In response to 'the case for self-regulation of infection prevention and control professionals in Ontario, Canada'

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In the Fall 2025 issue of the *Canadian Journal of Infection Control*, Candon et al. (2025) published a letter to the editor in which they proposed self-regulation of Infection Prevention and Control (IPAC) professionals in Ontario, Canada. In their submission, they suggested that the lack of regulation of the profession represents a critical gap in Ontario's healthcare system. This letter contributes to the conversation by providing a nuanced perspective on the regulation of IPAC practice.

Advantages of self-regulation

In their submission, the authors nicely articulated that the role of a professional regulatory body is to set and enforce professional and ethical standards, establish entry-to-practice criteria, define competencies for practice, maintain a member register, establish continuing education requirements, investigate complaints, and provide member discipline for the purpose of protecting the public from harm (Bourgeault & Chamberland-Rowe, 2023; Carlton et al., 2024). Such harm has been attributed to gaps in IPAC standards and may result in outbreaks of infectious diseases and antimicrobial-resistant organisms, among other consequences (*Canadian Military Family Magazine*, 2020; Salehi & Arafin, 2025). Additionally, self-regulation could enhance professional recognition among multidisciplinary healthcare teams (Drummond et al., 2023) and facilitate consistency and mobility across settings (e.g., home care, long-term care, and acute care) and interprovincial practice (Afzal et al., 2018; Candon et al., 2025; Eaton et al., 2018; Leslie et al., 2021; Myles et al., 2023; *Regulated Health Professions Act* [RHPA], 1991; Salemi & Arafin, 2025).

The importance of IPAC was particularly evident during the COVID-19 pandemic (*Canadian Military Family Magazine*, 2020). The pandemic also highlighted the increasing demands placed on IPAC leadership and the decisions IPAC professionals must make that affect not only the safety of patients, residents, families, and healthcare workers, but often decisions made during periods of resource scarcity and competing priorities (Association for Professionals in Infection Control and Epidemiology [APIC] & IPAC Canada, 2024; Tan et al., 2023).

While ethical principles are encouraged and promoted for all IPAC professionals (APIC & IPAC Canada, 2024) and are included in the IPAC Canada Core Competencies (Infection Prevention and Control Canada, 2022), there are currently no mechanisms to ensure that IPAC professionals achieve and maintain these competencies. The IPAC profession also lacks a defined career pathway, with no standardized entry-to-practice criteria or defined education requirements (Salehi & Arafin, 2025).

International perspectives

Efforts to curb professional misconduct and malpractice internationally have led to reforms moving away from self-regulation toward more accountable, publicly governed, and transparent models, such as co-regulation (Adams, 2020; Adams, 2022; Andrews & Christian, 2025; Carlton et al., 2024; Leslie et al., 2021; Leslie et al., 2023). In addition, political ideologies (Adams, 2017) have shifted the role of regulation toward a greater focus on cost containment, standardization, and efficiency (Andrews & Christian, 2025; Carlton et al., 2024), as

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self-regulation models have been viewed as inflexible, inefficient, and subject to the interests of the professionals they regulate (Adams, 2018; Adams & Wannamaker, 2022; Leslie et al., 2021).

In Canada, there has been a trend toward reducing the number of regulators to increase efficiency (Afzal et al., 2018; Adams, 2020; Adams & Wannamaker, 2022; Carlton et al., 2024; Leslie et al., 2021; Leslie et al., 2023). This has occurred in British Columbia, where the number of regulatory bodies was reduced from 20 to six (Andrews & Christian, 2025; Province of British Columbia, 2024).

In my opinion, achieving improved outcomes through self-regulation may pose challenges due to partner ambivalence. That is professional associations, the public, and consumer groups may coexist with the self-regulatory body with conflicting or competing priorities (Leslie et al., 2021; Adams & Wannamaker, 2022).

Alternatives to self-regulation

An alternative to self-regulation is co-regulation, which involves a combination of state oversight and third-party involvement (including market and civil society interests) to oversee a profession (Carlton et al., 2024). Two examples include the regulation of paramedics and personal support workers in Ontario (Gehry, 2024; *Health and Supportive Care Providers Oversight Authority Act*, 2021). This model involves legislation related to practice and ethical standards, entry-to-practice criteria, and education program standards, while also allowing equivalency pathways for newcomers from outside Ontario (Government of Ontario, 2025; *Health and Supportive Care Providers Oversight Authority Act*, 2021; HSCPOA, 2024).

Accredited registers represent another model in which professional organizations can voluntarily undergo accreditation and periodic formal evaluation by an arm's-length organization or external body (Carlton et al., 2024; Professional Standards Authority [PSA], n.d.). Through this approach, professions gain the advantages of oversight at a lower cost (Leslie et al., 2023), including accountability, maintenance of professional standards, public safety protections, and a publicly available register (Carlton et al., 2024; PSA, 2025; PSA, n.d.).

The regulation of IPAC in general, could begin with the recognition of education and training from accredited institutions to assure entry-to-practice competence (Leslie et al., 2023). This approach would leverage the well-established accreditation systems of Canadian educational institutions (Adams, 2020) and subsequent certification through the Certification Board of Infection Control and Epidemiology.

Many provinces continue to rely on nursing licensing mechanisms to enforce ethical and education standards (Government of Canada, 2026), for IPAC, the workforce is relatively diverse, with many professionals coming from other educational backgrounds, including public health, medical sciences, and epidemiology (Reese et al., 2026).

Furthermore, across Canada, there is increasing concern whether the healthcare workforce can meet current and future demands (Bourgeault & Chamberland-Rowe, 2019). Co-regulation and the establishment of a professional register, could support IPAC workforce planning (Bourgeault & Chamberland-Rowe, 2019; Carlton et al., 2024; Leslie et al., 2023).

Conclusion

Professionalization of IPAC requires policy change, and for this to occur, policy and politics must come together (Zahidie et al., 2023). In my opinion, policy advocacy must occur through sharing evidence, particularly regarding trends within the IPAC profession (Reese et al., 2026), using both direct approaches (e.g., meetings with politicians) and indirect approaches (e.g., editorial submissions, research, and public awareness campaigns). However, indirect approaches will likely take precedence, as IPAC professionals have not historically had the same level of influence in Canadian healthcare as others such as physicians (Adams, 2020) or the same numerical representation as nursing professionals (Adams, 2018; MacDonald et al., 2012). Together, while self-regulation of IPAC has merit, alternative approaches should also be explored.

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