institution.
5. The University expects that:
 - a. Paramedics are regulated and registered.
 - b. Regulatory guidelines exist to inform the education and development of paramedics at all levels of the professional education.
 - c. Professional practice of health practitioners, including paramedics, to be guided by professional standards as is the case with the Australian Nursing Council and the Australian Medical Council.

We therefore recommend that paramedics be included in the regulatory framework for the health professions in Victoria.

For further background information on the historical and educational developments of paramedic practice and MUCAPS' role in that process, as well as a summary of international contemporary regulatory frameworks for regulation of paramedic practice please see *Appendix A.

Author: Boyle, M., Burgess, S. et al.

MUCAPS RESPONSE TO THE MAJOR ISSUES AS IDENTIFIED IN THE DISCUSSION PAPER

MUCAPS is supportive of the principles guiding the review process which include that the operation of the regulatory system for health professionals should be accountable, transparent and fair, effective, efficient and flexible and consistent (p.10).

MUCAPS supports the criteria for assessing the need for statutory regulation of unregulated health occupations as agreed by the Australian Health Ministers' Advisory Council in 1995 as shown in Table 2.1 (p.12). These criteria are explicit and appropriate.

The nationally agreed process allows for an unregistered health profession to make a submission to any state or territory government requesting consideration of their case for statutory registration (p.126). It is in this context that MUCAPS makes this submission to the discussion process.

Criterion 1

Is it appropriate for health ministers to exercise responsibility for regulating the occupation in question, or does the occupation more appropriately fall within the domain of another ministry?

The administration, funding and Government guidance of the actions of Ambulance Service Victoria (ASV), which is comprised of Metropolitan Ambulance Service (MAS), Rural Ambulance Victoria (RAV) and Alexandra and District Ambulance Service, has in the past, and is currently, under the auspices of the Victorian Department of Human Services and responsibility for the activities of ASV rests ultimately with the Minister for Health. The vast majority of practicing paramedics in Victoria currently work for ASV.

The role, purpose and function of paramedic practice is aimed at restoring and maintaining the health of the patient. Accordingly, the proposal to regulate paramedics and their practice in Victoria appropriately also resides with the Victorian Minister for Health. In the majority of states in Australia the Minister with relevant jurisdiction for paramedic practice is the Minister for Health.

Criterion 2

Do the activities of the occupation pose a significant risk of harm to the health and safety of the public?

The professional and clinical activities of paramedics are aimed at preserving life, preventing further illness or injury and promoting patient recovery. However the execution of many interventions or the lack of timely and appropriate intervention where clinically indicated, also clearly poses a real risk of harm to the health and safety of the public.

Many of the interventions that paramedics undertake for patients involve time critical decisions about the immediate administration of restricted, powerful and potentially dangerous drugs

classified under Schedule 4 (prescription only drugs) or Schedule 8 (controlled drugs) of the Drugs, Poisons and Controlled Substances Act 1981 and regulations as amended.

It should be noted that unlike other kindred health professions that administer these types of drugs to patients, for example nursing, paramedics are not legislatively obliged to double check these drugs with a peer prior to administration. In many cases they simply do not have a peer with whom to confer. Thus the responsibility for the administration of these drugs in an emergency situation may well rest solely with the paramedic working alone.

Paramedic practice comprises a range of physically invasive procedures that all involve some degree of risk to the patient. The highest risk procedures are known to have potentially fatal consequences for the patient if the paramedic's clinical judgment supporting the intervention is wrong or if the execution of a dangerous procedure is poor.

The highest risk interventions are sedation, paralysis, endotracheal intubation and artificial ventilation of seriously ill patients, cardiac defibrillation and cardioversion, decompression of a tension pneumothorax and the infection risk of intravenous cannulation.

Sedation, paralysis, endotracheal intubation and artificial ventilation of seriously ill patients by paramedics is exactly the same clinical process that anaesthetists perform to render a patient unconscious and ready for surgery, except when performed by a paramedic, this procedure is invariably unplanned and the patient is not properly prepared for the procedure by methods such as fasting prior to anaesthesia, which is preferred to minimize the risk of aspiration (inhaling one's own vomitus).

Cardiac defibrillation and cardioversion are clinically different, but essentially similar procedures, which require the delivery by paramedics of carefully controlled doses of large electric shocks to a patient's chest to stun and completely stop a patient's heart rhythm in order to initiate a new, better heart rhythm that will allow a patient to survive.

