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Official Report of Debates (Hansard)

Monday 28 September 2009

Journal des débats (Hansard)

Lundi 28 septembre 2009

Standing Committee on Social Policy

Regulated Health Professions
Statute Law
Amendment Act, 2009

Comité permanent de la politique sociale

Loi de 2009 modifiant des lois
en ce qui concerne
les professions
de la santé réglementées

Chair: Shafiq Qaadri
Clerk: Katch Koch

Président : Shafiq Qaadri
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LEGISLATIVE ASSEMBLY OF ONTARIO

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

STANDING COMMITTEE ON SOCIAL POLICY

COMITÉ PERMANENT DE LA POLITIQUE SOCIALE

Monday 28 September 2009

Lundi 28 septembre 2009

The committee met at 1400 in committee room 1.

APPOINTMENT OF SUBCOMMITTEE

The Chair (Mr. Shafiq Qaadri): Chers collègues, j'appelle à l'ordre cette séance du Comité permanent de la politique sociale. Colleagues, I call to order this meeting of the Standing Committee on Social Policy. Before I begin substantive business, I would like to welcome three new committee members. They are MPP Sophia Aggelonitis, MPP Linda Jeffrey and MPP Carol Mitchell, entirely by coincidence all from the government side.

I'd now like to welcome Mrs. Jeffrey and invite her to please move the subcommittee amendments.

Mrs. Linda Jeffrey: I move that the subcommittee on committee business be appointed to meet, from time to time, at the call of the Chair or at the request of any member thereof, to consider and report to committee on the business of the committee, that the presence of all members of the subcommittee is necessary to constitute a meeting, and that that subcommittee be composed of the following members: the Chair as Chair, Ms. DiNovo, Mrs. Mitchell and Mrs. Witmer, and that substitution be permitted on the subcommittee.

The Chair (Mr. Shafiq Qaadri): Thank you. Is there any discussion on this subcommittee report? Seeing none, I'll take it as adopted as read.

SUBCOMMITTEE REPORT

The Chair (Mr. Shafiq Qaadri): I would now invite Ms. Mitchell to please enter into the record the draft report of that subcommittee report.

Mrs. Carol Mitchell: Your subcommittee on committee business met on Tuesday, June 2, 2009, to consider the method of proceeding on Bill 179, An Act to amend various Acts related to regulated health professions and certain other Acts, 2009, and recommends the following:

(1) That the committee meet for the purpose of holding public hearings on Monday, September 28, and Tuesday, September 29, 2009, in Toronto.

(2) That the clerk of the committee, with the authority of the Chair, place an advertisement for one day about the public hearings in major Toronto dailies before Monday, September 7, 2009;

(3) That the clerk of the committee post information regarding the hearings on the Ontario parliamentary channel and the Legislative Assembly website;

(4) That interested people who wish to be considered to make an oral presentation on Bill 179 should contact the clerk of the committee by Monday, September 21, 2009, at 5 p.m.;

(5) That the clerk of the committee provide a list of all interested presenters to the subcommittee following the deadline for requests;

(6) That the length of presentations for witnesses be 15 minutes for groups and 10 minutes for individuals;

(7) That the deadline for written submissions be Friday, September 25, 2009, at 5 p.m. and that presenters be allowed to submit follow-up information to the committee by Tuesday, September 29, 2009, at 5 p.m.;

(8) That the research officer provide the following to the committee:

—press releases from the colleges prior to the start of the hearings;

—summary of recommendations as complete as possible;

(9) That the deadline for filing amendments to the bill with the clerk of the committee be Friday, October 2, 2009, at 5 p.m.;

(10) That clause-by-clause consideration of the bill be scheduled for Tuesday, October 6, 2009;

(11) That the clerk of the committee, in consultation with the Chair, be authorized prior to the adoption of the report of the subcommittee to commence making any preliminary arrangements to facilitate the committee's proceedings.

I would move that report.

The Chair (Mr. Shafiq Qaadri): Thank you, Ms. Mitchell. Are there any questions, concerns or further amendments to be presented? Ms. Elliott.

Mrs. Christine Elliott: Thank you, Chair. I move that the report of the subcommittee dated Tuesday, June 2, 2009, be amended as follows:

(a) By adding the date of "Monday, October 5, 2009" for the purpose of public hearings in paragraph 1;

(b) By striking out paragraph 6 and replacing it with "That the length of presentations for witnesses be 10 minutes";

(c) By striking out paragraph 7 and replacing it with "That the deadline for written submissions be Monday, October 5, 2009, at 5 p.m.";

(d) By striking out "Friday, October 2, 2009" in paragraph 9 and replacing it with "Wednesday, October 14, 2009";

(e) By striking out "Tuesday, October 6, 2009" in paragraph 10 and replacing it with "Monday, October 19, 2009."

The Chair (Mr. Shafiq Qaadri): Should the amendments carry? Carried.

Shall the subcommittee report, as amended, carry? Carried.

REGULATED HEALTH PROFESSIONS STATUTE LAW AMENDMENT ACT, 2009

LOI DE 2009 MODIFIANT DES LOIS EN CE QUI CONCERNE LES PROFESSIONS DE LA SANTÉ RÉGLEMENTÉES

Consideration of Bill 179, An Act to amend various Acts related to regulated health professions and certain other Acts / Projet de loi 179, Loi modifiant diverses lois en ce qui concerne les professions de la santé réglementées et d'autres lois.

The Chair (Mr. Shafiq Qaadri): We'll now move to the presentations. I'd first of all like to welcome all the members and the various submitters, presenters and those who are here. As well, many have submitted written reports.

We are trying to set up an overflow room, as we have, it seems, standing room only. Just to inform you of the protocol: All presenters will have 10 minutes in which to make their presentation, which will be militarily enforced with precision. Any time remaining within those 10 minutes will be distributed, if any are remaining, evenly amongst the parties for questions.

ONTARIO ASSOCIATION OF SOCIAL WORKERS

The Chair (Mr. Shafiq Qaadri): I would now invite our first presenters to please come forward. Ms. Davies, the executive director of the Ontario Association of Social Workers, if you'd please come forward and be seated. If you do have any colleagues—and just the protocol for everyone else—please do introduce yourselves on an individual basis for the purposes of Hansard recording. We'll obviously be pleased to distribute your written materials.

Ms. Davies, I invite you to begin now.

Ms. Joan MacKenzie Davies: Thank you. Good afternoon. The Ontario Association of Social Workers, also known as OASW, appreciates this opportunity to participate in the public consultations related to Bill 179.

OASW is a bilingual, professional membership association for social workers in the province, and our mandate is to speak on behalf of the interests and concerns of the profession.

The issues I will be commenting on today relate to ensuring that appropriately qualified social workers can use the title "psychotherapist"; and removal of restrictions on use of the title "Doctor" by social workers with doctorates when providing health care services.

Firstly, I wish to state that OASW strongly supports the proposed amendment to the Social Work and Social Service Work Act, 1998, to add "psychotherapy" title as outlined in section 47.2, thus enabling social work members of the Ontario College of Social Workers and Social Service Workers who are authorized to perform the controlled act of psychotherapy to use the title "psychotherapist," either by using the restricted title "social worker" after "psychotherapist" or by identifying themselves as a member of our regulatory college.

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Additionally, we support the proposed amendment to the Regulated Health Professions Act, 1991, which grants similar access to the title "psychotherapist" to qualified members of the College of Nurses of Ontario, the College of Occupational Therapists of Ontario, the College of Physicians and Surgeons of Ontario and the College of Psychologists of Ontario. These amendments, we believe, serve the public interest by removing confusion on the part of the public about who is qualified to perform these services and, by assisting the public, identify the full range of professionals who have the requisite qualifications, training and skills to provide psychotherapy. Moreover, the amendments create an even playing field for the professions providing this service.

OASW also maintains that interprofessional collaboration and the public interest would be served by having representation from the existing regulatory colleges mentioned previously serve on the transitional council of the new college of psychotherapists and registered mental health therapists.

Additionally, OASW strongly encourages the standing committee to take this opportunity to expand access to use of the title "Doctor" by removing current restrictions on this title. The title "Doctor" is currently restricted to the following professions when delivering health care services: physicians, dentists, optometrists, chiropractors, psychologists and, more recently, naturopaths. All other professions with earned doctorates are denied use of this title when providing health care services in Ontario.

We believe that the proposed amendments to the RHPA and the Social Work and Social Service Work Act related to use of the title "psychotherapist" provide a useful template for broadening access to use of the title "Doctor" by members of regulated professions. We maintain that failure to recognize duly qualified social workers as doctors does not properly reflect the skill level of these health care providers.

With the growing trend across professions for professionals to seek advanced academic qualifications, thus transferring knowledge from clinical research to clinical practice, this outdated restriction casts Ontario as out of step with other jurisdictions, including other provinces in Canada, the United States, the United Kingdom, con-

tinental Europe, Australia and New Zealand. The restriction discourages social workers with doctorates from moving to Ontario from other jurisdictions and deprives the public of the important services they provide. Furthermore, it places Ontario at a significant disadvantage when attempting to attract highly qualified experts in the health care field.

The Health Professions Regulatory Advisory Council, HPRAC, after extensive consultations, stated in their report entitled Regulation of Health Professions in Ontario: New Directions, which was published in April 2006, that this issue "is a social, and not a health-related matter," and concluded that this restriction should be repealed.

I'd like to take this time to thank the standing committee for the opportunity to provide feedback on the issue of use of the title "psychotherapist" and our desire to see this committee take the opportunity to expand access to use of the title "Doctor" by regulated professionals so qualified when providing health care services. Thank you.

The Chair (Mr. Shafiq Qaadri): We have about a minute or so per side, beginning with the PC caucus. Ms. Elliott.

Mrs. Christine Elliott: I don't have any questions; it's very clear. Thank you very much for your presentation.

The Chair (Mr. Shafiq Qaadri): Thank you, Ms. Elliott. Madame Gélinas?

M^me^ France Gélinas: It's clear to me, too.

The Chair (Mr. Shafiq Qaadri): Thank you. To the government side. Mr. Balkissoon.

Mr. Bas Balkissoon: Thank you very much for your presentation. Can you just add a little bit as to how acquiring a doctor's title will really change the benefits to a patient?

Ms. Joan MacKenzie Davies: Well, as in use of the title "psychotherapist," currently it is only those professions which have access to the title "Doctor" that are able to indicate their advanced academic standing to clients they are serving and to the general public. All other professions who have earned doctorates are unable to reflect to the public what their advanced academic standing is, and we believe that this is discriminatory and really is not in the public interest.

Mr. Bas Balkissoon: Okay, thank you.

The Chair (Mr. Shafiq Qaadri): Thank you, Mr. Balkissoon, and thanks to you, Ms. Davies, for your presentation and presence today.

ONTARIO ASSOCIATION OF NATUROPATHIC DOCTORS

The Chair (Mr. Shafiq Qaadri): I would now invite our next presenters: Of the Ontario Association of Naturopathic Doctors, Ms. Dantas, CEO, and Ms. Baron, chair of the board. You are welcome. Please be seated. You've seen the protocol: 10 minutes in which to make your presentation. I would respectfully invite you to begin now.

Ms. Ruth Anne Baron: Good afternoon. My name is Ruth Anne Baron. I'm a naturopathic doctor and the past chair of the Ontario Association of Naturopathic Doctors. Joining me is Alison Dantas, the CEO of the association. The Ontario Association of Naturopathic Doctors is the professional association representing Ontario's registered NDs.

Our purpose for appearing here today is to communicate to this committee our recommendations for amendments to Bill 179. These amendments are specifically related to the Naturopathy Act in order to address shortcomings that will result in a loss of patient care if they're not made. These amendments also clearly support the goal of Bill 179 to ensure that our profession can deliver more health care services that we are already educated and competent to provide, improving patient access to primary care in the process. These amendments make sense and will not require funding from the government.

We've welcomed the opportunity to meet with many of you in recent weeks. We met with MPPs to show how naturopathic doctors are already contributing to a healthier Ontario. We also discussed the importance of removing barriers to our profession: working to the full extent of our qualifications. Our patients want this, and it's clear that, if permitted, naturopathic doctors will have the scope they need to address some of the largest challenges facing the health care system, using safe and effective natural therapies. Recent polling done by Innovative Research in 2006 shows that over 40% of Ontarians will seek a naturopathic doctor in the next few years, so it's clear that the people of Ontario want this.

We were pleased when HPRAC recommended needed changes to the Naturopathy Act but disappointed we were left out of this legislation despite HPRAC's very clear recommendations. We're here today to correct this situation and properly capture the full scope of practice of the profession under the Naturopathy Act.

If required amendments are not made to Bill 179, patients of naturopathic doctors will lose care they are currently able to receive from their ND under current legislation and the profession will fall further behind in the scope of practice of the profession in other regulated jurisdictions.

Our written submission provides much more detail on the seven years of extensive training required to become a naturopathic doctor, how we've been regulated in Ontario for over 80 years, and our unique approach to health care using natural therapies and natural substances. Ontario's 900 naturopathic doctors practise a unique and comprehensive form of medicine which helps our patients to live healthier lives and has resulted in a growing demand for our services.

The government committed to us, prior to the Naturopathy Act, that its goal was to ensure that we moved into the RHPA with our scope of practice intact. We remain focused on that objective as we prepare for the transition process to get under way. We'd appreciate your support

in making these needed changes, which will preserve our current scope of practice and the treatment options available to our patients. More detail on these required amendments, including specific wording of the amendments, is provided in our written submission.

I would like to summarize for you the amendments to the Naturopathy Act that naturopathic doctors are looking for through Bill 179 and to share why these are critical to the profession practising to their full training and expertise.

The first amendment we are seeking is to include the full controlled act of prescribing, dispensing, selling and compounding in the Naturopathy Act. First and foremost, this is about maintaining access to the natural substances that are essential to naturopathic practice. The problem is that more and more natural substances are being moved onto restricted schedules. This can be for good reasons, where patients shouldn't be self-diagnosing and self-medicating. However, without prescribing authority, preventing public access also prevents access for NDs and their patients. Some critical substances have already been lost, and this trend is expected to continue. Our patients are coming to us because we are the experts in the safe use of these natural substances. We have extensive training in their use and in avoiding interactions with other drugs.

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Without this controlled act, we will also lose the current exemption we now have to compound, dispense and sell when we move under the Naturopathy Act. HPRAC understands this and has recommended in three different reports that NDs be awarded the full controlled act to ensure ongoing access to substances that are integral to naturopathic medicine and allow naturopathic doctors to play a larger role in primary care. Prescribing authority has just been awarded to naturopathic doctors in British Columbia and is critical to the profession here in Ontario.

Next, I want to discuss diagnosis. This controlled act was awarded in the Naturopathy Act but it was done in a way that will pose a problem for patient care. The controlled act we were awarded is "communicating a naturopathic diagnosis," but this could create a misunderstanding that somehow our diagnosis is different from other professions, and that's just not true. Our training is to communicate the same kind of diagnosis as other professions. We have authority to communicate a diagnosis under our current legislation. Naturopathic doctors utilize the same ICD diagnostic codes used by other professions who provide a diagnosis, so there is really no difference in the diagnosis being provided to a patient. We want to make sure that the terminology does not create any misunderstanding between professions.

It would be a problem if the current wording of a controlled act created the impression that a diagnosis from a naturopathic doctor is somehow different than a medical diagnosis. Most importantly, this will create a new and potentially significant barrier to collaboration on behalf of our patients. HPRAC has recognized this problem and, as a result, recommended that the controlled act be changed from "communicating a naturopathic diagnosis" to simply "communicating a diagnosis."

The next amendment we are seeking is more certainty that naturopathic doctors will continue to be able to do in-clinic lab testing for their own patients. The authority that is supposed to exist, provided at the same time as the Naturopathy Act, is not very clear. What we are seeking is an exemption similar to the one that already exists for MDs doing testing for their own patients. As well, we will need authority to be able to send our blood work requests and other samples to Ontario laboratories rather than having to continue to send them out of province. Our written submission details the importance of access to lab testing for patient care, as well as our training to properly order and interpret these test results.

Similarly, we are seeking the authority to order diagnostic ultrasound for our patients. Again, this amendment was recommended by HPRAC. Naturopathic doctors clearly have the training, and the results are essential to provide a comprehensive diagnosis and to monitor the progress of the treatment. Right now, we have to send many patients to their MDs for simple diagnostic ultrasound, but this would be unnecessary if we could order the testing. There is no expectation that these tests will be funded by the health care system.

Finally, we're seeking that a change to the name of our future regulatory college should be in place. Calling it the College of Naturopaths of Ontario creates potential confusion because the initials "CNO" are the same as the College of Nurses of Ontario. As well, the profession is known as naturopathic doctors by patients and the public, and this is the designation assigned to the profession under the Naturopathy Act. We believe, as a result, that the name should be changed to the CNDO.

