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Tuesday 29 September 2009

Journal des débats (Hansard)

Mardi 29 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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ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

STANDING COMMITTEE ON SOCIAL POLICY

COMITÉ PERMANENT DE LA POLITIQUE SOCIALE

Tuesday 29 September 2009

Mardi 29 septembre 2009

The committee met at 1558 in committee room 1.

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.

Le Président (M. Shafiq Qaadri): Chers collègues, j'appelle à l'ordre cette réunion du Comité permanent de la politique sociale à l'Assemblée législative. Colleagues, I call to order this meeting of the social policy committee. As you know, we're here to deliberate on Bill 179. We have a number of presenters.

Just for the protocol for all presenters: Everyone will have 10 minutes in which to make their presentation. Should any time remain within those 10 minutes, they'll be distributed evenly amongst the parties for questions and comments and cross-examination. The times will be vigorously and precisely enforced in order to accommodate all the various members. I think we have more than 60 presenters or so coming to us over the next several days. We also have an overflow room next door, I'm told, because it was standing room only here yesterday.

CANADIAN SOCIETY OF DIAGNOSTIC MEDICAL SONOGRAPHERS

The Chair (Mr. Shafiq Qaadri): With that, I would now welcome our first presenters, Mr. Boles, president, and Ms. Foran, executive director, of the Canadian Society for Medical Diagnostic Sonographers.

Just before officially beginning your time I once again would like to welcome, on behalf of the committee, and by extension on behalf of the people of Ontario, one of our former colleagues, Richard Patten, member of provincial Parliament from Ottawa. So, welcome, Mr. Patten. I would now invite you all to please begin.

Mr. Kim Boles: Good afternoon, ladies and gentlemen. Thank you for taking the time to listen to us this afternoon. As Mr. Qaadri has said, my name is Kim Boles. I'm the president of the Canadian Society of Diagnostic Medical Sonographers, and also a practising sonographer. With me is Kathleen Foran, who is the executive director for the Canadian Association of Registered Diagnostic Ultrasound Professionals and is also a practising sonographer.

CSDMS represents approximately 2,500 ultrasound professionals nationally and includes practising sonographers, technical representatives, physicians, educators and students. CARDUP certifies approximately 3,100 sonographers throughout Canada.

Bill 179 has an important impact on the way health care will be delivered in Ontario. It seems that in most areas, CSDMS and CARDUP believe that the proposed legislation will have a positive impact. However, we believe that in some cases it goes too far and puts Ontarians at serious risk. We strongly believe that improving access to health care should not mean reducing the quality of care provided.

Ultrasound professionals, also called sonographers, go through extensive training and are certified to perform diagnostic ultrasounds. This training, provided at a number of postsecondary institutions throughout Ontario, is rigorous and usually takes over two years. Diagnostic ultrasounds are crucial in determining important medical diagnoses such as the development of the fetus, the existence or extent of a cancer, or the presence and severity of vascular and cardiac diseases.

Well-known organizations such as the Canadian Association of Radiologists and international experts such as Professor Taylor from Yale University recognize that sonographers play a crucial role in the interpretation of ultrasound images, which leads to a diagnosis. As you can understand, this cannot be left in the hands of someone without the proper training.

Ms. Kathleen Foran: This partially flawed legislation puts Ontarians at risk of misdiagnosis. This patient safety issue needs to be addressed in Bill 179 in the form of an amendment.

Misdiagnosis may lead to the patient following the wrong treatment for his or her ailments while the real issue is not properly addressed. Who will be held accountable if someone dies because a person without the proper training is responsible for a misdiagnosis? Rather than having to answer that question, we would prefer to be proactive and propose solutions. We would propose to

amend paragraph 5.1(1)4 by adding to the sentence "Applying or ordering the application of a prescribed form of energy" the following words: "as long as the person has the appropriate training and certification in the application of specialized forms of energy from a recognized post-secondary institution or its equivalent."

It is appropriate to have health care professionals with the proper training perform complicated procedures. However, having people without the appropriate training perform procedures for which they are not trained opens the door to very negative consequences for patients.

We know that the government intends to look at drafting regulations following the adoption of this bill. We believe that it would be more prudent to enshrine the requirement for training in the legislation.

Alternatively, the government may want to draft regulations requiring registered nurses to go through the required training and certification to perform diagnostic ultrasound examinations, as provided today by Ontario post-secondary educational institutions or their equivalent.

The government side has a chance to clearly state that these provisions will be included in the regulations. Will they do so today in this committee? Again, we would prefer a strong amendment to this legislation ensuring that Ontarians' health is protected by having the properly trained professionals look after them.

The Chair (Mr. Shafiq Qaadri): Thank you very much. You've left a generous amount of time for questions. We'll have about two minutes per side, beginning with the PC caucus. Ms. Witmer.

Mrs. Elizabeth Witmer: Thank you very much for your presentation. Now, if I understand it correctly, you're not opposed to the expansion of the scope of practice but you're wanting this amendment added in order to protect the safety of the patient. Is that right?

Mr. Kim Boles: That is correct. We want appropriate training, education and certification to be included in the competency profiles for nurses in the extended practice.