There are many other risky interventions that paramedics routinely practice that also have a significant inherent risk to the health and safety of the public. A detailed list of these procedures, as well as an index of potentially dangerous drugs that are administered by paramedics are shown in *Appendix B.

Paramedics work in a different clinical context to much of the acute health sector. Other health professionals who deal with acute problems usually practice within some defined clinical specialty, for example crisis assessment teams and the like. Paramedic practice is by definition broad in scope as it is completely defined by the patient's call and is therefore impossible to predict. Indeed it is the very breadth of practice, the immediacy of the life threat that is managed, and the time critical nature of crucial interventions that separates paramedic practice from most other acute health practitioners.

The immediacy and importance of paramedic interventions is well documented, especially in the setting of the management of trauma. The report series of the Consultative Committee on Road Traffic Fatalities¹ have consistently shown that approximately 20% of preventable deaths resulting from road trauma in Victoria were as a result of shortcomings in the prehospital management of these patients. The findings of these reports have been a major impetus to the

establishment of the Victorian State Trauma System which aims to decrease the number and severity of adverse patient outcomes following trauma in Victoria².

Paramedics work in a completely unsupervised clinical environment. Many paramedics practice alone, with junior student paramedics, or with only the assistance of volunteer and/or casual staff that are trained to an elementary level of assistance and in the use of basic equipment. In ideal circumstances paramedics will have a clinical peer with whom to work for the benefit of the patient. When dealing with urgent situations paramedics have little or no opportunity for timely consultation with appropriately trained medical practitioners. Paramedics practice without the benefit of a detailed record of a patient's medical history at hand.

It should be self evident that many of the patients attended by paramedics are at some level, vulnerable. They are universally (self) identified as having an urgent health crisis.

Paramedics are called to attend patients with every possible ailment which may range from exacerbation of chronic medical conditions, to acute medical emergencies, to minor and major trauma, to mental health crises, to drug and alcohol problems, or major social emergencies. Paramedics attend people of all ages from neonates through to geriatric patients.

The vulnerability of the patients attended by paramedics has many causes. Patients may be young children without a parent or guardian present, physically frail, suffering dementia, or acutely confused. They may be acutely mentally ill, or they may be suffering a serious or life threatening medical or traumatic event.

They may be in the process of being transferred to a tertiary hospital for stabilization or more sophisticated management of a medical problem, or they may be undertaking a prolonged series of treatment that requires frequent attendance at hospital e.g. chemotherapy. In any of these settings, patients need and deserve the best level of protection from the risk of harm to their health and safety.

In addition to their primary role as providers of emergency ambulance services, ASV also provide non-emergency, but often still acute, patient transport services. Some private providers of non-emergency patient transport services for inter-hospital transportation are provided on a sub-contracted basis to ASV. Some hospitals also directly engage private providers of non-emergency patient transport services for inter-hospital transportation. A series of clinical audits have demonstrated that a significant proportion of the patients attended by private providers are experiencing a genuinely acute but not immediately life threatening episode and require admission to an appropriate emergency department within 60 minutes of the call for attendance.

This important issue of public safety has been recently recognized by the Victorian parliament with the passing for the Non-Emergency Patient Transport (NEPT) Act 2003 with promulgation of accompanying regulations to follow. The Act will lead to the making of regulations to set minimum standards for non-emergency transport that may vary according to the type/clinical condition of patient to be transported. Regulations are expected to cover areas such as:

- the kinds of patients who may be transported and with what level of care;
- safety, cleanliness and hygiene;

- staffing including the minimum number of staff required for specified types of transports, as well as requirements as to their qualifications and clinical accreditation;
- maintenance of vehicles and equipment; and
- quality assurance and clinical supervision.

As the Minister for Health stated during the second reading speech before Parliament “the current system of simply requiring providers to hold a [driving] licence issued by the taxi directorate, does not provide an effective means of ensuring that those providing such transports have the clinical skills and equipment required to protect the patient’s health and safety”. She is completely correct.

It is therefore curious, indeed anomalous, that the effect of what is proposed by the passing of the Non-Emergency Patient Transport (NEPT) Act 2003 is a regulated non-emergency patient transport sector, but a completely unregulated emergency sector. In short, paramedics that attend routine or non-emergency patients will be regulated, but paramedics that attend time critical life threatening emergencies will not. The rationale and internal consistency of such a situation is obscure and undesirable.

Criterion 3

Do existing regulatory or other mechanisms fail to address health and safety issues?