We believe that our amendments will strengthen Bill 179, increase the contribution we can make to the health care system and enhance our ability to provide safe and effective patient care. Our written submission includes more details and proposed wording.

Thank you for the opportunity to present to this committee today. I want to thank members of all three parties for the support you've shown naturopathic medicine over the years. I'd welcome the chance to answer any questions you may have.

The Chair (Mr. Shafiq Qaadri): We really have 20 seconds per side. Madame Gélinas?

M^me^ France Gélinas: I go first? I was surprised to see here that for ordering diagnostic ultrasounds, you said "no expectation that these tests will be funded by the health care system." You would use the private labs but have the patient pay for them?

Ms. Ruth Anne Baron: Yes, that would be the understanding.

The Acting Chair (Mr. Shafiq Qaadri): With apologies, I will have to intervene; really, 20 seconds, please. Government side, Mr. Balkissoon.

Interjection.

The Chair (Mr. Shafiq Qaadri): Thank you. To the PC side, Ms. Witmer.

Mrs. Elizabeth Witmer: Thank you so much. What would you see as your most pressing amendment?

Ms. Ruth Anne Baron: I think the controlled act of prescribing is the most pressing amendment.

The Chair (Mr. Shafiq Qaadri): Thank you, Ms. Witmer, and thanks to you, Ms. Dantas and Ms. Baron, for your deputation on behalf of the Ontario Association of Naturopathic Doctors.

COLLEGE OF MIDWIVES OF ONTARIO

The Chair (Mr. Shafiq Qaadri): I would now invite our next presenter, Ms. Adams, the registrar and CEO of the College of Midwives of Ontario, and colleagues. As I've mentioned, please do introduce yourselves individually, as we directly attribute remarks in the recording of Hansard. I'll just give you a moment to settle.

I'd invite you to officially begin now.

Ms. Deborah Adams: Thank you for this opportunity to appear before the committee today. I'm Deborah Adams, registrar of the College of Midwives of Ontario. With me are Robin Kilpatrick, our deputy registrar and a former midwife who actually participated in drafting the legislation that saw midwives regulated, as well as Julie Maciura, our legal counsel.

We intend today to focus our presentation on the midwifery-specific amendments, but I would like to note that we identified issues with the more general amendments in our written submission. I'd also like to note that we are signatories on the Federation of Health Regulatory Colleges of Ontario's submission and our views are represented there.

While the college very much supports the bill, we do feel strongly that it hasn't gone far enough to achieve its stated goals of supporting the province's health human resource strategy, developing much-needed new health care provider roles or enabling health professionals to work to their full scope of practice. There's an increasingly acute shortage of maternity care providers in this province and this bill affords us the opportunity to take significant steps towards addressing this growing scarcity of resources. Without amendments, though, Bill 179 will not have the hoped-for results for the people of Ontario, particularly for women who choose or who would like to be able to choose midwifery.

The first piece of the bill that we'd like to bring to the committee's specific attention is the proposed amendment to the Laboratory and Specimen Collection Centre Licensing Act. The bill proposes an amendment that will exclude a place where a dietitian provides services. The same exclusion for midwives, who provide a significant amount of care to women in their homes, would provide clear legislative authority for important point-of-care access for midwifery clients. This access supports the safety of continuity of care and is a more efficient use of the health system, since it provides one-stop shopping for women who can have tests done in their home by their primary care provider.

Ms. Robin Kilpatrick: Our college has been advocating for changes to the regulation-making process—

The Chair (Mr. Shafiq Qaadri): I'd invite you to introduce yourself, please.

Ms. Robin Kilpatrick: I'm sorry. I'm Robin Kilpatrick, the deputy registrar for the College of Midwives of Ontario.

Our college has been advocating for changes to the regulation-making process, particularly with respect to drug regulations, for the past five years. In 2004, one of the only two medications midwives were authorized to use to treat post-partum hemorrhage became unavailable in Canada. This shortage put the public at risk because midwives had no independent access to a second-line medication, should the first prove ineffective. We worked with the ministry to expedite an amendment to add another medication to the midwifery drug regulation. This took one year. This emergency situation highlighted for us the need for a more responsive and timely process with respect to regulations.

While we acknowledge that amendments have been proposed to alter the regulation-making process with respect to drugs, we remain concerned that this process will not improve sufficiently.

The amendment-making process must enable midwives to access the most effective medications as they become available. For this reason, in our submission, we proposed a framework that would allow midwives to prescribe and use classes or categories of drugs, rather than a limited list. This will allow midwives to provide the safest care according to the accepted standard of care, and provides options when availability is an issue. We are not convinced or confident that the proposed changes will deliver, and would ask that this piece of the legislation be reviewed with the goal of ensuring that it provides the needed degree of responsiveness.

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Every woman in Ontario, regardless of her care provider, choice of birthplace, or geographic location is entitled—and should expect—access to the same quality and safety of maternity services. The current midwifery scope of practice does not authorize midwives to work to their full competency or to provide the full complement of services that should be available through a primary maternity care provider. In effect, the restrictive scope of midwifery practice denies this entitlement to women who choose to receive care from a midwife in Ontario.

We have proposed amendments to create an extended class of midwife who can provide care that is not currently available in many underserviced communities.

The limited amendments that have been proposed to the Midwifery Act, such as communicating a diagnosis and the controlled act of intubation, will support midwives in their role as primary maternity care providers. However, there are a number of other areas of the scope of practice that also need to be amended in order to create the best-case scenario for women by allowing midwives to meet the primary care needs of their communities, to have access to the most up-to-date best clinical practices and to bring the regulation of midwifery in line with the other provinces where the profession is regulated.

We thank you very much for the opportunity to make this submission to the committee. We look forward to working with you to enhance public safety for women in this province. We'd be pleased to answer any questions you might have.

The Chair (Mr. Shafiq Qaadri): Thank you. We have about 90 seconds per side, beginning with Mr. Balkissoon of the government.

Mr. Bas Balkissoon: I'll pass, Mr. Chair.

The Chair (Mr. Shafiq Qaadri): Thank you, Mr. Balkissoon. To the PC side, Ms. Elliott.

Mrs. Christine Elliott: Just a quick question: Do you have any specific recommendations with respect to these amendments that you've sent around. I just don't see them in your presentation.

Ms. Deborah Adams: Related to the scope of practice?

Mrs. Christine Elliott: Well, the several issues that you've raised.

Ms. Deborah Adams: Related to the scope of practice, in our submission to HPRAC and also in our written submission we highlighted the need for an extended class of midwife to provide services in underserviced communities, and also specific changes to both the process for amending the drug regulation and access to classes and categories of drugs for midwives, as opposed to a prescriptive list.

The Chair (Mr. Shafiq Qaadri): Thank you, Ms. Elliott. Madame Gélinas.

M^me^ France Gélinas: I have reviewed quite a few and already I'm a little bit confused, so I just want to make sure—when HPRAC did your review, did they put forward this idea that you could prescribe within classes of medication, or is this something that is new?

Ms. Deborah Adams: We've been asking for classes and categories for some time and HPRAC in fact did support the idea of classes and categories for midwives in their response.

M^me^ France Gélinas: So in their response, they supported it and then when the ministry put the bill forward, it got dropped again?

Ms. Deborah Adams: Correct.

M^me^ France Gélinas: Okay, thank you.

The Chair (Mr. Shafiq Qaadri): Thank you, Madame Gélinas, and thanks to you, Ms. Adams and Ms. Kilpatrick and your colleague, from the College of Midwives of Ontario.

INDEPENDENT PHARMACISTS OF ONTARIO

The Chair (Mr. Shafiq Qaadri): I would now invite our next presenters to please come forward, representing the Independent Pharmacists of Ontario. Welcome. We'll be pleased to distribute that for you. I'd invite you to begin now.

Ms. Tina Langlois: Good afternoon, ladies and gentlemen of the committee. My name is Tina Langlois and I appear before you on behalf of the Independent Pharmacists of Ontario. First of all, I bring greetings from Mr. Ben Shenouda, who unfortunately was unable to be here. He's the president of IPO and would like to have attended, but unfortunately, time did not allow.

IPO is pleased to have an opportunity to make a submission regarding Bill 179. Generally speaking, IPO is very supportive of the thrust of Bill 179 but has two specific concerns that it wishes to address to the committee today. One is related to the proposed amendments to the Drug and Pharmacies Regulation Act which would allow remote dispensing, and the other related to the amendments to the Ontario Drug Benefit Act, which propose to allow for different classes of pharmacies as it relates to markups and dispensing fees.

First of all, to tell you a little bit about who IPO is, IPO is a non-profit organization that was created to represent and advocate on behalf of Ontario's independent pharmacists. Independent pharmacies make up about 40% of the pharmacies in Ontario. They are often family-owned and tend to be prescription-focused. These independent pharmacies provide quality, accessible, community-based patient care to patients across the province, particularly in those areas that are underserviced by primary health care providers.

The IPO believes strongly that every patient in Ontario is entitled to quality pharmacy care, which they believe includes access to a professional pharmacist who is aware of their health condition and concerns, who has a relationship with their physician or physicians and can evaluate and monitor their medication profile and provide them with information and recommendations.

The IPO fears that unless Bill 179 is amended, some patients in the province may in fact be denied access to this vital pharmacy care and will instead be subject to fragmented, less-than-optimal service that will negatively impact their health and eventually increase the costs to the overall health care system.

As I said before, the IPO is generally very supportive of the thrust of Bill 179, particularly as it relates to expanding the role of health professionals, making the highest and best use of each health professional within the system. The IPO is particularly pleased to see that the role of pharmacists is expanding through Bill 179 and that pharmacy technicians will be regulated through this bill as well. We are, however, concerned about two specific aspects of the bill, which I will now detail.

Section 8 of Bill 179 proposes to make amendments to the Drug and Pharmacies Regulation Act to allow for remote dispensing. It should be noted that at this point in time in Ontario, in order to dispense prescriptions, a pharmacy must have a pharmacist present. The IPO believes that this safeguard is important to ensure patient care and patient safety. Unfortunately, there is no definition in Bill 179 about what exactly remote dispensing will involve or what kind of remote dispensing will be permitted. However, the IPO is aware that there are drug dispensing machines in existence that have been piloted in places in the province, and it is with regard to these machines that we are particularly concerned. Needless to say, professional pharmacists are somewhat shocked that

in a province that banned the dispensing of cigarettes from vending machines, any proposal would be put forward to dispense prescription medications in this fashion.

The proposed amendments were introduced very quickly, with very little consultation and, in our opinion, research. The IPO is not aware of any shortage of pharmacies in the province that would lead to a pressing need for remote dispensing. However, if such a need is shown to exist, we believe that it would be infinitely more appropriate to establish satellite dispensing locations that are under the direct supervision of an accredited pharmacist and hopefully under the direct supervision of a regulated health care professional, perhaps a regulated pharmacy technician, for instance. We would suggest that further study of remote dispensing is required before making what we believe is a fairly drastic move in terms of the distribution of prescription medication. We would encourage the research to include the experience of other jurisdictions that currently permit remote dispensing and any concerns or patient safety issues that have arisen in those jurisdictions.

The IPO is very concerned that the proposed amendments contain very little substantive information, with most of the detail proposed to be set out in regulation to be developed at a future date. As you know, regulations are not developed with the type of openness and consultative process that amendments to legislation are, and this causes us some concern. If remote dispensing is in fact to be contemplated, the specifics need to be clearly set out in legislation, particularly those elements that are important to ensure patient safety and public protection. The IPO feels that there is just too little detail in the proposed amendments to provide comfort and too many opportunities for unintended negative consequence to occur as a result of these amendments.

Pharmacists take their profession and their professionalism very, very seriously. The IPO does not believe that drug dispensing machines reflect the values of professional pharmacists or, frankly, those of the health care system as it's been transformed, namely interprofessional collaboration and patient-centred care. Bill 179 seeks to expand the role of many health care professionals, granting prescribing authority for the first time to some and expanding the prescribing authority of others. The IPO believes that at a time when we are expanding prescriptive authority for more health care professionals, the role of pharmacists becomes even more important in the overall health care team.

Pharmacy in general as a profession has evolved a great deal in terms of cognitive patient care, and frankly, the IPO believes that automated drug dispensing machines are a step backwards. The relationship between patient and pharmacist is an important one to the overall health of a patient and it should be encouraged and nurtured, not fragmented.

Remote dispensing is, in our opinion, no substitute for traditional pharmaceutical care and can provide only partial service at best. As you might imagine, a machine cannot possibly hold all the various amounts, dosages, dosage forms etc. that a patient might require. There will be a selection, probably of the most popular. Unfortunately, this means that patients who avail themselves of these machines will also have to have another, separate relationship with a pharmacist in order to obtain these other medications, or in fact obtain any compounded medication. Patients have long been encouraged to establish a relationship with one pharmacy in order to improve their overall health care. We believe that this remote dispensing framework will not allow patients to in fact do that.

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The machines will also not give patients access to over-the-counter medication or, frankly, the valuable advice and recommendations that pharmacists make every day that are in no way associated with the sale of a drug or the dispensing of a prescription.

The IPO is concerned that allowing remote dispensing without further detail or research will dilute and fragment patient care and may negatively impact patient health and safety. We're simply not convinced that this type of dispensing arrangement is necessary or in fact prudent at this time.

It's important to remember the role that face-to-face patient-pharmacist interaction plays in determining whether or not a medication is appropriate for a patient. The way a patient presents, their demeanour, their mobility, their ability to speak, the manner in which they hold themselves: all are clues that pharmacists use every day to determine the appropriateness of medication. The IPO is concerned that video interface, assuming that it is even required—because we're not clear whether that would be required—and working correctly, simply will not permit the same level of interaction and connection between the patient and pharmacist, and that patient care will suffer as a result.

Finally, we are concerned that by promoting machines instead of health care professionals within communities, we are in fact fragmenting and diluting the care that is provided across the province.

If remote dispensing is in fact deemed necessary, it should only be permitted in areas where there are currently no community pharmacies and should be discontinued if a community pharmacy is opened, this just reflecting the fact that a community pharmacy with a health professional available to serve the members of that community is far preferable to a machine that dispenses prescriptions.

The Chair (Mr. Shafiq Qaadri): You have 30 seconds left, Ms. Langlois.

Ms. Tina Langlois: I'm sorry. If I could just move, then, to the amendments to the Ontario Drug Benefit Act: We are specifically concerned about section 19, which proposes that regulations could be brought in to designate classes of pharmacies or pharmacy operations. We are concerned that there should only be one class of pharmacy in Ontario serving the patients of Ontario, and that is first-class. Therefore, we would recommend that these amendments be removed from the legislation.

I would encourage the committee to view the IPO's YouTube video which is linked to this submission and which sets out our concerns in greater detail.

The Chair (Mr. Shafiq Qaadri): Thank you very much, Ms. Langlois, for your presentation on behalf of the Independent Pharmacists of Ontario.

BOARD OF DIRECTORS OF DRUGLESS THERAPY—NATUROPATHY

The Chair (Mr. Shafiq Qaadri): I'd now invite our next presenter, Ms. Moore, executive director of the Board of Directors of Drugless Therapy—Naturopathy. If you are present, yourself and colleagues, I'd invite you to please come forward. If you have any written materials for distribution, we'll be happy to do that as well. As mentioned, please do identify yourselves for the purposes of Hansard recording. I invite you to begin now.

Ms. Angela Moore: Thank you, Chair. My name is Angela Moore. I'm a naturopathic doctor and the executive director for the Board of Directors of Drugless Therapy—Naturopathy, the regulatory board for the profession in Ontario. With me, from Port Hope, is board member Mary-Ellen McKenna, also a naturopathic doctor.

We very much appreciate the opportunity to appear before the committee. I'll be as brief and concise as I can. Our written submission with the details of our response to Bill 179 and our proposal with respect to section 17 has been provided to the committee clerk.

By way of background, there are nearly 1,000 naturopathic doctors who have met the requirements to practise in Ontario and who are currently registered with the board. Nearly all are graduates of the four-year program offered by the Canadian College of Naturopathic Medicine, located at Sheppard and Leslie in Toronto. Most also have an undergraduate degree in the sciences.

Our profession is in transition. Naturopathic doctors have been regulated in Ontario since the 1920s, first under the Medicine Act and subsequently under the Drugless Practitioners Act. In 2007, legislation was passed that will move regulation of the profession to the RHPA. We understand that the transitional council will soon begin work on the foundational regulations, bylaws and standards of practice that will enable the college of naturopathy to take over regulation of the profession. We expect the transition to the RHPA and the opening of the new college to take 18 to 24 months. Throughout the transitional period, the Board of Directors of Drugless Therapy—Naturopathy will continue to regulate naturopathic doctors under the Drugless Practitioners Act as before.