Mrs. Elizabeth Witmer: Okay, and that's the only group you're referring to because of what is—

Mr. Kim Boles: It's the only group of concern to us in Bill 179, yes.

Mrs. Elizabeth Witmer: What type of training and education do you see being necessary? I think you've indicated here that your own professionals receive at least two years of training.

Ms. Kathleen Foran: There's a national competency profile for sonographers that basically says what an entry–level person practising sonography should be doing. We would like to see that incorporated in the education requirements for nurses in the extended classes. That's our first and foremost concern. The length of time that it takes them to complete these competencies to be at an entry level would be entirely up to them.

Mrs. Elizabeth Witmer: Okay, so they would be developing their own program?

Ms. Kathleen Foran: They have programs in place as nurse practitioners. We would just want to ensure that the competency profiles to perform sonography are included.

Mr. Kim Boles: It would seem to us that they would probably piggyback onto programs which currently exist in the province.

Mrs. Elizabeth Witmer: All right. Thank you very much.

Mr. Kim Boles: Thank you.

Le Président (M. Shafiq Qaadri): Merci, madame Witmer. Je passe la parole à M^me^ Gélinas.

M^me^ France Gélinas: Merci. I want to make sure I understand. Under Bill 179, the way it is written now, nurse practitioners are in an extended class and will be allowed to order ultrasounds, but I didn't think they would be allowed to perform them.

Mr. Kim Boles: And apply forms of energy, which leaves—it's wide open. Not only can you order but you can also perform the examination, which we feel is inappropriate, particularly without appropriate training and certification.

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Ms. Kathleen Foran: In the bill, as it stands right now, it would allow nurse practitioners to order the ultrasound, do the ultrasound scan and communicate the diagnosis, without any training.

M^me^ France Gélinas: Okay. So I take it that you don't have any problem with them requesting an ultrasound.

Mr. Kim Boles: None whatsoever.

M^me^ France Gélinas: You have a problem with doing the actual ultrasound, if they haven't got the proper training.

Mr. Kim Boles: We would consider that their ability to order the examination would be a designated act from the College of Physicians and Surgeons of Ontario. It's the application of the form of energy—in this case, ultrasound—that we have a problem with, without expansion of their existing competency profiles.

M^me^ France Gélinas: Thank you.

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

Mr. Bas Balkissoon: Thank you very much for your presentation. Since you're raising the issue with nurses only at this time—and I guess legislation can always change—do you see that this could be adequately achieved through the college of nurses, that their standards and requirements for certification to perform this process would be part of their certification and only those who are trained would be allowed to practise?

Mr. Kim Boles: I would be concerned that a regulatory body or the association would set their own standards and police their own standards. I would like to see something in legislation requiring them to do so.

Mr. Bas Balkissoon: But currently don't most of the colleges set their own standards and police them—

Mr. Kim Boles: They set their own standards; they do. That's part of the thing. But you're setting your own training requirements; the whole routine. It just has to be a mandatory requirement. The colleges would be—the weakness in that system is that they're always allowed to make their own changes without—

Mr. Bas Balkissoon: So you don't view this legislation similar to others, that the legislation enables the colleges to do that type of work on behalf of the government to certify their people, to police their people and ensure the right training? Even liability insurance is protected. You don't support that at all?

Mr. Kim Boles: No, I do support that, but what I'm saying is that without the appropriate language in the bill, there is no requirement for them to do so.

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

The Chair (Mr. Shafiq Qaadri): Thanks, Mr. Boles and Ms. Foran, for your deputation on behalf of the Canadian Society of Diagnostic Medical Sonographers.

ONTARIO MEDICAL ASSOCIATION

The Chair (Mr. Shafiq Qaadri): I now invite Mr. MacLeod, president-elect of the Ontario Medical Association, and colleagues. Welcome. I would invite you to please begin now.

Dr. Mark MacLeod: Mr. Chairman and members of the committee, my name is Mark MacLeod. I am president-elect of the Ontario Medical Association. I'm a practising orthopaedic surgeon in London, Ontario, and I'm an associate professor of orthopaedic surgery at UWO.

On behalf of Ontario's doctors, I would like to begin by thanking the committee and its members for the opportunity to be here today and to continue to lend our voice to this important discussion about the future of health care in this province.

My comments today will focus on several key points in Bill 179. We have also submitted to you a detailed written response for your review.

With me today is Ada Maxwell, senior policy analyst at the OMA.

The OMA believes that every Ontarian deserves to have access to the care and expertise of a physician. That being said, we also recognize the value of inter-professional care. We support initiatives that enhance the ability of health care professionals to work to the full scope of their responsibility as long as patient safety is protected. When physicians, nurse practitioners, pharmacists, dietitians and others work together, we can deliver a more comprehensive level of care to our patients than when we work in silos.

The OMA endorses several proposals in this bill. We agree that the Regulated Health Professions Act should set parameters for HPRAC's activities. As a body that advises the minister, HPRAC should be directed by the minister. We are also pleased that the minister has not adopted HPRAC's proposed regulatory oversight body.