The existing statutory regulatory and self-regulation mechanisms for paramedic practice are non-existent. MAS and RAV have a process of clinical review and audit which examines self-reported and/or self-documented cases of variant clinical practice, but these processes vary, and are primarily designed for the purposes of clinical reporting of key performance indicators at macro level to Government. Further, they are post-hoc in nature and therefore do nothing to necessarily decrease the incidence or prevalence of adverse clinical outcomes.

There is a structural problem that is inherent in the current clinical review and audit processes within MAS and RAV. Such processes necessarily have an ‘employer bias’. We contend that there exists a tension between maintenance of best clinical practice and operational demands on emergency ambulance services. Detected cases of adverse variant clinical practice may well require a period of intense education, training, counselling and clinical mentoring for optimal remedial development for the paramedic involved. Unfortunately the fiscal implications to the employer of such a remedial program inevitably lead to tensions between the clinical and operational demands on the organization. Subsequently such remedial programs are often less than optimal.

The role of trade unions in this process too is problematic. The relevant union almost invariably acts as the advocate for the paramedic that has engaged in adverse clinical variant practice. Naturally, unions too have a bias, in that they exist to protect and preserve the employment conditions of their members, and are not driven by the need to protect the health, safety and well being of the public. Where tensions arise between the industrial welfare of a member and the protection of the public, the union’s primary responsibility is the needs of their member.

The expanding scope of paramedic practice in conjunction with the changing structure of prehospital health care has introduced opportunities for employment for paramedics outside traditional emergency service providers. In this context it is important to note that paramedics not employed by ASV, that is in the private sector, are not subject to even the current level of clinical scrutiny that applies in the state ambulance services. Paramedics who work for an organisation that has no ongoing relationship with the state ambulance services is subject to no clinical scrutiny or audit whatsoever, no matter how serious any adverse clinical variations may be.

While MAS and RAV have traditionally provided the right to practice for their employees, there is no body to oversee paramedic practice outside of these organizations. Many paramedics already practice in industry, mining operations, isolated oil and gas rigs, interstate and overseas or with privately operated aeromedical retrieval services. These paramedics practice today in the complete absence of any sort of regulatory framework and without mandatory professional indemnity insurance.

If a paramedic chooses to leave employment with either MAS or RAV they effectively lose the right to practice their chosen profession. This situation certainly applies to paramedics that choose to pursue an academic career, and is an unreasonable and unfair restriction on their ability to maintain their clinical practice.

Therefore, it is not appropriate that an employing body should also serve as the regulating body and possess such influence on an individual's right to determine their access to clinical practice.

While it is potentially in the best interest of the employer to maintain high clinical standards, consideration also needs to be given to economical constraints placed upon organizations and the possible conflict that may arise between the two. Transferring responsibility for professional standards to an external body removes this potential for an internal conflict of interest and helps ensure the safety of the public.

Criterion 4

Is regulation possible to implement for the occupation in question?

In all respects the regulation of paramedic practice should be a relatively straightforward process. Paramedics have an established culture of unified and coherent responses to developments in the industry. Paramedics work for a relatively small number of public and private organizations. Paramedics are highly unionized with a single union the Liquor Hospitality and Miscellaneous Workers' Union, Ambulance Employees' - Victoria (AEA-V) covering the profession's industrial dimensions; and the Australian College of Ambulance Professionals (ACAP) is the only professional association for paramedics.

Given the profile of professional stability and the relative ease of identification of the currently unregulated paramedics that comprise the profession, regulation of paramedics should be completed quickly and easily.

Criterion 5

Is regulation practical to implement for the occupation in question?

Author: Boyle, M., Burgess, S. et al.

Given the nature, scope and recent developments in paramedic practice, it seems inevitable that regulation of paramedic should occur. Given the relatively long periods between reviews of health practitioner regulation by government, and the effort required to undertake the review process, it is most convenient and practical to undertake regulation of paramedics while the current legislative review is underway.

There is no reason to anticipate that regulation of paramedics would be any more problematic than the regulation of any other discrete health profession. For the reasons outlined in response to criterion 4, the practical aspects of the implementation of regulation of paramedics should be straightforward.

Criterion 6

Do the benefits to the public of regulation clearly outweigh the potential negative impact of such regulation?