The ministry has already introduced one amendment to the Naturopathy Act in section 17 of Bill 179. It closes a gap that posed a significant concern for the board. This amendment ensures that the new college will be able to investigate and prosecute complaints that relate to conduct that occurred prior to proclamation while the practitioner was registered with the board, but that only came to light after proclamation. This amendment is clearly very important to protect the public interest. We are grateful to the ministry for introducing it and we urge the committee to support it as well in order to ensure seamless and effective regulation of the profession during the transition.

We were particularly anxious to appear before the committee, however, because we believe an additional amendment to the Naturopathy Act is critically important to the public interest. The OAND has already spoken to this as well. We ask for an amendment that authorizes naturopathic doctors to perform the RHPA-controlled act of prescribing, dispensing, selling or compounding a drug as defined in subsection 117(1) of the Drug and Pharmacies Regulation Act. We need access to this controlled act in order to maintain—and I emphasize maintain, not expand—the naturopathic scope of practice as practised historically under the Drugless Practitioners Act, and thereby continue to provide patients with the same treatments they have had and expect to continue to have from their NDs.

This may prompt the question, why would naturopathic doctors who have been regulated under the Drugless Practitioners Act need to prescribe drugs? A full discussion can be found in our written submission. The simple explanation, though, is this: Over the past several years, the federal government has moved a number of natural substances that were obtained over the counter on recommendation by a naturopathic doctor to restricted schedules that now require a prescription. This includes substances NDs are uniquely qualified to use, such as vitamins A, D and niacin over certain daily dosages and higher-risk botanical medicines such as rauwolfia and colchicum. We expect that this trend will continue and we actually support it because it ensures that only those who are competent to use these substances have access to them. Access to these substances by health care practitioners now requires prescribing authority under provincial legislation; hence our request for access to the "prescribing" controlled act.

I thought it was important to mention also that our request does not seem to be particularly controversial. Access to the controlled act has been recommended by HPRAC twice. We have consulted with a number of other professions and with the Ontario Medical Association, all of whom have indicated they do not oppose our request. We don't know of any stakeholder who has raised concerns about it. It is also our understanding that the Ministry of Health and Long-Term Care has come to recognize that access to the controlled act is really the only way to address the problem I've described, and that the ministry and other stakeholders have come to appreciate this fully.

Accordingly, we ask for the addition of the controlled act of prescribing, dispensing, selling or compounding in the Naturopathy Act, as detailed and explained in our written submission, to ensure continuity of the scope of practice of the naturopathic profession in Ontario.

Finally, we're also asking for this committee to use Bill 179 to correct an anomaly in the Naturopathy Act,

2007. This correction was also recommended by HPRAC. It relates to authorized act 5 in subsection 4(1) of the act, relating to communicating a diagnosis. We're asking for the removal of the adjective "naturopathic" before "diagnosis" and also removal of the phrase "that uses naturopathic techniques."

The purpose of these amendments is to put our profession on the same basis as other professions that are authorized to perform this particular controlled act and also to remove the risk that the current wording would be interpreted as being more limited or limiting than what NDs currently do in terms of diagnosis.

Thank you for your attention. I welcome your questions.

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The Chair (Mr. Shafiq Qaadri): Thank you, Ms. Moore. About a minute per side, beginning with Madame Gélinas.

M^me^ France Gélinas: When HPRAC made its recommendation toward the prescribing, was it open prescribing or was it limited to classes? I can't see an ND ever prescribing a narcotic, but am I wrong?

Ms. Angela Moore: HPRAC's recommendations in terms of prescribing were to classes and categories and to a specific list of additional substances. The board at this point is only asking for access to substances that would maintain the existing scope of practice, so that would be those kinds of substances that NDs have always prescribed for patients that have been moved to restricted lists.

M^me^ France Gélinas: But that's not what you have in your recommendation. Your recommendation makes it look like open prescribing; you have "prescribing, dispensing, selling...."

Ms. Angela Moore: The wording would include—sorry, I can't remember specifically. It's in the written submission, but it would be as set out in regulation.

The Chair (Mr. Shafiq Qaadri): Thank you, Madame Gélinas. To the government side, Mr. Balkissoon.

Mr. Bas Balkissoon: Just to carry on, if we were to grant you what you're requesting, would there be more training required by the people who hold your designation today?

Ms. Angela Moore: No, there would not be. And it would be as set out in regulations, so there would be specific substances that NDs would have access to. There are things that they already are trained and educated to use.

The Chair (Mr. Shafiq Qaadri): Thanks, Mr. Balkissoon. To the PC side, Ms. Witmer.

Mrs. Elizabeth Witmer: Yes, just to continue, based on the question asked by Ms. Gélinas regarding the prescribing of drugs, you've got in here, "prescribing, dispensing, selling or compounding a drug as defined in the Drug and Pharmacies Regulation Act"?

Ms. Angela Moore: Yes, and it should also say, "as prescribed in regulation." I think that's the answer to the question you asked.

Mrs. Elizabeth Witmer: So that would be specific.

Ms. Angela Moore: Yes.

Mrs. Elizabeth Witmer: Yes, okay.

The Chair (Mr. Shafiq Qaadri): Thank you, Mrs. Witmer, and thanks to you, Ms. Moore and your colleague, on behalf of the Board of Directors of Drugless Therapy—Naturopathy.

ONTARIO PHYSIOTHERAPY ASSOCIATION

The Chair (Mr. Shafiq Qaadri): I would now invite our next presenter, Madame Sauvé, CEO of the Ontario Physiotherapy Association. I invite you to please come forward. If you have materials for distribution, our clerk will be happy to distribute those. Thank you. I'd invite you to please begin.

Ms. Dorianne Sauvé: My name is Dorianne Sauvé and I'm the CEO of the Ontario Physiotherapy Association. I am also a registered physiotherapist and have practised in many different settings during my career, but I've been working in policy and administration for the last several years.

The Ontario Physiotherapy Association is a voluntary professional association representing over 4,800 physiotherapists practising in Ontario today and physiotherapy students at all five university physiotherapy programs in the province. There are close to 7,000 registered physiotherapists in practice today in Ontario.

Physiotherapy is one of the few health care professions that are found in almost every sector or stream of health care delivery. You will find physiotherapists in hospitals, community health centres, in home care, in long-term care and retirement homes, in private clinics, in industry and educational institutions. Physiotherapy is funded in the publicly funded system, including CCACs, by the WSIB, in auto insurance, extended health benefit plans and private pay.

Section 22 of Bill 179 contains a number of amendments to the Physiotherapy Act to update the physiotherapy statutory scope of practice and add six additional authorities, including five new authorized acts, as recommended by the Health Professions Regulatory Advisory Council. Ontario physiotherapists very much support these amendments as positive steps forward to allowing physiotherapists to contribute up to their full competencies in an interprofessional, collaborative health system.

These amendments are a result of a long process that in many respects goes back to the original drafting of the Physiotherapy Act, 1991. We appreciate the support of Minister Caplan, his ministry and HPRAC in initiating these amendments, and we are gratified by the support that has come from other health care associations, regulatory colleges and, from the front lines, our colleagues in other health care professions.

Our written submission explains the background and rationale for the physiotherapist's access to these additional authorized acts and explains how they will be performed by those physiotherapists who are acknowledged by the College of Physiotherapists of Ontario as having the competencies necessary to perform them. I'd

be pleased to answer any questions you may have about that.

The Chair (Mr. Shafiq Qaadri): Thank you, Ms. Sauvé.

Ms. Dorianne Sauvé: Oh, I'm not done.

The Chair (Mr. Shafiq Qaadri): Okay.

Ms. Dorianne Sauvé: That was a pause. Sorry.

My purpose in asking to appear before the committee—this is the good part—however, is to ask for an amendment to the current draft of Bill 179. That amendment is to correct what we believe to be a drafting error, but that drafting error effectively neutralizes the amendment it's designed to achieve. I'm referring to the proposed new subsection 4(3), which refers back to the new authorized act number 7, administering a substance by inhalation.

Currently, physiotherapists are often called upon to administer oxygen during the performance of one of our existing authorized acts, namely tracheal suctioning. During the performance of tracheal suctioning, physiotherapists often have to adjust the level of oxygen being administered to maintain oxygen saturation during the procedure. Oxygen and other substances administered by inhalation, such as ventolin, are often required during physiotherapy assessment and treatment of patients with cardiorespiratory impairments where substances have already been prescribed for these clients. The act of administering them by inhalation is an entry-level competence for physiotherapists across Canada.

Despite this, under the current legislative regime, physiotherapists may perform this act by virtue of a medical directive or some other form of delegation from a physician or another authorized profession. The amendments in Bill 179 are designed to allow the physiotherapist to administer oxygen or another substance by inhalation where there is an order analogous to a prescription from a physician or another authorized profession. The problem is, under the current wording in subsection 4(3), the order applies to the member, namely the physiotherapist, and not to the procedure of administering oxygen or another substance by inhalation. This represents no change over the current status quo. This type of order is no different from a medical directive or delegation under which physiotherapists currently do this act.

The order should apply to the procedure, not to the member, and our written submission provides wording to this effect. You will find that on page 5 of our written submission, which has been distributed to you today.

It is our understanding from consultations with the ministry that our proposed wording reflects the ministry's intent. It's simple, and what appears to be a subtle change, but it's important to the profession and to effective and efficient health care delivery. As I said, the current wording represents continuation of the status quo.

Chair, this actually does conclude my prepared remarks, and I'd be happy to respond to any questions or comments.

The Chair (Mr. Shafiq Qaadri): Thank you, Madame Sauvé. There are about 90 seconds per side, beginning with the government. Mr. Balkissoon.

Mr. Bas Balkissoon: Would you say that this one technical problem is the most important issue to your organization?

Ms. Dorianne Sauvé: In terms of the section relating to physiotherapy, absolutely.

Mr. Bas Balkissoon: Okay. Thank you very much.

The Chair (Mr. Shafiq Qaadri): From the PC side?

Mrs. Elizabeth Witmer: We're happy.

The Chair (Mr. Shafiq Qaadri): To the NDP, Madame Gélinas.

M^me^ France Gélinas: I understand the change clearly, and we'll make sure we put it forward for you.

Ms. Dorianne Sauvé: Thank you very much.

The Chair (Mr. Shafiq Qaadri): Thank you, Madame Sauvé, for your deputation on behalf of the Ontario Physiotherapy Association.

NURSE PRACTITIONERS' ASSOCIATION OF ONTARIO

The Chair (Mr. Shafiq Qaadri): I now invite our next presenter, on behalf of the Nurse Practitioners' Association of Ontario, Ms. Hurlock-Chorostecki, president. Welcome, and I invite you to please begin.

Ms. Tina Hurlock-Chorostecki: Good afternoon. My name is Tina Hurlock-Chorostecki, and I'm a practising adult nurse practitioner. Today I am speaking to you as the president of the Nurse Practitioners' Association of Ontario, NPAO.

On behalf of almost 1,400 nurse practitioners, we thank the committee for the opportunity to speak to the proposed Bill 179. To provide the committee with an opportunity to ask questions, I plan to share key messages only. Our detailed paper for the committee will provide more context for comments made here today.

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We commend the government for the significant changes proposed in Bill 179, especially in regard to the removal of legislative barriers to NP practice.

NPAO's position on the need to expand the authority of nurse practitioners to open prescribing remains unchanged and is supported by an extensive body of literature and interjurisdictional reviews. As nurse practitioners, we practise within the context of the health care system. That system today is challenged with issues of access to care, wait-lists and an increasing burden of chronic disease, coupled with looming health human resource shortages and interprovincial labour mobility pressures.

The need to support an efficient and effective use of resources is paramount if we're to sustain our health care system. Legislative change for prescribing in the proposed Bill 179 is a step in the right direction, but is an insufficient response to the real problems for Ontarians and the health care system.

NPs are the most extensively researched health care provider role in history. This published literature of more than 1,200 papers includes numerous descriptive studies and about a dozen randomized control trials, many of

which have been conducted by Dr. Alba DiCenso of McMaster University. For most medical researchers, one randomized control trial is considered sufficiently strong evidence to change practice. For nurse practitioners, researchers have provided an overwhelming body of evidence describing safe practice in a number of clinical settings. No studies have demonstrated harm. No other single health professional group can claim such a strong body of evidence of safety and efficacy.

In most other Canadian and international jurisdictions, nurse practitioners have full authority to prescribe. In others, there are limited restrictions. In the US, 48 states have open prescribing for nurse practitioners. In the United Kingdom, general class nurses, not nurse practitioners, can take additional education and be regulated as a prescriber with access to the entire national formulary.

So why must Ontario go further? Let me give you five reasons:

(1) To expand the authority of nurse practitioners to open prescribing is not leading-edge and does not break new ground. It's based on solid evidence, national NP standards, existing regulatory approaches and almost 30 years of Canadian experience.

(2) Since the HPRAC review, other jurisdictions have continued to move forward with open prescribing for nurse practitioners. Nova Scotia is the seventh of 11 provinces and territories that regulate NPs to move to open prescribing.

(3) There is one national standard of NP education and practice and one national standard of NP entry-to-practice examinations in Canada.

(4) There's a strong rationale for a national scope of practice so the public and other providers are no longer confused about the NP role.

(5) Finally, labour mobility requirements under the federal agreement on internal trade justify a national practice scope to support patient safety and interprofessional care.

What will opening up prescribing do? It will simply bring Ontario up to meet the bar, not set the bar, in improving access to care and reducing wait times. It will make the system more efficient and effective and will retain health human resources within Ontario. It will not harm; there's no evidence of increased risk. There is plentiful evidence of increased benefit to patients, providers and the health care system.

There are other aspects needed to bring Ontario NPs in step with other jurisdictions, and these you will be able to find in our written submission.

I'd like to leave you with a final message: no Ontarian left waiting for a national standard of care, and no Ontario NP left behind. Thank you.

The Chair (Mr. Shafiq Qaadri): Thank you very much, Ms. Hurlock-Chorostecki. I'd now invite the PC side to begin: up to 90 seconds per side.

Mrs. Elizabeth Witmer: Thank you very much for your presentation. I'd just like to ask you, how does open prescribing impact access and wait times in Ontario's health care system?

Ms. Tina Hurlock-Chorostecki: Open prescribing for nurse practitioners will enable the right treatment for the right patient at the right time. Open prescribing for nurse practitioners in Bill 179 alone enables two thirds of Ontario NPs to impact access to care, and when coupled with a change to regulation 965 of the Public Hospitals Act, it will authorize nurse practitioners to treat hospital in-patients. Only then will all Ontarians be able to receive timely care.

The Chair (Mr. Shafiq Qaadri): Thank you, Ms. Witmer. Madame Gélinas.

M^me^ France Gélinas: Right now, NPs are limited to prescribing from a list. Can you talk to us about some of the problems with the present system?

Ms. Tina Hurlock-Chorostecki: I could give you an example of a problem with the present way that we are prescribing. Because of the list approach that nurse practitioners are currently restricted to, we don't know if we're going to be able to prescribe the vaccine for the H1N1 flu. It will all depend on the name that is given to that particular vaccine. If it's called "influenza vaccine," we're able to prescribe that. If it's called something else, as simple as H1N1, it will not be on our list and we will not be able to prescribe, but nurse practitioners in other provinces will.

In addition to that, when you look at the expert panel, it would not likely get approved and placed on the list in a timely manner to actually affect what was going to be happening this fall. I suggest government might consider looking at that issue today.

It also highlights that whole importance of the regulation tying to the open prescribing in the bill that in regulation 965 we need to have all nurse practitioners prescribing the H1N1 vaccine. I myself work in a hospital and would not be able to prescribe that particular medication for my patients.

The Chair (Mr. Shafiq Qaadri): To the government side. Mr. Balkissoon.

Mr. Bas Balkissoon: Thank you very much for your presentation. In your request for open prescribing, would the nurse practitioners in Ontario require further education?

Ms. Tina Hurlock-Chorostecki: No.

Mr. Bas Balkissoon: What about insurance risk protection? Would they require additional?

Ms. Tina Hurlock-Chorostecki: We have appropriate insurance currently.

Mr. Bas Balkissoon: And it will cover this extended scope of practice?

Ms. Tina Hurlock-Chorostecki: It will. There have been with the Canadian Nurses Protective Society, which is the organization that has the liability insurance for nurse practitioners, no claims to date against nurse practitioners, and they say that we are covered with an appropriate amount of liability insurance currently.

Mr. Bas Balkissoon: Thank you very much.

The Chair (Mr. Shafiq Qaadri): Thank you, Ms. Hurlock-Chorostecki, for your deputation on behalf of the Nurse Practitioners' Association of Ontario.

COLLEGE OF DENTAL HYGIENISTS OF ONTARIO

The Chair (Mr. Shafiq Qaadri): I'd now invite Ms. Richardson, registrar of the College of Dental Hygienists of Ontario. Welcome, and we'll distribute that for you. I'd like to you to, please, officially begin now.

Ms. Fran Richardson: Thank you, Mr. Chair. My name is Fran Richardson, and I'm the registrar/CAO of the College of Dental Hygienists of Ontario, which is the statutory regulatory body for the over 10,000 dental hygienists who practise today in this province.

"Pain" is an ugly word, and so is "disease." The most common disease in the world occurs in the mouth. Nearly everyone has some form of periodontal or gum disease. The good news is that both gum disease and tooth decay are preventable.

The college that I represent regulates those members of the health care family who are dedicated to the prevention of oral disease. However, if gum disease has been allowed to progress, then treating that condition may be painful. In today's world, with modern health care and modern drugs, there is no reason why anyone should have to suffer pain when they get their teeth cleaned.

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Pain management and pain control are important components of health care. Dental hygienists are integral members of the health care team, and the patients/clients we serve deserve to have access to modern methods of pain control.

Local anaesthesia—or freezing, as most people will call it—is safely administered daily by thousands of dental hygienists in western Canada, but not in Ontario; by tens of thousands of dental hygienists in the United States, but not in Ontario; by thousands of dental hygienists in Europe and in other parts of the world, but not in Ontario. For some unexplained reason, the public of Ontario has been denied modern pain management when receiving periodontal therapy or teeth cleaning. Dental hygienists educated in Ontario move west, successfully complete a local anaesthesia course, practise out west, return to Ontario and then are told, "No, not in this province." There is no logic to this situation.

Two years ago, the then Minister of Health and Long-Term Care, George Smitherman, had the foresight to propose amendments to the Dental Hygiene Act so that the public could have direct access to preventive oral health care. Those amendments were approved by the Legislature, and the accompanying regulations were put in place by cabinet in September 2007. There are now many, many Ontarians who have the dental hygienist come to them in their homes, in their residences or in their long-term-care facilities. More people than ever have an increased quality of life because their mouth is clean, thereby enabling them to eat, to smile and to laugh. These people deserve to have a pain-free experience.

So what is our request? Our request is that, through Bill 179, the Dental Hygiene Act be amended to grant dental hygienists access to the controlled act of administering a substance by injection, supported by a CDHO-specific standard of practice relating to the administration of local anaesthesia that would come into force when the regulations are approved. We have that standard already drafted in the written submission to you.

What will the college do if you grant this to us? Well, we will ensure that we will enact a professional misconduct regulation prohibiting a CDHO registrant from administering local anaesthetics without certification form the college, and that is already drafted as well. We will provide certificates of authorization to those so certified and require that that certificate be displayed in the registrant's place of practice. We will also initiate a pilot project with selected accredited dental hygiene programs in Ontario, in which the administration of local anaesthesia would be included in their curricula with defined outcomes. We will collaborate on that aforementioned project with two faculties of dentistry, the one at the University of Toronto and the University of Western Ontario's Schulich School of Medicine and Dentistry and/or the University of Manitoba's School of Dental Hygiene, to develop that Ontario curriculum. We will include contraindications to the use of local anaesthesia and the product monographs on the CDHO website, and we will provide information on our Knowledge Network on the CDHO website. Lastly, we will initiate, in conjunction with the Ministry of Health and Long-Term Care and the Ministry of Training, Colleges and Universities, a research project which includes dental hygienists and members of the public in the use and acceptance of the administration of local anaesthesia by dental hygienists in Ontario.

The CDHO has provided you with a detailed written submission that includes back-up material, including statistics indicating the safety of the administration of local anaesthesia by dental hygienists. Of those dental hygienists in other jurisdictions, there have not been any discipline cases in any of the other jurisdictions related to local anaesthesia. This college currently has 300 dental hygienists on a roster who have already received the appropriate education; many were practising local anaesthesia for years before they moved here.

I assure you, members of the committee and the people of Ontario, that the College of Dental Hygienists of Ontario is making this request for the comfort of the people our registrants serve.

Thank you very much.

The Chair (Mr. Shafiq Qaadri): Thank you, Ms. Richardson. About a minute or so per side, beginning with Madame Gélinas of the NDP.

M^{me} France Gélinas: I think you made your point very clearly: well documented, well presented, well understood. We'll put them forward. Thank you.

The Chair (Mr. Shafiq Qaadri): To the government side, Ms. Mitchell.

Mrs. Carol Mitchell: I just have a couple of quick questions. Since the legislation was passed with regard to dental hygienists, how many are acting independently, and in what settings are they acting independently today?

Ms. Fran Richardson: Currently, my understanding is that we have listed on our website over 110 independent practices. Well over half of those have mobile practices that go into residences and different people's homes.

They are all over the province. It seems that most of the mobile ones are in rural areas, areas where there have been some access problems to oral health care. But there are more and more opening up all the time.

As I say, though, the majority are working towards having some mobile aspect, which is of course what we had asked for the legislation change for.

The Chair (Mr. Shafiq Qaadri): To the PC side.

Mrs. Christine Elliott: I'd just like to thank you very much, Ms. Richardson, for your presentation: very clear, concise and entirely supportable.

Ms. Fran Richardson: Thank you very much.

The Chair (Mr. Shafiq Qaadri): Thank you, Ms. Elliott, and thanks to you, Ms. Richardson, for your deputation on behalf of the College of Dental Hygienists of Ontario.

ONTARIO ASSOCIATION OF MEDICAL RADIATION TECHNOLOGISTS

The Chair (Mr. Shafiq Qaadri): I now invite our next presenter, Mr. Hesler, CEO of the Ontario Association of Medical Radiation Technologists, and colleague. I just want you to introduce yourselves as you speak, for Hansard. I would invite you to please begin.

Dr. Robin Hesler: I'm Dr. Robin Hesler, CEO of the Ontario Association of Medical Radiation Technologists. With me today is the deputy CEO and manager of professional services, who looks after all the education and practice areas of the Ontario Association of Medical Radiation Technologists.

Mr. Chair and committee members, I'd like to thank you very much for allowing us to appear today and give a presentation. I will be talking briefly on it, as I know you have this submission, and I'll be hitting on the highlights.

This is an exciting time for medical radiation technology in terms of what is happening out there in regard to technology and changes in practice, which are rapidly evolving. It's an exciting time because the Regulated Health Professions Act is being updated. I commend the government for taking this step to update the Regulated Health Professions Act.

As part of our experience in Regulated Health Professions Act updating, it was a real collaborative effort, and I would like to praise several areas of the government, external and internal.

First is HPRAC, who did a lot of work and, particularly in regard to our profession, presented some very, very good information and arguments. During that process, thanks to the HPRAC chair, we learned a great deal about other professions that we were involved in. That's part of this whole interprofessional collaboration experience.

I'd also like to commend Shabnum Durrani, the political person in the minister's office whom we worked with, for educating us, and also Marilyn Wang and her crew for the work they did in helping us and keeping us on the path as to where we should be going or thinking of in regard to our profession.

As part of this collaborative effort, we worked with the Ontario Association of Radiologists, the Ontario Physiotherapy Association, the Ontario Hospital Association and quite a few others in regard to where we've come to related to our scope of practice issues and some of the other matters related to Bill 179.

Our three main areas—really, the key areas that we're concerned about, as were stated in the submission: One is our scope of practice statement; we feel a piece is missing in that scope of practice statement.

The second is related to professional liability insurance in regard to clarifying what professional liability insurance actually really means. It isn't clear to us in the proposed bill.

1520

The third item relates to the Healing Arts Radiation Protection Act. Although we have no issue in terms of nurse practitioners and physiotherapists being able to order diagnostic imaging tests, we think it's a bit premature at this time, given the condition of the Healing Arts Radiation Protection Act and the education and training of nurse practitioners and physiotherapists related to diagnostic imaging exams, in terms of utilization and the radiation protection aspects.

We're concerned about those three particular key things because of the impact that they have on the ultimate patient care in the province of Ontario. We feel that diagnostic imaging is a very key component—in fact, it's a very expensive component for the government—and therefore care must be taken in regard to the practice of the profession and those individuals impacting on the practice of the profession.

That's my opening statement. As I noted, the three key areas: One is the scope of practice statement, where we believe that the condition-of-the-patient issue is an extremely important one for us. If it's not clear and transparent to others that the MRT can do this, then it causes barriers. These are barriers to interprofessional collaboration, which is what we're trying to achieve, I believe. The second is the PLI clarification issue and the third is the Healing Arts Radiation Protection Act, where we believe that needs to be updated first, the checks and balances put in place and then other health care professionals would be in a better position to order diagnostic imaging tests.

The Chair (Mr. Shafiq Qaadri): Thanks very much, Dr. Hesler. We've got about 90 seconds per side, beginning with the government. Mr. Balkissoon.

Mr. Bas Balkissoon: Your first issue: I'm not quite clear what it is. Could you expand on that so there's some clarity in laymen's terms?

Dr. Robin Hesler: We believe that there's a component missing where the medical radiation technologist is allowed to assess the condition of the patient. That's missing in the scope of practice statement. We had asked for that originally. We had asked, in fact, that the statement would read that we would assess the patient's condition before, during and after a procedure because we were getting resistance from other sectors of the health care profession that, our scope of practice statement, even though it is supposed to be a generalized statement and an overview of what the profession does—they were taking the statement literally. We were running into resistance as to what technologists could do or not do, and that was causing a lot of inefficiencies in those particular areas where that was happening. So we believe—and I believe you'll be hearing from the College of Medical Radiation Technologists of Ontario later about the same issue—that it would be clearer and more transparent to the public that they understand that an MRT does—

The Chair (Mr. Shafiq Qaadri): Thank you, Mr. Balkissoon. To the PC side, Ms. Elliott.

Mrs. Christine Elliott: Thank you very much for your presentation. I was wondering if you could expand just a little bit about the concern that you have about the extended diagnostic imaging practice for nurse practitioners and for physiotherapists, specifically what your concern is.

Dr. Robin Hesler: The issue is really about patient quality and patient care in terms of radiation protection and also the challenges to the health care system. The more individuals who are allowed to order diagnostic tests, the more of a burden it becomes on hospitals and independent health facilities to try and get those patients through, meet wait times, and also the amount of radiation that patients will get.

What we would like to see here is that the proper education and training is in place first so that those individuals understand that when they're ordering a test, this is the most appropriate test that they're ordering. "Should I in fact be ordering an ultrasound versus a CT?", as an example. Or, "Should I be ordering general X-rays versus a CT?" We're very concerned that right now what is happening out there is that we're going to see increased pressure on the MRTs, who are already stressed out in their workplaces as it is with the number of tests coming. So we just want to see the education and training in place first, the checks and balances put back into the HARP Act, which is outdated and needs updating, and—

The Chair (Mr. Shafiq Qaadri): Thank you, Ms. Elliott. To you, Madame Gélinas.

M^me^ France Gélinas: So are you under the impression that if physios and NPs can order radiation therapy diagnostics, that will lead to an increased demand?

Dr. Robin Hesler: I believe that if the proper education and training is not there, yes, that will happen.

M^me^ France Gélinas: Okay. So you don't agree with their arguments that right now, what they do is they just ask the family physicians to require the test. Do you think this is not a valid argument?

Dr. Robin Hesler: I'm not sure what you're asking me. Can you ask me that question again? Sorry.

M^me^ France Gélinas: Sure. Physios and NPs say that what happens now is that if they need this to continue their treatment, they will simply refer them back to their family physicians, who will order the diagnostic test.

Dr. Robin Hesler: That probably will happen, yes.

M^me^ France Gélinas: Okay.

The Chair (Mr. Shafiq Qaadri): Thank you, Madame Gélinas, and thanks to you, Dr. Hesler, for your deputation, and to your colleague, on behalf of the Ontario Association of Medical Radiation Technologists.

Just before I call our next presenters, on behalf of the committee and, by extension, on behalf of the people of Ontario, I'd like to welcome Mr. Richard Patten, MPP in former Parliaments here, and of course one of our colleagues from Ottawa.

ONTARIO COLLEGE OF PHARMACISTS

The Chair (Mr. Shafiq Qaadri): I now invite Mr. Clement and Ms. Williams on behalf of the Ontario College of Pharmacists. Welcome. Please be seated. You've seen the protocol. I invite you to begin now.

Mr. Stephen Clement: Thank you. Mr. Chair and members of the standing committee on Bill 179, good afternoon. My name is Stephen Clement and I am the president of the Ontario College of Pharmacists and a practising pharmacist from Callander, Ontario. With me today is our registrar, Deanna Williams.

The Ontario College of Pharmacists appreciates the opportunity to attend before you today to share our comments respecting Bill 179. I am pleased to express the college's strong support for Bill 179. In particular, the Ontario College of Pharmacists is delighted with the proposals that will give effect to an enhanced scope of practice for pharmacists. The expanded scope of practice will optimize the role of Ontario pharmacists so that the public may fully benefit from the pharmacists' unique expertise in medication therapy management. It also brings pharmacy practice in Ontario into line with that of other jurisdictions across Canada and around the globe.

It is the college's view that all pharmacists currently licensed in Ontario possess the knowledge, skills, ability and judgment to safely and effectively perform the four new authorized acts proposed for pharmacy. The college is committed to working with government, educators and other professions so that these new authorized acts are done in accordance with appropriate terms and conditions to ensure public safety and protection.

To meet the needs of Ontario patients, pharmacists will, as part of the health care team, adapt, modify and extend existing prescriptions to best monitor and manage their patients' drug therapy. Permitting pharmacists to order and interpret lab tests for the purposes of medication therapy management, to administer substances by injection or inhalation for the purpose of demonstration

and educating patients, and to prick the skin for purposes of blood glucose monitoring will contribute to patient care by improving access and increasing the efficiency of the interprofessional health care team. The ability of pharmacists to administer a drug by injection will also enable those pharmacists who have been trained to do so to provide vaccinations in the event of a pandemic.

The Ontario College of Pharmacists has serious concerns, however, respecting the proposed provision that would give the minister the power, in the absence of any articulated or defined criteria, to appoint a college supervisor to assume control of a health regulatory college in Ontario. It is extremely difficult to support this proposed provision without any understanding as to why such measures are deemed necessary or what circumstances or situations would give rise to such measures.

The Ontario College of Pharmacists takes very seriously its legislative and regulatory mandate and holds itself to a high level of accountability in protecting the public. All Ontarians should be proud of the self-regulatory model for professional regulation that we have in Ontario. It is one that is both admired and aspired to around the world and is held up as a model for self-regulation.

1530

While this college strongly supports the principle of accountability and transparency, we also support the principle of fairness. If this provision goes forward, it must only do so where the criteria for appointment of a college supervisor are clearly articulated; where parameters as to the role and responsibilities of such a supervisor, once appointed, are defined; and where due processes are in place and followed to ensure that such measures are only taken in the interest of public protection.

The Ontario College of Pharmacists recognizes and supports interprofessional care and collaboration as a way of providing more efficient and effective health services to the public of Ontario. We look forward to collaborating with our colleagues to ensure that all of us who are prescribing, dispensing, compounding, selling and administering drugs do so to a common standard of high-quality care for Ontario patients.

The Ontario College of Pharmacists has considerable experience and expertise with respect to dispensing. As such, we hope to provide leadership in working with other colleagues to develop standards that will maintain Ontario's safe and effective drug distribution system.

Although not currently contemplated, the council of the Ontario College of Pharmacists would support discussions with government respecting the future implementation of a minor ailments program, such as that which exists in Great Britain. Making the pharmacist the primary care practitioner for some 30 minor ailments—for example, diaper rash, pink eye, cough and cold, athlete's foot—has shown to have improved access to family physicians for those patients with more serious ailments, while optimizing the role of the pharmacist.

On a personal note, as a pharmacist from a small town in northern Ontario, I can say that this legislation will enable pharmacists such as myself to work together and collaboratively with physicians, nurse practitioners and other health care professionals in small communities across the province to optimize health care access and provide continuity of care to our patients.

Thank you very much.

The Chair (Mr. Shafiq Qaadri): Thanks, Mr. Clement. We have about 90 seconds per side, beginning with the PC caucus. Ms. Elliott?

Mrs. Christine Elliott: I just have one question. Thank you very much, Mr. Clement. I take it you agree with everything except perhaps the proposed provisions that would give the minister the power to appoint the college supervisor and you'd like to see that section deleted; is that fair to say?

Ms. Deanna Williams: We're not suggesting—either it should be deleted so that more consultation could happen, but in the event that it does go forward, it needs to go forward with clearly articulated parameters and criteria under which a supervisor might end up being propelled into a self-regulatory college and what they would do once they're in there.

Mrs. Christine Elliott: Thanks.

The Chair (Mr. Shafiq Qaadri): Madame Gélinas.

M^me^ France Gélinas: My question is along the same line with the part of the bill that talks about the appointment of a supervisor. You were a signatory to a document that was shared by a number of colleges, and basically—I'm not sure I understand. I thought I understood what you had in writing clearly, which doesn't seem to be in line with what you just said. Did you want it to remain or did you want subsection 5(1) of the college to be expanded so that if there is conflict there, it could be resolved at that level?