Paramedic practice is unregulated today. The well-being, health and safety of the public is at present poorly serviced by the absence of any effective regulation or self regulation of paramedic practice. Paramedic practice poses a clear and present risk to public safety. Given the undisputed potential for catastrophic clinical events in paramedic practice to adversely and severely affect the health and safety of the public, the need to consider regulation of paramedics is overwhelming and clear.

Criteria 1, 2, and 3 make the case for the need and appropriateness of regulation of paramedic practice under the auspices of the Minister for Health. Criteria 4 and 5 address the possibility and practicality of regulation of paramedics, and point to the relative ease of the implementation of such a proposal.

Given the unambiguous way in which paramedic practice meets the criteria 1 to 5, it is difficult to foresee any potential negative impacts of the regulation of paramedic practice. Such regulation is unlikely to have any perceivable effects on the operational or financial aspects of either the state or private ambulance services, and so the negative impact of such regulation is negligible to non-existent.

Regulation of paramedic practice would also resolve the legislative anomaly between paramedics in state ambulance services and paramedics in the non-emergency patient transport sector that is described and discussed under criterion 2 above.

The benefits of proposed regulation of paramedics extend to other areas of professional practice. Regulation by government of paramedic practice creates a context of professional practice and conduct that actually matches the roles and responsibilities that paramedics have. Regulation of practice reinforces to paramedics that regardless of their employer, they are a health profession that is regulated and registered for good reason.

It is arguable that paramedics may be disinclined to consider the full spectrum of a health professional's attributes due to the unregulated nature of their profession. We contend that it is desirable for paramedics, given the nature of their clinical practice, to always have a

consciousness of their personal responsibility to the public in addition to the responsibilities that are carried by their employer.

Regulation serves as a constant reminder to all health professionals that they are *personally* responsible for the consequences of their professional actions and that potentially there are legal ramifications and consequences for them personally and professionally for unacceptable professional conduct and performance. An employer's vicarious liability for the actions of a paramedic would be cold comfort in the setting of a regulated and registered profession.

COMPETITION POLICY TEST

The Discussion paper also asks respondents to consider whether any proposed regulation of paramedics would be able to pass the competition test, that is, that any proposed changes should be consistent with the National Competition Policy (NCP), the Competition Principles Agreement and the Conduct Code Agreement.

MUCAPS contends that regulation of paramedic practice in Victoria would have no implications for Part IV of the Trades Practices Act 1974 as it applies to health practitioners, would not constitute an anti-competitive provision and would not affect competitive neutrality. In short, the proposal to regulate paramedic practice in Victoria is consistent with all aspects of the NCP and its associated agreements and principles.

As discussed in criterion 3, it may be arguable that the current arrangement of the state ambulance services acting as effective regulators of who is able to practice as a paramedic constitutes a restriction on paramedic practice that is in conflict at least with the spirit, if not the letter of the NCP and its associated agreements and principles.

RESPONSE TO SECTION F: REGULATION OF UNREGISTERED HEALTH PRACTITIONERS.

In relation to unregistered health practitioners the Discussion paper states on page 126:

“Self-regulation in this paper refers to a model of regulation where there are no occupational licensing or registration laws that require members of a particular profession to be registered with a body that has statutory powers to regulate the profession. Self-regulation generally involves the formation of a body or association with voluntary membership, supported by voluntary standards and codes of practice and a recognised and accredited body of knowledge ... Consumers rely on a practitioner's voluntary membership of the professional association as an indication that the practitioner is suitably qualified, safe to practise and subject to a disciplinary scheme. Where the practitioner is an employee, their employer also has responsibility for ensuring their safe and competent practise.

Self-regulation is recommended as a regulatory tool where the implications of non-compliance by members of a profession with its standards of practice are not catastrophic (Office of Regulatory Reform 1995, p.27). Self-regulation applies to all Victorian health professions that are not subject to statutory registration, including the following (note this is not an exhaustive list):

Aboriginal health workers	Ambulance officers
Childbirth educators	Counsellors and psychotherapists
'Doula' birth helpers	Herbalists
Hypnotherapists	Lactation consultants
Massage therapists	Music therapists
Naturopaths	Occupational therapists
Optical dispensers	Orthoptists
Personal care Attendants	Speech therapists

It is correct and important to document that there are no occupational licensing or registration laws that require paramedics to be registered with a body that has statutory powers to regulate the profession.