Ms. Deanna Williams: We were unclear as to why the existing powers that are there in section 5 wouldn't be first maximized before something else went to another step, and that isn't there. So certainly that would be a preference, a demonstration that section 5 were used to its maximum, and if that wasn't appropriate or the public safety concern was still in place, then we should go to another provision.

M^me^ France Gélinas: Any idea why that was put in?

Ms. Deanna Williams: No, and I think this is part of the problem. We don't know why this was put in. There was no explanation as to why this was put in.

M^me^ France Gélinas: And do you know where it comes from?

Ms. Deanna Williams: No.

The Chair (Mr. Shafiq Qaadri): Thank you, Madame Gélinas. To the government side, Ms. Mitchell.

Mrs. Carol Mitchell: Thank you very much for your presentation. A previous presenter brought up some concerns with regard to remote dispensing, but I can see by your presentation you support remote dispensing. The concerns that were raised were specifically not being able to address the health and safety of Ontarians in remote or rural areas. I wanted to give you the opportunity to speak

specifically to that as you were from a northern area previously.

Mr. Stephen Clement: In a sense, for the last 35 years I've dispensed in a remote location, and the definition of "remote" is many-pronged. The Ontario College of Pharmacists has recently defined what it feels remote dispensing should and would look like. It's currently being spoken about at district meetings that we're holding across the province, and I think if the previous submitter was to attend one of those meetings, they would be very happy with what we're going forward with as far as remote dispensing goes.

The Chair (Mr. Shafiq Qaadri): Thank you, Ms. Mitchell, and thanks to you, Mr. Clement and Ms. Williams, on behalf of the Ontario College of Pharmacists.

ONTARIO ASSOCIATION OF OPTOMETRISTS

The Chair (Mr. Shafiq Qaadri): I invite now our next presenter, Dr. Nicol, on behalf of the Ontario Association of Optometrists. Welcome to you and your colleagues. I'd just invite you to introduce yourselves as you speak individually, and I'd invite you to please begin officially now.

Dr. Christopher Nicol: Thank you, Chair Qaadri and members of the committee, for this opportunity to present before the standing committee today. My name is Dr. Christopher Nicol. I'm an optometrist and policy consultant at the Ontario Association of Optometrists. With me are the past president Dr. Derek MacDonald and also policy consultant; Melissa Secord, assistant executive director; and Christine Morrison, OAO's government relations manager. We welcome this opportunity to provide the members of the committee with our opinions on Bill 179.

Founded in 1909, the OAO is a voluntary professional organization that represents more than 1,300 optometrists in Ontario. We're celebrating our 100th anniversary this year. The association proudly serves the profession by undertaking government advocacy, membership education and public awareness initiatives. Optometrists play a vital role in the assessment, diagnosis, treatment and continuing management of eye conditions for three million residents of Ontario every year.

While Bill 179 will expand the scope of practice for a variety of regulated health professions, we are pleased to acknowledge that the Health System Improvements Act, 2007, authorized optometrists to perform the controlled act of prescribing drugs. OAO is pleased that Minister Caplan has accepted the recommendation from the January 2009 HPRAC report, Critical Links: Transforming and Supporting Patient Care, to expand the medications optometrists are authorized to prescribe to include drugs used in the treatment and management of glaucoma. This expansion will improve access to care for many patients with glaucoma, particularly for those in rural areas.

I'm going to talk about four sections of the bill: Optometry Act, the expert committees and college supervisor.

Section 20, Optometry Act:

OAO strongly supports the proposed amendments to Section 20, but wishes to again stress the increased benefits to Ontarians should authorized drugs be identified by category and not as part of a list.

Current Ontario legislation governing non-physician prescribers is outdated and relies on lists of authorized drugs set in regulations. In contrast, in other Canadian jurisdictions where optometrists have been granted the controlled act of prescribing, drugs are commonly identified by category. Delays caused by the necessity of a regulation change for the introduction of a new drug will prevent non-physician prescribers from accessing the most up-to-date drug therapies and therefore prevent patients from receiving the care that they deserve.

For example, two new steroid-class medications for the treatment of ocular inflammation, Alrex and Lotemax, have a superior safety profile, improved efficacy and minimal adverse effects. If these medications were not part of an approved list, patients would be denied better and safer care.

Notwithstanding that either individual drugs or categories of drugs are referenced in the bill, identifying drugs by category would virtually eliminate unnecessary delays in accessing the most appropriate drug therapies and allow for the timely integration of evidence-based best practice.

Accordingly, OAO strongly supports the amendments to the Optometry Act through Bill 179 to permit the College of Optometrists to designate the drugs that optometrists can prescribe. The introduction of "rolling incorporation" as a regulatory mechanism permits a more reasonable way to authorize drug use among non-physician prescribers. These proposed changes create a more streamlined and efficient method of drug regulation, resulting in a timelier introduction of new drugs.

1540

Section 24, expert committees: The RHPA is also being amended to permit the establishment of one or more expert committees to oversee rolling incorporation as a regulatory mechanism to authorize drug use among non-physician prescribers. While OAO supports the establishment of such committees as a means to expedite approval of new drugs for use among non-physician prescribers, it is critical to have optometric representation as part of the expert committee when considering approval of drugs for optometric use. Excluding optometric representation when reviewing optometric drugs would confuse the process and propagate an over-dependence on medical directives in regulating other health care professions.

Additionally, it is important to provide regulated health professions with a clear overview of the duties and powers conferred upon the expert committee by the Lieutenant Governor.

OAO would like to seek reassurance that reviews by the expert committee would be conducted in a timely

fashion with an aim to complete reviews within a reasonable time frame. Further, there should remain a commitment to review drugs for optometric use on an annual basis, at a minimum.

College supervisor: OAO appreciates that self-regulation is a privilege granted to health professions under the RHPA. Consequently, regulatory colleges are afforded the freedom to establish regulations, standards and guidelines for the profession they govern. However, the RHPA also requires that colleges function within a framework consistent with the objectives stated in the Health Professions Procedural Code. The overriding principles of the code require that a college protect the public interest and govern the profession in accordance with the RHPA.

Currently, under the RHPA, the minister has broad powers to oblige a college council to comply with the intent of the RHPA, including the authority to make, amend or revoke a regulation. Notwithstanding these broad powers, this bill would further increase the minister's powers. The appointment of a college supervisor will further assist the minister in ensuring that the administration of a college is consistent with the expectations of the RHPA and associated legislation.

I would now respectfully ask that you consider the recent actions of the College of Opticians of Ontario. Opticians are health professionals regulated under the RHPA, authorized to dispense eyewear only upon a prescription from an optometrist or a physician. Opticians have sought to expand their scope of practice to perform only one aspect of a comprehensive eye examination, a test of the focusing of the eye, and to use this test in isolation to dispense eyewear, thus bypassing the legislative requirements for a prescription.

To this end, the College of Opticians unilaterally and independently published standards of practice in the fall of 2007 that authorized certified opticians to perform eye tests and prescribe and dispense eyewear without a prescription. The published standards of practice were not only a contravention of the Opticianry Act, but also disregarded recommendations in the April 2006 New Directions report from HPRAC, which had been asked to review this matter.

In 2001, then Minister of Health Elizabeth Witmer directed the College of Opticians to advise their members that they should not perform tests to measure the focusing of the eye. Notwithstanding this explicit directive from the Ministry of Health, the college continued to allow opticians to perform refractions, including rejecting a recent letter from the assistant deputy minister Dr. Joshua Tepper reminding the college of the direction.

This provides a clear and timely example of a college refusing to comply with a direction from the minister and attempting to expand the legislated scope of practice for the profession without either due process or legal authority. With the amendments proposed in section 24, the minister will have a more direct mechanism to require the College of Opticians and any other college under the same circumstances to immediately comply with the act.

OAO would, however, stress that any increase in power must be carefully considered and scrutinized. OAO requests clarification on what actions would trigger the appointment of a college supervisor. Further explanation is also required regarding who bears the cost and what happens with complaints and disciplinary actions that are in process at the time of the intervention by the college supervisor.

Generally, OAO is pleased with the legislation, and we anticipate that the committee will approve Bill 179, as tabled, with our concerns addressed.

Thank you for your time today and the opportunity to present our views on the bill. If you have any questions, I'll be pleased to answer them.

The Chair (Mr. Shafiq Qaadri): Thank you, Dr. Nicol. About a minute or so per side, beginning with the NDP. Madame Gélinas.

M^me^ France Gélinas: Thank you for coming here. I just wanted to clarify something. I was under the impression that the list of medications that an optometrist could prescribe had not been finalized. Am I wrong?

Dr. Christopher Nicol: No, you're correct; that's right. However, it will be a list, and we would rather see drugs regulated by category as opposed to a list.

M^me^ France Gélinas: Okay. So the first list that was promised way back has never actually appeared?

Dr. Christopher Nicol: No. It's been revised based on the recommendations of HPRAC that glaucoma medications be included. So the list was revised. However, the question is, should it be a list or categories? We believe it should be categories.

M^me^ France Gélinas: Okay. Thank you.

The Chair (Mr. Shafiq Qaadri): Thank you, Madame Gélinas. To the government side, Mr. Balkissoon.

Mr. Bas Balkissoon: Just for clarification on the supervisor: If the legislation is clarified that existing procedures would be exhausted before a supervisor is sent in by the minister, would that make your association happy?

Dr. Christopher Nicol: Well, I think the problem may be that the minister in the past has been loath to exercise the authority that he has under the act. Perhaps if an alternative method to do that is available, he would choose that method rather than delay action.

The Chair (Mr. Shafiq Qaadri): Thank you, Mr. Balkissoon. To the PC side, Ms. Elliott.

Mrs. Christine Elliott: I just have one quick question, and that's with respect to the composition of the expert committees and whether you're looking for any kind of statutory change, or if this is just something that you want to have ironed out, I guess, in the normal course of things once the committees are established.

Dr. Christopher Nicol: If we could have assurance that we would have optometric representation on that committee, whether statutorily or with guidelines, that would be acceptable. But the most important part is having an optometrist on that committee.

Mrs. Christine Elliott: Thank you.

The Chair (Mr. Shafiq Qaadri): Thank you, Ms. Elliott, and thanks to you, Dr. Nicol, and your colleagues on behalf of the Ontario Association of Optometrists.

ASSOCIATION OF ONTARIO MIDWIVES

The Chair (Mr. Shafiq Qaadri): I invite now our next presenter, Ms. Kilroy, president of the Association of Ontario Midwives, and colleagues. I invite you to please be seated. I invite you to begin now, please.

Ms. Kelly Stadelbauer: Good afternoon. Thank you for inviting the Association of Ontario Midwives to present on Bill 179. My name is Kelly Stadelbauer, actually, and I'm here presenting on behalf of Katrina Kilroy, the AOM president, who is a practising midwife and who could not be here today because she has been called away to attend a birth. Such is the life of a practising midwife. I'm also here with my colleague Alisa Simon, who is part of our policy department at the AOM. I am the executive director at the Association of Ontario Midwives, the professional body representing midwives and the practice of midwifery in Ontario.

I'd like to thank the Minister of Health and Long-Term Care for tabling this important bill, and I'd like to thank all three political parties for their support of midwifery over the years. Midwives are excited about the potential of Bill 179. This bill represents a real opportunity to positively affect the care of mothers and newborns in Ontario.

The association has prepared a written submission to the committee, so I won't review the entire content of that today, as we have limited time, and I know the committee will have an opportunity to consider our submission in its entirety.

Before I delve in to Bill 179, however, I wanted to give a quick summary of the kind of care that midwives provide. Midwives are primary health care providers on call for their clients 24/7. Midwives are experts in low-risk pregnancy and birth. They provide primary care to women during pregnancy, labour, birth and six weeks postpartum, and they're also primary care providers to newborns until six weeks of age. The Ministry of Health has evaluated and recognized midwives as primary care providers with excellent clinical outcomes, safe practice and exceptionally high rates of client satisfaction.

I have just noticed that Ms. Kilroy, our president, has arrived. Do you want to continue?

Ms. Katrina Kilroy: Sure. Thank you so much. The nature of the job: I've come directly from Mount Sinai Hospital, where I was at a labour.

Mr. Vic Dhillon: Boy or girl?

Ms. Katrina Kilroy: It's not out yet. I'm going to go back when I'm done.

Mr. Vic Dhillon: A work in progress.

Ms. Katrina Kilroy: We'll send you an e-mail.

The Chair (Mr. Shafiq Qaadri): We want pictures—

Ms. Katrina Kilroy: Well, I can do that with my BlackBerry now, you know.

Anyway, it's a real pleasure to be speaking to you today, and thank you for your patience with our little dosi-do here.

Really, the essence of what we want to say to you today is that the Association of Ontario Midwives wholeheartedly supports all of the changes related to midwifery that are addressed in Bill 179. These changes, like enabling midwives to communicate a diagnosis and administer suppository drugs, are long overdue. They're things that are just naturally a part of the work that we do every day in caring for pregnant women and their newborns, and the intent is, really, that midwives are able to provide that care that is necessary for a normal, healthy delivery. So these things really will help us to do that.

1550

The other part of it is that they allow us to function more fully in an interprofessional setting and to fully maximize our skill and expertise. If we're going to work interprofessionally with other people trained in maternity care, it is important that we have these things within our scope of practice. This will strengthen the maternal-newborn care system in Ontario.

They are important steps that ensure that the legislative framework that regulates midwifery keeps pace with the changing health care environment so that we can care for low-risk women and newborns in the most safe and effective manner. It doesn't make sense for a midwife to be referring someone to a physician for something that's a normal part of pregnancy and birth. I think the legislation, as it was originally drafted, recognized that, so we're doing some catch-up here.

The changes that are outlined in Bill 179 will help to reduce the duplication of care and unnecessary consultations and transfers of care to physicians. As I said, this is very critical to creating a foundation for a collaborative environment that might help us contribute to interprofessional care models.

Although we're quite pleased with the changes that have been proposed, further changes are also needed to enable midwives to optimally contribute in that collaborative and interprofessional setting and to provide basic care to normal healthy women and newborns.

Today what I want to do is really focus on one vital change that's needed, and that is to improve and streamline the drug approvals process. Since 1994, midwives have had the authority to prescribe and administer particular drugs for low-risk clients. The original list that was drafted was intended to ensure that midwives could engage in that routine prenatal, intrapartum and postpartum care.

Midwives have demonstrated competency and have quite an exemplary safety record. However, the past 15 years have revealed a number of shortcomings in the drug-approval process. In particular, the process to add new drugs to the midwifery pharmacopeia is unduly lengthy and restrictive and, ultimately, it compromises patient safety. We can't get new medications added in a timely enough way to provide the safe and comprehensive care to women and newborns that we want to provide, that we're trained to provide.

An example of this which you may have already heard tell of somewhere in your deliberations is that at the time the midwifery legislation came into being, routine antibiotics for group B strep prophylaxis were not part of routine intrapartum care. Since the time when that was drafted in the early 1990s, that has changed, and it is a routine part of care for about 25% of women who test positive for group B strep in their pregnancies. The standard of care is to provide prophylaxis to these women in labour.

We've been trying to get that added to our pharmacopeia for a long time. The college of midwives requested that antibiotics be added in 2004. We still have not achieved that, nor have we been able to get antibiotics in our scope for treating straightforward mastitis. The process has really dragged on, and five years later we're still consulting in order to get a simple prescription for something that is routine.

I can tell you, because I've just come from a HealthForceOntario project going into a number of communities around the province, that this is a great irritant in relationships between midwives and physicians, that midwives need to wake up a physician at 3 o'clock in the morning to get a prescription for something that is a routine part of prenatal care. I can't tell you how many times doctors have said to me, "Why can't you guys do that? I don't understand why you guys can't do that. You guys really need to be able to do that." That's in my downtown hospital where the doctors are on the floor all the time, so I can only imagine what the midwives in those more outlying communities who are having to call somebody in from half an hour away to do that consultation go through. We really did hear around the province that this is putting a strain on relationships and people want a solution to this.

Our first request for improving Bill 179 is to ask for the addition of antibiotics to the drugs that midwives can prescribe. This is critical. I recognize this would be a bold step, but I'm really asking the committee to take this step. It's long overdue. It's the right thing to do. It's the one thing—when midwives were looking forward to these reviews, it was like, "Thank God, we might finally fix that problem with drugs in general and with group B strep in particular." I can tell you, for midwives in the field—and their clients, and of course, the physicians they consult with—they're really hoping for some change here.

In trying to improve the current drug approvals process, Bill 179 specifies that regulations governing midwives' ability to prescribe may designate either a drug list or drug categories. However, we contend that the bill should specify that midwives be regulated by categories alone. This would allow the College of Midwives to determine, within a category of drugs, which drugs specifically midwives would be able to prescribe. One example of why this is important: Ergonovine maleate is one of the two medicines that midwives were regulated to use for postpartum hemorrhage—

The Chair (Mr. Shafiq Qaadri): You have about a minute left, Ms. Kilroy.

Ms. Katrina Kilroy: How much?

The Chair (Mr. Shafiq Qaadri): One minute.

Ms. Katrina Kilroy: When that drug became unavailable—so this was an urgent situation—it took one year to get special permission for midwives to get access to a different drug of the same type to use at home births and in other emergency situations. This is critical. The rest of our input you will read in our submission.

I really just want to say that I became a midwife because I wanted to provide high-quality care, excellent care to women at a very pivotal time of their life. I'm asking you to be bold and ensure that Bill 179 will allow me and my colleagues to continue to provide midwifery care in a way that fully utilizes our expertise and in a way that moves Ontario to fostering a positive interprofessional environment for pregnant women.

Thank you for your time.

The Chair (Mr. Shafiq Qaadri): Thank you to you, Ms. Kilroy, and to your colleagues—and to the unborn child—on behalf of the Association of Ontario Midwives.

JOYCE ROWLANDS

The Chair (Mr. Shafiq Qaadri): I'd now like to invite our next presenters to please come forward, Ms. Rowlands of the Transitional Council of the College of Psychotherapists and Registered Mental Health Therapists of Ontario, if present. Ms. Rowlands, welcome.

Ms. Joyce Rowlands: Thank you.

The Chair (Mr. Shafiq Qaadri): We'd invite you and your colleagues to—we'll distribute that on your behalf. I'd like to invite you to please begin now.

Ms. Joyce Rowlands: Yes. Good afternoon, members of the standing committee. Thank you for the opportunity to appear here today to comment on Bill 179. My name is Joyce Rowlands. I'm the registrar with the Transitional Council of the College of Psychotherapists and Registered Mental Health Therapists of Ontario. With me today is Krystina Walko, our policy and communications analyst.

Members should have a copy of my remarks as well as a submission. If you're following along, you'll probably want to use the remarks.

Before I address a couple of issues raised by Bill 179, I should give you some background about the new college.

Though the Psychotherapy Act received royal assent in 2007, only parts of the act—those allowing for the appointment of the transitional council of the college and the registrar—have been proclaimed. I was appointed in January of this year, and members of the transitional council are expected to be announced shortly. The college is in the very earliest stages of becoming a fully functioning regulatory body. That process is expected to take about three years.

I bring this to the committee's attention because it's important for you to understand that I do not speak on behalf of the transitional council of the college. The views expressed here are my own, informed by discus-

sions with stakeholders, ministry officials and legal counsel. For these reasons, I will not be addressing any of the broader issues raised by Bill 179. I will be confining my remarks to proposed amendments to the Psychotherapy Act and to changes I wish to propose to the wording of the "holding out" clause in our act.

Specifically, there are two issues I would like to comment on. The first is the amendment included in Bill 179 to change one of the restricted titles in the Psychotherapy Act from "psychotherapist" to "registered psychotherapist."

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As registrar, I wish to express my strong support for this amendment. This change will strengthen regulation by making it clear that practitioners using the title "registered psychotherapist" are regulated professionals, and it will help clients identify practitioners who are qualified and accountable. Unfortunately, there is a potential downside to the proposed title change. Fortunately, there's also a remedy, one I urge the committee to consider.

Here's the downside: If Bill 179 passes as it is, we will have inadvertently, I believe, created a situation where use of the title "psychotherapist" by itself is unprotected, where anyone can use the title with or without qualifications. This is exactly the situation the Psychotherapy Act was intended to remedy.

Currently, and until the act is fully implemented, anyone, with or without qualifications, can hang up a shingle and call himself or herself a psychotherapist. Re-creating this situation, I believe, would seriously undermine public protection and be confusing to the public.

Some may argue that the prohibition against using abbreviations and variations of protected titles in the Psychotherapy Act, along with the "holding out" clause, will suffice to prevent unqualified practitioners from using the title "psychotherapist" by itself. However, legal counsel has expressed concerns that these arguments may not sway the courts. The concern is that a court will take the view that the intent of the Psychotherapy Act is to leave the title "psychotherapist" in the public domain. As a result, the door may once again be open for unqualified people to use the title "psychotherapist," an unintended consequence with the potential to seriously undermine the intent of the act and to hinder effective regulation.

Fortunately, there is a remedy. It is to include the title "psychotherapist" as a restricted title in the Psychotherapy Act, 2007. This would be consistent with protection of the title "nurse," along with "registered nurse," "nurse practitioner" and "registered practical nurse" in the Nursing Act, for instance.

By including the title "psychotherapist" as a restricted title, along with "registered psychotherapist" and "registered mental health therapist," there can be no doubt that only regulated professionals are permitted to use the title "psychotherapist" in any form.

The second issue I wish to address is the representation of qualifications provision in the Psychotherapy Act, commonly known as the "holding out" clause. The wording of the clause as proposed by Bill 179 reads as follows: "No person other than a member shall hold himself or herself out as a person who is qualified to practise in Ontario as a registered psychotherapist or a registered mental health therapist."

I respectfully suggest that the word "psychotherapist" be added to this clause to make it clear that non-members of the college are not permitted to hold themselves out as any kind of psychotherapist.

In addition, an anomaly of the "holding out" clause in the Psychotherapy Act has come to my attention. The wording of the clause is unique among health professions legislation in that it does not prohibit non-members of the college from holding themselves out as individuals qualified to practise in a specialty of psychotherapy.

The effect is that unqualified individuals may choose to avoid regulation by using titles such as "family therapist," "cognitive behavioural therapist" or "psychodynamic therapist"; in other words, by combining the title "therapist," which is not protected, with words relating to a specialty of psychotherapy. This loophole serves to undermine the intent of the Psychotherapy Act, which is to ensure that people practising psychotherapy are qualified and accountable.

The solution here is to change the wording of the "holding out" clause to read, "No person other than a member shall hold himself or herself out as a person who is qualified to practise in Ontario as a psychotherapist, registered psychotherapist or registered mental health therapist or in a specialty of psychotherapy." This matches the wording of the "holding out" clauses in the profession-specific acts of all the existing colleges and all the new regulated health professions. The purpose of this change is to strengthen the regulation of psychotherapy in Ontario by discouraging unqualified non-members of the college from using the title "therapist" along with words pertaining to a specialty of psychotherapy.

In conclusion, I respectfully urge members of the standing committee to seriously consider the changes I have outlined. Not to do so, I suggest, will serve to undermine the intent of the Psychotherapy Act and play into the hands of unqualified people who would seek to avoid regulation.

Thank you for your time. I'm happy to answer any questions.

The Chair (Mr. Shafiq Qaadri): Thank you, Ms. Rowlands. About a minute per side.

Mrs. Christine Elliott: Thank you for your presentation. I'm just referring to the summary of changes on the back page of your presentation. I'm presuming those are the only three changes that you're proposing to make to Bill 179 as it relates to psychotherapy?

Ms. Joyce Rowlands: Yes, they are.

Mrs. Christine Elliott: Thank you.

The Chair (Mr. Shafiq Qaadri): To the government side.

Mr. Bas Balkissoon: I just want to thank you for your presentation. It's quite clear. So if this technical change is made, your organization is very supportive of the bill?

Ms. Joyce Rowlands: Sorry?

Mr. Bas Balkissoon: If the technical problem is corrected—

Ms. Joyce Rowlands: Oh, yes, absolutely, and particularly the primary amendment that's included in bill 179, which is to change one of the two protected titles from "psychotherapist" to "registered psychotherapist." We absolutely support that.

The problem is that in doing it the way it has been done, it leaves the title "psychotherapist" by itself unrestricted—

Mr. Bas Balkissoon: I realize that.

Ms. Joyce Rowland: —and it could be interpreted as being in the public domain and available for anybody to use, which would be a problem for the college and could certainly undermine the effectiveness of regulation.

Mr. Bas Balkissoon: Thank you very much.

The Chair (Mr. Shafiq Qaadri): Thanks to you, Ms. Rowlands and Ms. Walko, on behalf of the Transitional Council of the College of Psychotherapists and Registered Mental Health Therapists of Ontario.

CANADIAN COLLEGE OF NATUROPATHIC MEDICINE

The Chair (Mr. Shafiq Qaadri): I now invite our next presenters, Mr. De Groot and Mr. Bernhardt of the Canadian College of Naturopathic Medicine, to please come forward. Welcome, gentlemen. I invite you to please begin now.

Mr. Bob Bernhardt: Thank you very much. My name is Bob Bernhardt, the president and CEO of the Canadian College of Naturopathic Medicine, and accompanying me is ND Nick De Groot, who's the dean of the program.

The Canadian College of Naturopathic Medicine wants to thank the Standing Committee on Social Policy for the opportunity to provide feedback on Bill 179. As Canada's premier institute for education and research in naturopathic medicine, CCNM has a keen interest in the regulation of naturopathic medicine here in the province and also in other provinces in Canada. It is vital that the college's students and graduates are able to learn, and ultimately practise, in a jurisdiction that allows naturopathic doctors to work to an appropriate scope of practice. It's our belief that Bill 179 as currently drafted contains omissions which, if not addressed, could lead to significant negative repercussions for the profession and for the practice of naturopathic medicine. There are three issues that I'll address.

One will be that we need to protect the current practice of naturopathic doctors in the province through providing NDs with the unambiguous authority for prescribing, compounding, dispensing or selling a drug as designated in the regulations. Second, as you've heard from the Ontario Association of Naturopathic Doctors, we need to clarify the scope of practice by amending the Naturopathy Act to get rid of the term "naturopathic diagnosis," to make it clear that the controlled act is communicating a diagnosis. And we need to ensure that NDs have access to the diagnostic tools they require, in particular unambiguous access to lab testing and specimen collection.

The college itself, the Canadian College of Naturopathic Medicine, is an educational institution; it's not a regulatory college. It was established in 1978. It's a registered charity. The college receives no direct government funding and employs approximately 100 full-time employees and about another 100 contract and part-time employees. We have an annual operating budget in the neighbourhood of $12.5 million, and would presumably have an estimated annual economic impact on the GTA of about $35 million.

We provide an intensive four-year medical program. The only people admitted into the program are those who have a university degree with your typical pre-med prerequisites. We currently have 550 students and we've had 1,611 graduates. Those graduates represent almost a quarter of practising NDs across North America, and in Ontario about 95% of those who are practising have graduated from the college.

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The program itself involves over 4,000 hours of instruction, including 1,200 hours of supervised clinical experience. It's accredited by the Council on Naturopathic Medical Education, which, as I mention here, is in turn recognized by the US Department of Education.

CCNM is also a major GTA health care provider. We have a clinic at the college that provides over 25,000 patient visits per year. In addition, we operate out of five community health clinics in Toronto and we see about another 6,000 patient visits per year there.

Of interest, at our own clinic, when we surveyed the patients, 45% of them said that they use our clinic as their primary care provider, so we'd only assume that the statistic would be there or higher for those who use NDs out in the community.

CCNM also does a great deal of research and we're internationally recognized for it. We have done a number of studies with Canada Post Corp. and the Canadian Union of Postal Workers looking at chronic disease there and naturopathic treatment as compared to traditional treatment for that chronic disease. In particular, we've looked at chronic back pain, we've looked at stress, we've looked at rotator cuff tendinitis, and currently we have a major study looking at cardiovascular risk. In addition, along with Ottawa Hospital, we are looking at the use of melatonin as an adjunctive therapy for cancer for those with non-small-cell lung cancer who have had a portion of the lung removed. We've just completed a study with Health Canada looking at the use of naturopathic medicine, potentially, for helping with some of the issues in aboriginal health care. The research suggests that naturopathic medicine can be particularly efficacious in addressing chronic conditions.

Ultimately, the college's position as a North American leader in research and education related to naturopathic medicine is contingent on our ability to offer students the opportunity to gain not only a top-notch theoretical

education but also broad clinical experience that prepares a graduate for practice throughout Canada and the United States. For that reason, it is important to the college that the regulatory framework in Ontario is supportive of NDs working to an appropriate scope of practice that is aligned with North American best practice. As an academic leader in research and education related to naturopathic medicine, the college has been keen to share its expertise and best practices to support the evolution of strong public policy in the province.

With respect to Bill 179, CCNM eagerly awaited the introduction of Bill 179 with a strong hope that the new legislation would introduce changes to rectify some of the important issues related to NDs' scope of practice that were not resolved with the passage of the Naturopathy Act in 2007. Although the Naturopathy Act, a portion of the Health System Improvements Act, 2007, delivered long-overdue changes to fundamentally restructure the regulatory framework of naturopathic medicine, changes which were strongly supported by the college and by NDs, it did leave some additional issues that had to be rectified.

In particular, we have concern regarding the fact that the Naturopathy Act remains silent on whether naturopathic doctors retain the ability to prescribe within their field of expertise. As the federal government moves to bring an increasing number of natural therapeutic products under restricted schedules, NDs face the very real possibility of being forced to refer their patients to physicians licensed by the College of Physicians and Surgeons of Ontario to simply maintain patient access to the current forms of treatment.

A second issue refers to the confusing reference to the ability of NDs to communicate a "naturopathic diagnosis." There seems to be no consensus, either legal or otherwise, as to what the phrase actually means. Naturopathic doctors communicate diagnoses to patients after extensive assessment based upon traditional medical diagnostics. Such diagnoses differ in no material way from those communicated by nurses, doctors or others who have the legislated right to communicate a diagnosis.

The final significant issue left unresolved in the Naturopathy Act relates to clarifying the ability of naturopathic doctors to order appropriate laboratory tests for their patients. Naturopathic doctors must be able to collect specimens and submit them for analysis in order to be able to complete a diagnosis.

We were encouraged by much of the work of HPRAC. HPRAC is very familiar with the regulation of naturopathic medicine, having previously provided recommendations to the government on the issues in both 2001 and 2006. The Critical Links report follows up on this earlier work and provides an unequivocal message to government that changes were required to the Naturopathy Act to improve the regulation of naturopathic medicine. Given HPRAC's clear recommendation and compelling rationale, it was a real disappointment to the college that the government ignored the body's expert advice with the introduction of Bill 179. The current version of the bill does not address any of the substantive issues raised in HPRAC's report, and arguably leads to an outcome that is drastically opposed to HPRAC's goal of expanding access to naturopathic medicine while promoting the public interest.

The three specific recommendations are as follows:

Recommendation 1: protect the current practice of naturopathic doctors through providing NDs with unambiguous authority for prescribing, compounding, dispensing or selling a drug designated in the regulations. As the Critical Links report noted, without specific authorized acts granted under the Naturopathy Act, 2007, NDs will not be able to practise to their full scope of practice and their patients will not be able to receive the treatments that they choose and prefer. For this reason, it's imperative that the Legislature introduce changes to Bill 179 that would clearly add the controlled act of prescribing, compounding, dispensing or selling a drug to the ND's scope of practice.

With respect to the education that NDs receive in the area of prescribing, they receive extensive training in the prescribing of botanicals—

The Chair (Mr. Shafiq Qaadri): You have a minute left.

Mr. Bob Bernhardt: Thank you; as well, 70 course hours focused on pharmacology. In addition, there are about 190 hours that look at the use of contraindications and the monitoring of patients who are receiving either botanicals or drugs.

I think I should leave the remainder for questions.

The Chair (Mr. Shafiq Qaadri): Sure. Minimal time, Ms. Gélinas.

M^me^ France Gélinas: In your recommendations, you talked about prescribing, compounding, dispensing and selling a drug. Other people have talked about naturopathic medicine, and basically, what they really want is a lot narrower than all of the drugs. I give the example of narcotics—

The Chair (Mr. Shafiq Qaadri): Sorry, Ms. Gélinas, I will have to intervene. To the government side.

Mr. Bas Balkissoon: Thank you very much for your presentation.

The Chair (Mr. Shafiq Qaadri): Thanks, Mr. Balkissoon. To Ms. Elliott.

Interjection.

The Chair (Mr. Shafiq Qaadri): Thanks to you, Mr. Bernhardt and Dr. De Groot, for your presentation on behalf of the Canadian College of Naturopathic Medicine.

COLLEGE OF MEDICAL RADIATION TECHNOLOGISTS OF ONTARIO

The Chair (Mr. Shafiq Qaadri): I would now invite our next presenter to please come forward: Ms. Gough, registrar of the College of Medical Radiation Technologists of Ontario, and colleagues, I presume.

Welcome and please be seated. We'll distribute those for you, and I'd invite you to begin.

Ms. Linda Gough: Thank you. The College of Medical Radiation Technologists of Ontario appreciates the opportunity to appear before the Standing Committee on Social Policy regarding Bill 179. My name is Linda Gough, and I'm the registrar of the CMRTO. With me today is Debbie Tarshis from WeirFoulds, who is the college's legal counsel.

The CMRTO is a regulatory body for medical radiation technologists in Ontario. Our mandate is to serve and protect the public interest through self-regulation of the profession of medical radiation technology. The college regulates more than 6,300 MRTs who provide essential services such as radiation therapy, CT, X-ray, MRI, nuclear medicine and PET scans to Ontario's population. Our members are instrumental in ensuring timely access to the diagnostic and cancer treatment patients need.