Self regulation is not an appropriate model for paramedics for the following reasons:

1. In the usual patient/health professional clinical setting patients may well “... rely on a practitioner’s voluntary membership of the professional association as an indication that the practitioner is suitably qualified, safe to practise and subject to a disciplinary scheme.” But this model does not apply to paramedic practice. A minority of paramedics are members of the professional association ACAP, and only a tiny proportion of these are active in the association.

When patients are attended by paramedics they have no control over the clinician that attends to them – simply put, they are managed by whoever attends to them at the time, and they must take whomever they get.

In this circumstance the usual opportunity for patients to make a considered choice about the qualifications, experience and membership of a professional association of their health practitioner simply vanishes. In the setting of paramedic practice, the patient is effectively disempowered and disenfranchised in terms of the usual preliminary patient/practitioner interchange. Patients cannot choose their paramedic practitioner, nor can they request an alternative practitioner if they find their allocated one disagreeable or unsatisfactory for whatever reason.

2. Whilst it is true that “Where the practitioner is an employee, their employer also has responsibility for ensuring their safe and competent practise.”; it is difficult to see how the employer’s shared responsibility for an employee’s safe and competent practice is sufficient safeguard for a patient in the case of a paramedic, but insufficient in the case of a medical practitioner or a registered nurse who, as registered and regulated health practitioners, and also employees of the receiving hospital, will continue the treatment and care that has been instituted by the paramedic.

Indeed it could be argued that within a hospital setting the patient is better served by the employer’s responsibility to ensure an employee’s safety and competence than they are in the unstructured, unpredictable and unsupervised clinical environment in which paramedics practice.

3. While it is an arguable position that “self-regulation is recommended as a regulatory tool where the implications of non-compliance by members of a profession with its standards

of practice are not catastrophic.”; unfortunately, this is completely at odds with the realities of paramedic clinical practice where the consequences and sequelae of poor judgement or poor technical execution of critical skills could easily lead to catastrophic outcomes including the demise of the patient. These dreadful consequences have been mentioned earlier in response to criterion 1, and the relevant procedures and drugs are also listed in detail in *Appendix B, so will not be laboured here.

4. The difficulties with self regulation that is canvassed in Section 23.3 of the Discussion paper *Difficulties with self-regulation* (p.127) where we note that the first of these difficulties is correctly identified as “reliance solely on self-regulation is problematic where the practice of a profession presents potentially serious risks to public health and safety”. The other identified difficulties with self regulation also largely apply to paramedic practice. It should be clearly noted that the principles underpinning effective self-regulatory arrangements and the key elements of an effective self regulatory model outlined in section 23.2 of the Discussion paper (p.127) do not currently exist in any meaningful way in paramedic practice.
5. The non exhaustive list of health professions that are listed under *Difficulties with self-regulation* (p.126) appear to have no relationship at all to the nature, scope or potential adverse clinical consequences that is intrinsic to paramedic practice. Unlike paramedic practice, the health and safety implications for members of the public of poor clinical practice on behalf of the remainder of the listed professions seem to be minimal. None of these professions has the potential for serious and permanent harm from just one clinical encounter as applies in paramedic practice. The only similarity between paramedics and the other professions listed seems to be that paramedic practice is currently unregulated.

From this brief discussion of self regulation it is clear that self regulation does not protect the health, safety and well being of the public and is not appropriate for paramedic practice.

*** Appendices have not been included with this copy of the submission. For further details please contact Steve Burgess at: stephen.burgess@med.monash.edu.au**

REFERENCES

1. McDermott, F.T., Cordner, S.M., Tremayne, A.B., Report of the Consultative Committee on Road Traffic Fatalities in Victorian Report, Victorian Institute of Forensic Medicine, Melbourne. (Series 1993 to 2003).

2. Victorian State Trauma System:
<http://www.health.vic.gov.au/trauma/>

BIBLIOGRAPHY

Nursing Regulation and Practice, National Review of Nursing Education, Commonwealth of Australia, Canberra, 2002.

NSW Medical Board, A Draft Model for Medical Registration – for Consultation, Australian Council for Safety and Quality in Health Care, August 2001.

NREMT website:

http://www.nremt.org/about/policy_disciplinary.asp

Health Professions Act, British Columbia:

http://www.qp.gov.bc.ca/statreg/stat/H/96183_01.htm

Health Professions Act, Alberta:

www.health.gov.ab.ca/public/document/HPAbooklet/about_HPA.pdf

Health Professions Council, United Kingdom:

<http://www.hpc-uk.org>

Health Professions Council of South Africa:

<http://www.hpcs.co.za>