The college has three recommendations which we're presenting to the standing committee today. The college also has some suggestions regarding the proposed amendments to RHPA and the Healing Arts Radiation Protection Act, which are set out in the written submission of the college.

The CMRTO's first recommendation is that the government proceed with the proposed amendments to the MRT's scope of practice statement and authorized acts as set out in Bill 179, with the proposed amendments set out in the college's second and third recommendations. The college supports the government's proposed changes to the scope of practice statement for MRTs and the controlled acts authorized to them. The college believes that these proposed changes will provide clarity to the public and other health care practitioners, improve efficiency by maximizing the use of MRTs within interprofessional care settings, improve patient access to state-of-the-art diagnostic and therapeutic procedures, and will update the legislative framework to reflect the current practice of MRTs.

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The proposed amendments to the MRT Act represent the culmination of a process that began in April 2008. Based on the minister's request for advice, HPRAC made a request to the college and the Ontario Association of Medical Radiation Technologists for a submission of a review of the scope of practice for MRTs, being one of the professions identified as being most directly involved in interprofessional care. After extensive consultations with stakeholders, the college and the OAMRT provided a joint submission to HPRAC. In general, HPRAC supported the recommendations set out in the joint submission, as is summarized in the following paragraph from HPRAC's Critical Links report:

"HPRAC has concluded that medical radiation technologists (MRTs) are critical members of interprofessional health care teams. They are valuable technical experts in the safe and effective use of rapidly evolving and highly sophisticated diagnostic and therapeutic equipment. MRTs provide crucial information to support diagnosis and monitor the progress of treatments. They are also involved in direct patient care through the delivery of therapeutic interventions. HPRAC's review supports the requests for changes in the scope of practice of medical radiation technology as reasonable, since they reflect the daily functions of MRTs in all areas of practice and are supported by their education and training."

The CMRTO's second recommendation is that Bill 179 should be strengthened by reflecting an important aspect of what MRTs do in their practice; that is the significant role of the MRT in the assessment of an individual's condition before, during and after their procedure. The proposed scope of practice statement set out in Bill 179 does not currently reflect this role. The college recommends that the phrase "and the assessment of the condition of an individual related to the procedures" be added to the end of the scope of practice statement.

The college believes that the role of the MRT in the assessment of a patient's condition is a fundamental element of the practice of the profession. The MRT is often alone with the patient, as the interpreting physician, radiologist or oncologist is not present for most procedures. Thus, the safe and effective performance of the procedures by an MRT involves the assessment of whether a patient's condition meets the clinical requirements for the procedure to proceed safely, the assessment of the patient's condition during the procedure, and responding to the patient's physical, medical and emotional needs.

The college's standards of practice for the profession set out the competencies required of MRTs to practise safely. Several of these competencies refer to the assessment of a patient's condition, such as:

—ensure that there are no contraindications present that could harm the patient or would exclude the patient from having the examination;

—making modifications to procedures based on the patient's physical, medical and/or emotional status or needs;

—assess the patient's condition during the course of treatment or procedures and respond accordingly.

I'll now provide some short examples taken from the four specialties of medical radiation technology in which the assessment of the patient's condition by the MRT is a fundamental element of the procedure. The more complete examples can be found in our written submission.

For patients undergoing CT scans, MRTs in the specialty of radiography perform the injection of the contrast media into the patient's veins to enhance the visualization of certain organs. The MRT must identify any contraindications to the administration of contrast media by reviewing the patient's blood test results and obtaining a history of allergies and medical conditions. In this way, the MRT assesses whether the patient's condition will allow the safe injection of the contrast media in accordance with established protocols.

Following the injection, the MRT must constantly assess the condition of the patient for any signs of allergic reaction by monitoring the patient's blood pressure and blood-oxygen levels, and checking whether the patient develops rashes or hives. The MRT must initiate emergency response procedures if a patient suffers any adverse reaction.

MRTs in the specialty of magnetic resonance carefully screen and assess each patient prior to the MRI examination to ensure that there are no dangerous implants or devices which could harm the patient or would exclude the patient from having the procedure. If a patient has a magnetically activated implant or device, such as a cerebral spinal fluid shunt or eye socket implant, he or she cannot undergo an MR exam because there's a high likelihood of altering the function or displacing the implant because of the MR magnetic field.

Certain individuals who undergo magnetic resonance procedures may find the experience associated with great emotional and psychological distress, so the MRT must assess the patient's psychological condition to identify anxiety or claustrophobia to determine whether the patient would benefit from a sedative prior to the procedure.

MRTs in the specialty of nuclear medicine must constantly assess patients undergoing cardiac stress testing, a study to determine the blood flow to the heart muscle. This involves the patient exercising on a treadmill until he or she reaches his or her peak exercise rate. The MRT injects the patient with a radiopharmaceutical which concentrates in the heart muscle. During the procedure, the MRT monitors the patient's heart rate, blood pressure, respiratory rate and ECG to recognize a potential cardiac arrest.

MRTs in the specialty of radiation therapy assess their patients over a course of radiation treatments that may take a few days to a number of weeks. Radiation treatment has a severe effect on the patient's health during the course of treatment, which requires constant assessment. The radiation therapist, being the one health care professional who sees the patient each day, performs this assessment. Radiation therapists must decide when it's inappropriate to treat the patient and to refer the patient to the physician before proceeding. They may also refer the patient to another health professional such as a dietitian if the patient is losing a significant amount of weight.

Our third and final recommendation to the standing committee today relates to the additional requirements for MRTs to be able to perform authorized acts.

The Chair (Mr. Shafiq Qaadri): You have about a minute left.

Ms. Linda Gough: An MRT may not currently perform an authorized act unless a procedure is ordered by a member of CPSO. As a result of the proposed amendments to the scope of practice of other health professionals, Bill 179 amends the MRT Act in order to permit an MRT to apply a prescribed form of energy if it's been ordered by a member of the CPSO or a member of any other college. However, the language of the proposed amendment refers to the member being ordered rather than the procedure being ordered, and accordingly the college believes that a technical amendment is needed so that the language reflects that it's the procedure being ordered and not the MRT.

We'd like to thank the members of the committee today for listening to us, and if you have any questions, we'd be happy to answer them.

The Chair (Mr. Shafiq Qaadri): I'd like to thank you, Ms. Gough, and your colleague for your deputation and presence on behalf of the College of Medical Radiation Technologists of Ontario.

COLLEGE OF PHYSIOTHERAPISTS OF ONTARIO

The Chair (Mr. Shafiq Qaadri): I would now like to invite our next presenters to please come forward: Ms. Robinson, registrar of the College of Physiotherapists of Ontario, and colleagues, if any. Do you have any written materials for distribution?

Interjection.

The Chair (Mr. Shafiq Qaadri): We received it already. That's fine, thank you. I invite you to please be seated and officially begin.

Mr. Rod Hamilton: Good afternoon. My name is Rod Hamilton, and I'm the associate registrar, policy, at the College of Physiotherapists of Ontario. With me is Jan Robinson, and she's the registrar and CEO of the college.

The college was created under the Regulated Health Professions Act to register physiotherapists for practice in Ontario and regulate them in the public interest. The college has nearly 7,000 member physiotherapists. The college has come before this standing committee to offer its general support for Bill 179, the Regulated Health Professions Statute Law Amendment Act.

The college believes that promoting interprofessional collaboration and recognizing the skills and competencies of Ontario's health professionals through scope changes will improve Ontarians' access to the health care services they need and ultimately improve the health care system for all. The college looks forward to a continued role in implementing these changes.

More specifically, the college would like to offer its support for the proposed changes to the Physiotherapy Act. The college believes that the proposed changes to physiotherapists' scope of practice will enable them to practice to the full extent of their competencies and facilitate their ability to engage in interprofessional collaborative practice.

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The college also supports the additional authorized acts that are being proposed for physiotherapists. These additional authorized acts are within the scope of practice of physiotherapy. The changes will enable physiotherapists to participate more fully in varied models of health care delivery, working with multiple caregivers to deliver integrated, quality care.

However, the college does have a very specific concern about the proposed revision—subsection 4(3)—of the Physiotherapy Act. This subsection is a proposal for an additional requirement that would apply when a physiotherapist needs to perform the authorized act of administering a substance by inhalation to a patient. As the clause is currently drafted, it would forbid physiotherapists from administering a substance by inhalation unless the member has been ordered to perform the procedure by a member of the College of Physicians and Surgeons of Ontario or a member of any other college who is authorized to perform the procedure.

The college believes that physicians or other qualified health professionals should order the substances that patients need when they are to be administered by inhalation. However, instead of permitting physiotherapists to administer these substances once they have been properly ordered, the current wording actually requires physicians to take the extra step of then ordering a physiotherapist to administer the substance. The college believes this requirement will continue to impose significant practical barriers that create inefficiencies in the provision of quality care. The college suggests that the intent of the proposed additional requirement was that the substance be ordered rather than the physiotherapist be ordered to administer the substance.

To resolve this concern, the college suggests that a minor amendment be made to the proposed subsection 4(3). The revised subsection 4(3) might read: "A member shall not perform a procedure under paragraph 7 of subsection (1) unless the procedure has been ordered by a member of the College of Physicians and Surgeons of Ontario, or a member of any other college who is authorized to perform the procedure."

In summary, the college supports the majority of the changes and additions to the RHPA proposed by Bill 179. However, there are some areas that would benefit from additional consideration and clarification. Please see the college's written submission for more information on the college's suggestions.

Thank you very much for the opportunity to offer comments on this important set of proposals. We would be happy to answer any questions.

The Chair (Mr. Shafiq Qaadri): Thank you, Mr. Hamilton. About two minutes per side, beginning with the PC caucus. Ms. Witmer.

Mrs. Elizabeth Witmer: Basically, you're happy with the changes that are being recommended. Do you want to just go into the supervisor position and some of your recommendations for that new position that's to be created? I know it's creating a little bit of concern for some of the colleges.

Ms. Jan Robinson: I think there has been concern across colleges for sure, and certainly during discussion at our council table as well. I think our college is very strongly in favour of accountability and public accountability related to the interests that we hold and the trust we hold related to the college and its activities.

We were a bit surprised with the wide-sweeping change, particularly given that much of the rollout was something where there was broad consultation around these kinds of opportunities. Our belief is that it would have benefited—these particular clauses would likely have benefited greatly from the opportunity for deliberation around them.

We're currently suggesting that we believe that the current section 5 holds very broad powers for the minister, and we continue to support those. However, should there be a continued desire to want to strengthen that, we believe that that should remain within section 5 and be better linked to some of the parameters and procedural fairness around what that might look like, such as sets of criteria, an opportunity to appeal those sorts of pieces that would generally be about due notice etc.

Mrs. Elizabeth Witmer: Thank you very much.

The Chair (Mr. Shafiq Qaadri): Thank you, Ms. Witmer. Ms. Gélinas?

M^me^ France Gélinas: Thank you for your presentation. It certainly was clear, and I give you my assurance that I will bring forward the changes that you want to subsection 4(3).

I'm also interested in continuing the conversation. Where do you think this idea of the minister being able to appoint a supervisor came from?

Ms. Jan Robinson: I would say, actually, that broadly—in the broader community—there is some confusion around that, as to what the specificity is of what we're attempting to fix. I think that certainly our college and many of my colleagues at other colleges are very interested in understanding what we're trying to correct and fix, knowing that there has been opportunity on occasions in the past where the minister has used section 5 or other means to coordinate discussions and collaborate with colleges. I'd have to quite honestly say, Ms. Gélinas, that I'm a bit unclear about exactly what we are attempting to fix, but knowing that there's obviously a concern around broader accountability schemes in the current environment in which we work, which I think we're happy to be part of a dialogue on.

M^me^ France Gélinas: Okay. And you've basically set out some parameters for the dialogue that would be within section 5 where we would work on developing more accountability. Nobody else knows either, so it's the great big secret out there. Thank you.

The Chair (Mr. Shafiq Qaadri): Thank you, Madame Gélinas, and to the government side.

Mrs. Carol Mitchell: Thank you very much for your presentation. We have no questions at this time.

The Chair (Mr. Shafiq Qaadri): Thank you, Ms. Mitchell, and thanks to you, Mr. Hamilton and Ms. Robinson, for your deputation on behalf of the College of Physiotherapists of Ontario.

The Chair (Mr. Shafiq Qaadri): I would now invite Ms. Crump and Ms. Elm, on behalf of the Nurse Practitioner Network of the Central East LHIN, to please come forward, if present. Ms. Crump and Ms. Elm of the

Nurse Practitioner Network of the Central East LHIN—going once.

All right. With that, do we have Ms. Kasperksi, the CEO of the Ontario College of Family Physicians, present, either in this room or on the premises? All right.

Do we have Dr. Polgar, Dr. Riedel Bowers and Mr. Turner of the Social Work Doctors' Colloquium, Use of Title Task Force?

Do we have anyone at all in the province of Ontario who would like to come forward and testify? A 10-minute recess.

The committee recessed from 1632 to 1633.

SOCIAL WORK DOCTORS' COLLOQUIUM, USE OF TITLE TASK FORCE

The Chair (Mr. Shafiq Qaadri): I'll reconvene the committee. I would invite you to please, Mr. Turner, Dr. Polgar and Dr. Riedel Bowers, the Social Work Doctors' Colloquium, Use of Title Task Force. Welcome gentlemen; we are pleased to see you.

Thank you for appearing earlier than scheduled and for the trip from next door. You've seen the protocol—10 minutes in which to make your presentation. Please do introduce yourselves individually for the purposes of Hansard recording, and I would respectfully invite you to please begin now.

Dr. Frank Turner: Dr. Frank Turner.

Dr. Alex Polgar: Dr. Alex Polgar.

The Chair (Mr. Shafiq Qaadri): The floor is yours, gentlemen.

Dr. Frank Turner: Dr. Polgar and I represent a task force on the use of the title "Doctor." We are social workers who have doctoral degrees from accredited institutions of higher learning who are presently restricted from use of the title "Doctor" in the health care settings where we practise.

We urge this committee to modify sections 33 and 43 (1) of the Regulated Health Professions Act to include social workers with doctorates in the group allowed to use the title "Doctor" when providing health care services in Ontario.

The restriction on the use of the title "Doctor" is an anomaly, specific to Ontario. The restriction has two negative effects: First, it serves to discourage social workers from achieving higher levels of education and competence, and secondly, it fails to acknowledge the link between higher education and training and enhanced quality of service inherent in the level of competence of a doctoral degree.

For example, the Minister of Health and Long-Term Care, David Caplan, recently made a commitment to make mental health and addictions a priority. For the most part, this agenda will be accomplished and implemented by social workers. At a very practical level, front-line social work services in addressing such issues as trauma, stress and relationships, seen all too often within child welfare and mental health settings, are all informed and advanced by doctoral-trained researchers and clinicians. The restriction on the use of the title "Doctor" is regressive because it negates the evolution of professional programs that has characterized the advancement of knowledge of social workers for over 200 years.

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The profession of social work has been responding to the growing complex needs of the people of Ontario for this period. Over 60% of social workers in Ontario provide health care services in hospitals, prisons, psychiatric facilities, mental health clinics, homes for the aged, child welfare and family service agencies, and rehabilitation facilities.

As recently as 1977, there was only one social work doctoral program in Ontario. However, the escalating complexity, severity and magnitude of the problems social workers are required to address impelled social work to rigorously develop its knowledge and skill base. Social work responded to this challenge through increasing accredited, university-based doctoral programs. Today, Ontario has more than four social work doctoral programs, the benefits of which are enjoyed by all the people of this province.

A doctorate, by its very definition, represents a significant contribution to knowledge in a particular discipline. From better-informed practice, professionals and consumers of their services benefit.

Excellence in design and delivery of social work services has been, and continues to be, significantly enhanced by each doctoral dissertation and by the subsequent professional activities of the doctoral graduates. So the profession of social work is evolving, as are the quality of services being provided by all social workers wherever and with whomever they practise.

Regardless of whether we can or cannot use our earned title "Doctor" when we offer or provide health care services, social workers with doctorates will continue to use all their advanced knowledge and skills gained through formal education and continuously developed since our graduation. Our group will continue to strive to advance the services provided by social work through our research endeavours, publications and teachings. We could not and would not do otherwise.

Our concern, however, is for those who come after us. More precisely, our concern is that, in the province of Ontario, there will be increasingly fewer bright, energetic and compassionate people pursuing a doctorate in social work. Our concern is that the prohibition will intensify declining enrolment in social work doctoral programs. Already, social workers with doctorates are leaving the province, seeking jurisdictions where their discipline is actively valued and its natural evolution is unconditionally encouraged, funded and publicly celebrated.

Our concern is also that since the restriction on the use of the title "Doctor" and its reflection on the profession of social work is now widely known, new graduates with doctoral degrees who choose to practise in the health care field will leave Ontario to pursue careers elsewhere. As we noted already, Ontarians who, justifiably, expect the best quality of service from every discipline, including social work, will suffer as a result.

With forecasts of a looming human resource shortage in the coming decade, this restriction on the use of the title "Doctor" places Ontario at a significant disadvantage in attracting highly qualified experts in the health care field. At a time when the downturn in the economy is increasing the need for the services that social workers provide, the restriction on the use of the title "Doctor" also has the potential to limit the immigration of social workers who hold earned doctorates to Ontario. This restriction sends a discouraging message to those considering moving to Ontario from other jurisdictions. This also affects those who may consider an academic post in Ontario since many doctoral-level faculty members also continue to practise clinically.

At this time of socio-economic crisis and associated mental health care needs, increased quality of service is required. We urge the members of this committee to encourage their colleagues and the government to remove the restriction on the use of the title "Doctor" by qualified social workers. Thank you.

The Chair (Mr. Shafiq Qaadri): Thank you, gentlemen. We have about a minute or so per side, beginning with Madame Gélinas.

M^me^ France Gélinas: I think your presentation was very clear. Thank you for coming. I have no questions. Your request is reasonable and will be put forward.

The Chair (Mr. Shafiq Qaadri): Thank you, Madame Gélinas. To the government side, Mrs. Mitchell.

Mrs. Carol Mitchell: Just a quick question: How many social workers within Ontario would hold a doctorate now?

Dr. Alex Polgar: Approximately 200.

Mrs. Carol Mitchell: Your presentation has been very clear. Thank you very much.

The Chair (Mr. Shafiq Qaadri): Thank you, Mrs. Mitchell. To the PC side, Mrs. Witmer.

Mrs. Elizabeth Witmer: Thank you very much for coming before us one more time. I know this is an urgent situation, that we ensure that we would have the appropriate social workers with doctorates in our province to provide support to our communities and our people. You can be assured that our caucus will continue to give you our unqualified support.

The Chair (Mr. Shafiq Qaadri): Thank you, Mrs. Witmer, and thank you, Dr. Polgar and Dr. Turner, for your deputation on behalf of the Social Work Doctors' Colloquium.

NURSE PRACTITIONER NETWORK OF THE CENTRAL EAST LHIN

The Chair (Mr. Shafiq Qaadri): I would now invite our recently located next presenters, Ms. Crump and Ms. Elm, to please come forward on behalf of the Nurse Practitioner Network of the Central East LHIN. Welcome. I'm sure you've seen the protocol. I'd invite you to please begin now.

Ms. Colleen Elm: We are here today representing the nurse practitioners from the Central East LHIN. Two well-organized nurse practitioner groups exist in our area, the Peterborough nurse practitioner group and the Durham region nurse practitioner group. Together we represent 60 nurse practitioners as active members, with a larger membership that is associated with our group.

Our members work in urban as well as rural practices. We are both community- and hospital-based. Within our geographic area, nurse practitioners work solo in small communities with links to primary health care physicians 45 minutes away. We provide care to First Nations communities, new immigrants and the poorest of the poor in Ontario. You will find us in large urban practices working with multiple providers. In the hospital, we provide care to the most vulnerable population in our area. Several of our members work in specialty areas such as forensic psychiatry, geriatrics and sexual health clinics.

We are a very diverse group, yet we are united in that we cannot properly provide service to the people of Ontario if Bill 179 is passed in its present form. All of our practices are compromised by not being able to prescribe the medications our clients need.

Ms. Leanne Crump: My name is Leanne Crump and I represent the nurse practitioners from the Peterborough region. I graduated from the McMaster University School of Nursing in 1990, and after working 11 years in various capacities, including emergency medicine, palliative care and community health, I chose to return to school and become a nurse practitioner. I attended Queen's University in 2001 and graduated as a primary health care NP in 2004. After graduation, I worked in the underserviced area of the city of Kawartha Lakes and then for the Peterborough family health team.

I currently share a primary care practice with two family physicians, and combined, we care for approximately 4,000 patients. I care for patients from birth to death, with chronic and acute illnesses, and function very similarly to your family physician. However, my emphasis is on education and optimizing health. Our focus is not illness, but prevention.

A major responsibility for the provincial government is to ensure safe, effective health services for the citizens of this province. Many people today cannot access primary health care services in Ontario. They are called the orphan patients. In our area, we know all too well this dilemma, as three years ago we had over 20,000 people without a family physician, or over 25% of our population. The Ontario government, in its wisdom, brought nurse practitioners into the health system. Now we continue to have orphan patients, but that number is only 2,000. Our emergency visits are down and our physician satisfaction is up. Our patients are receiving better and more timely health care.

Ms. Colleen Elm: My name is Colleen Elm and I represent the nurse practitioners from the Durham region. Over my 37 years of being a registered nurse, I've worked in every health care environment possible. I've worked in busy hospital settings, such as the Toronto Hospital for Sick Children, and isolated communities in Nunavut and northern Ontario.

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In 2004, I graduated from Queen's University as a primary health care nurse practitioner. In June of this year, I obtained my Master of Science in nursing from the University of Ottawa. Although I have a special interest in aboriginal health, currently I'm setting up a clinical service for the Brock Community Health Centre in northern Durham.

For two years, the executive director of the Brock Community Health Centre was unable to attract any health care providers to the area, in spite of a large number of unattached patients in the community. Since I like challenges, I decided to see if I could assist with the situation. I was hired eight weeks ago, and on Thursday, September 24, we put an open sign over our clinic door. Without any other advertisement, within two days we had 80 applications from people coming for care.

Our team consists of a physician and three nurse practitioners. It is my belief that the physician would not have been attracted to the community if an experienced nurse practitioner was not present to share the workload. He had certain concerns when considering coming to our community, such as, "Will I be on call 24/7," and, "What type of patients can you manage as a nurse practitioner?"

While certain medical associations seem to want to restrict nurse practitioners in their practice, on a day-to-day basis the physicians we collaborate with want us to work to our full scope of practice.

Ms. Leanne Crump: As of June 2, 2009, there are 1,367 NPs in the province of Ontario. The education and practical experience of these NPs is a resource that, if fully utilized, can have an enormous positive effect on the population's health and the government's bottom line.

NPs are professional health care providers as well as citizens of our communities. When we petition the government to make changes, it's because we want our families and friends to enjoy access to superior health care services. It is also because we know that we have something to contribute to make the system better.

Under Bill 179, people in Ontario will continue to unnecessarily suffer delays and poor access to best-practice medications, because NPs will be expected to continue to function with extremely limited prescribing authority. Every NP in Ontario has to face the situation, on a daily basis, where patients seeing him or her are disadvantaged due to unnecessary legislative restrictions. The legislated list of medications forces us to delay treatment for patients and utilize NP and physician time ineffectively. At a time in our society when the bottom line is tight and the fat is trimmed from each system, failure to provide open prescribing causes waste in this health system.

There are serious consequences for patients when delays or less than optimal treatment occurs simply because of unnecessary barriers. When our busy physician colleagues, working to full capacity, have to be interrupted to order a medication that an NP could have safely prescribed, it is a waste of resources as well as a source of interprofessional conflict. How many patients could be seen if the nurse practitioner was not waiting in the hall to get her collaborating physician to sign a prescription that he or she has recommended? There are situations where the physician is not on-site and the delay may be a number of days until the physician is present to see a patient.

One might say, "Then use a medical directive to avoid this waste of valuable time." Medical directives are time-consuming and cumbersome. It is impossible to create a medical directive for each situation that we might encounter as nurse practitioners in hospitals and communities, and the need to review them yearly puts a large strain on nurse practitioner and physician time.

Ms. Colleen Elm: We understand that, as a government body, patient safety is the prime concern in considering if nurse practitioners should have open prescribing. NP safety in prescribing has been demonstrated in Canada and internationally. The Canadian Nurses Association has done a risk analysis of NP prescribers in Canada. This is important to add, because other Canadian provinces already have more liberal legislation concerning NPs' prescribing authority. The results indicate that NPs are safe prescribers.

Ontario was the leader in establishing the extended class nursing role. Now we have fallen behind in allowing NPs to expand their scope of practice and function within our system. As other provinces expand the role of nurse practitioner, their health systems have thrived and not fallen apart, as other lobby bodies would have you believe. Patients are receiving more timely health care and cost savings have been seen.

In the United States, 49 states have authorized nurse practitioners to prescribe on their own signature. A few states restrict nurse practitioners' ability to order controlled drugs such as narcotics, but in 37 states, nurse practitioners have no restrictions and can order controlled drugs as well. The American research concludes that nurse practitioners are safe providers.

Nurses and physicians are two professions that work with diverse populations. Other professions, such as midwifery or optometry, have a focused practice. A nurse practitioner working in a cardiology specialty is familiar with and uses a very different list of drugs than a nurse practitioner working in neonatology. It therefore follows that nurse practitioners have different skill sets, either because of their education—pediatric, adult, primary health care or anesthesiology training—or as a result of their professional development and experiences.

It is for this reason that no list can adequately address the needs of all nurse practitioners and their clients. What is universal to the profession is that nurse practitioners must have the ability to accept and manage consequences of their professional actions.

The Chair (Mr. Shafiq Qaadri): You have about a minute left.

Ms. Colleen Elm: Competency is achieved through rigorous science-based education and training. The College of Nurses of Ontario regulates nurse practitioners

and ensures that ongoing competency is maintained. With these stringent safeguards in place, the public is protected.

Ms. Leanne Crump: As NPs, we consult other professionals—physicians, pharmacists and physiotherapists—when the knowledge base of the NP has been surpassed. This is part of a responsible NP practice. This type of collaboration ensures that the client receives the best care possible, as our physician counterparts do in their practice: If they see a patient who is beyond their scope, they refer them to a specialist. In our case, if we see a patient and do not have the knowledge, skill and judgment to handle this with confidence, we would consult or refer that patient to our physician partner or an appropriate specialist.

Open prescribing does not give any NP the right to prescribe a medication if the NP does not have the knowledge, skill and judgment to manage the consequences of the drug's effects. What open prescribing does is make the health—

The Chair (Mr. Shafiq Qaadri): Thank you, Ms. Crump and Ms. Elm, for your deputation on behalf of the Nurse Practitioner Network of the Central East LHIN.

ONTARIO COLLEGE OF FAMILY PHYSICIANS

The Chair (Mr. Shafiq Qaadri): I now invite our final presenter of the day, Ms. Kasperski, CEO of the Ontario College of Family Physicians.

Ms. Jan Kasperski: The Ontario College of Family Physicians has been actively participating in the HPRAC process, and the documents that we've brought with us today will certainly show that we very much support the intent of Bill 179. We wish to place emphasis on the need to support interdependent collaborative practices amongst health care professionals.

Many of the concerns that Bill 179 is attempting to address arose from the critical shortage of family physicians in this province. Family physicians and the patients they serve are very appreciative of the government's many efforts to address the shortage of family physicians in this province. As the educational college representing 9,300 family physicians in this province, we're very pleased with the efforts of the past few years, and they are starting to show great promise. Ontario's medical universities are leading the country in the percentage of medical students who identified family medicine as their specialty of choice this year. Among the universities out west, the average percentage of medical students choosing family medicine residency programs was 27%, in Quebec it was 29%, and in the eastern provinces it was 31%. Here in Ontario, it was 41%, and that's something to celebrate.

In the practice environment, over nine million people are formally enrolled with their own family doctor, and the number of our members who are privileged to work in an interprofessional team environment is growing by the day. Their patients are the true beneficiaries of the type of collaborative care that Bill 179 supports.

However, in the minds of the media and the public, increased scopes of practice for non-physicians is tied to the shortage of family physicians and not to the enhancements in patient care that accrue when physicians, nurses, pharmacists and other health care professionals establish collaborative relationships. A quote in this past weekend's newspaper illustrates this point: "With so many parts of this province suffering an acute physician shortage, surely if a doctor isn't available, a well-trained nurse practitioner is better than nothing?" The government, family doctors and especially nurses do not want to see nurse practitioners described as "better than nothing," nor do we wish NPs to be viewed as physician substitutes. Bill 179 needs to be seen as an enabler of collaborative care.

The Canadian Nurses Association and the College of Family Physicians of Canada released a vision statement two years ago which the OCFP strongly endorses. We envision a health care system in which every Canadian would have the majority of their care provided in a family practice by a family doctor and a registered nurse and/or a nurse practitioner. The vision recognizes that family practices are the bedrock, the very foundation of our Canadian health care system, and studies show that health outcomes are better when patients have their own family doctor and when that care by the family doctor is supported by primary care team members. The key role that RNs and nurse practitioners should play in family practices is highlighted in this vision, and the evidence used to support the vision clearly emphasizes the importance of collaboration in the primary care sector.

The OCFP recognizes that when a doctor or a nurse practitioner works in isolation, the impact on quality patient care can be described as one plus one equals one. When they work in parallel or sequentially, then one plus one equals two. It is only when superb nursing skills combine with excellent medical skills that we end up with the synergy that makes one plus one a three.

The safe prescribing of medications requires training in taking a medical history, performing a physical examination, determining the medical interventions that are needed, and then interpreting results and formulating a differential or a working diagnosis for the patient in each of the clinical presentations. These are the skills that the family doctor brings to the collaborative team.

When we work with pharmacists collectively, we have the ability to effectively monitor adverse drug reactions, provide guidance and advice in regard to the best medication regimes, review chronic disorder prescriptions for a limited period of time, and counsel patients regarding the use of medications, prescribed and over the counter. In other words, one plus one equals three yet again.

Bill 179 could be used as an attempt to create independent practices if expanded scopes of practice are seen as the end goal. The bill needs to be strengthened by ensuring that its language makes it very clear that its intent is not to provide expanded scopes of practices in order to support independent practices and more silos in the system, and the regulations need to be very carefully

construed to ensure that Bill 179 results in fostering true interdependent practices among all health care providers.

The OCFP reviewed Bill 179 through the lens of its ability to support collaborative practices and improve access to care, but with an overlay of concern for patient safety. The sections of the bill that we have reviewed are as follows:

We support the adoption of a new object for the health professional regulatory colleges that makes it clear that each college should develop its own standards of practice but should do so through a process that includes collaboration and consultation with the other colleges.

The appointment of a supervisor for the established colleges, such as the College of Physicians and Surgeons of Ontario or the College of Nurses of Ontario, should occur rarely, if ever, given the commitment of government to self-regulation among the health professionals. The circumstances under which such a supervisor would be appointed need to be clearly delineated.

Remote dispensing should be limited to those areas of the province that are able to establish an acute need for the service, since the personal, ongoing relationship with a pharmacist is an important adjunct to patient safety. Increased powers to prescribe, administer, dispense, compound, sell, mix and use drugs or other substances, as stated in the bill, for each profession requires careful consideration. Each college that is granted added powers should be required to review its implementation plan with an expert committee appointed by the Lieutenant Governor in Council. The committee should review the circumstances when the powers would be needed, the conditions required to ensure patient safety and the methods that would be used to address conflicts of interest, particularly in the arena of prescribing and selling.

Our views on the expanded roles of pharmacists, nurse practitioners and others are well documented in the papers that we have already presented to HPRAC and the minister.

The amendment to allow the Lieutenant Governor in Council to create an expert panel to identify the list of drugs and other substances that various professionals would be allowed to prescribe is very much supported by the OCFP and seen as a key factor in patient safety. A similar expert committee should be established to review and guide the safe implementation of additional authorized acts to ensure that the process is anchored in concerns regarding patient safety and is a model of collaboration and consultation among the colleges. Again, the documents that we have provided document our concerns in this area.

The powers afforded to HPRAC will ensure that the minister receives required advice and that there is transparency in the activities conducted by HPRAC.

The requirements that colleges make team-based care a key component of their quality assurance programs to ensure ongoing competence of registered health professionals is very much supported by the college. Again, an expert panel would be helpful in assisting colleges to add rigour in the areas of maintenance of competency for all professionals.

Given the increased risks of liability in the provision of team-based care, all health professionals should be required to have personal professional liability insurance—

The Chair (Mr. Shafiq Qaadri): You've got about a minute left.

Ms. Jan Kasperski: —but we like the term "liability protection" rather than "insurance." It seems to be a much more appropriate term since it implies responsibilities to protect not only the individual professional but other individuals and organizations that may be impacted if a problem occurs. The language seems to indicate that it would be the colleges themselves that would be responsible for providing the insurance language. We may need to look at that.

In summary, the college very much supports Bill 179 in principle and we definitely see its value. If used appropriately and if good regulations are in place, it will support the movement toward true interprofessional collaboration among all of us.

The Chair (Mr. Shafiq Qaadri): Thank you, Ms. Kasperski, for your deputation on behalf of the Ontario College of Family Physicians.

That brings to a close our deputations for today. If there is no further business before the committee, we're adjourned until 4 p.m. in this room tomorrow.

The committee adjourned at 1703.

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