The OMA also agrees that mandatory liability coverage for all health professionals is necessary.

Finally, we encourage the government to pursue an independent expert committee to review proposed drug lists for colleges with prescribing authorities.

From the OMA's perspective, successful inter-professional care means that mechanisms are in place for ongoing communication amongst and between caregivers. It means that we foster respect for the contributions of all professionals within this group. Most importantly, it means that our patients are receiving safe and effective care.

With those principles in mind, I would like to turn to the topic of nurse practitioners. Physicians have practised in some type of collaborative style with nurses for decades. One only has to look at our province's shared-care pilot projects with nurse practitioners based in fee-for-service office settings to see that good things can happen when health care providers complement one another, not replace one or the other.

In terms of nurse practitioners prescribing, it is not the OMA's intention to recommend regulatory practice standards for other self-regulated professions. However, as a matter of patient safety, we do feel that the nursing council should welcome a ministerial expert drug committee to support it in the regulatory function.

We have no objection to nurse practitioners casting fractures; the critical issue for us is assessing the injury to make a correct decision about treatment. As an orthopaedic surgeon, I can assure you that there are significant differences between open and closed reductions, two of the techniques that we use to treat fractures. An open reduction involves making an incision in the skin, manipulating the fragments and directly stabilizing those fragments with implants. Closed reduction means just that: No incision is made, the fracture is manipulated indirectly, and then a cast is usually applied. Open techniques are often the best option but can only be performed by a physician. I am worried that a nurse practitioner will see a patient and decide to treat a fracture with a closed technique when an orthopaedic consultation would have revealed that an open reduction was indicated. Inappropriate use of a closed reduction technique could result in the loss of function or future unnecessary deterioration. This is a good example of the kind of problem our patients would face if nurse practitioners acted without proper consultation with physicians.

One final comment on nurse practitioners: There has been significant discussion around allowing nurse practitioners to admit patients to hospitals. The OMA supports the government's decision not to take this step. While this issue is not directly discussed in Bill 179, we anticipate further debate on this point. Hospital admission is reserved for patients whose medical condition is sufficiently serious or unstable to require in-patient care. It is important for patient safety and resource utilization that every in-patient admission be under the authority of a physician.

I would like to offer a few brief comments on the proposed changes to the Pharmacy Act. First, as I mentioned, the OMA believes that communication between health care providers is key. We suggest that an integrated electronic medical record system is an important preliminary step before we have multiple health care providers prescribing. Under Bill 179, pharmacists would be able to adjust, adapt or extend prescriptions. While we

appreciate that this does not mean that pharmacists would have broad prescribing rights, we are troubled by lingering issues around patient safety.

If you are a diabetic patient, your family doctor will recommend how often you should test your blood sugar levels. Testing times are based on the kind of medication your family doctor has prescribed and on how well your sugar levels are controlled. You and your family doctor spend time to carefully map out your treatment plan. Now imagine that, instead of following your physician's plan of care, as a patient you walk into a pharmacy and have your blood sugar level tested, and your medications are altered by the pharmacist. You now have two separate treatment plans. This may be confusing for you as the patient, and it will make it extremely difficult for your family physician to accurately monitor your progress in your diabetes management. While we think that pharmacists can and should play a more active role in the health care system, we do not think that promoting disconnected practice silos is the right way to go.

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We also see an issue around when physicians are informed about changes to patient prescriptions. There has been little discussion around whether a pharmacist should consult a physician before altering a prescription or whether notifying a doctor after the fact is sufficient. Certainly, these decisions hinge on a number of factors, but this is a critical issue that needs attention before changes are implemented.

One final comment: As pharmacists take on more significant roles in patient management, they will have to develop appropriate record-keeping skills to ensure patient safety. At this time, physicians can be required to keep patient records for up to 28 years.

When it comes to inter-professional care, physicians have worked based on the premise that we are all striving to deconstruct silos of care. If that is our goal, we strongly believe that we should prevent silos at the professional level by maximizing opportunities for inter-professional collaboration.

We are pleased that the government has seen fit to continue discussion on some of the outstanding issues in this bill, and we hope these issues will be addressed in the coming weeks. We look forward to seeing the amendments to this bill and the draft regulations as you conclude your committee hearings.

The Chair (Mr. Shafiq Qaadri): Thank you, Professor MacLeod. A brisk 40 seconds each. Madame Gélinas.

M^me^ France Gélinas: Pleased to meet you, Dr. MacLeod. I was glad you mentioned that you support inter-collaborative care and that, really, through regulation and legislation, we should make that easier. Some of your colleagues, though, talk about inter-collaborative care always governed by a physician. Do you agree?

Dr. Mark MacLeod: First of all, we support our professional colleagues. We think that all of the health care professionals in this province contribute significantly towards health care. We support a collaborative model of care—

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

Mr. Bas Balkissoon: I want to thank you very much for taking the time to give us your input.

The Chair (Mr. Shafiq Qaadri): Ms. Elliott.

Mrs. Christine Elliott: Thank you very much, Dr. MacLeod. I'm just wondering if you have any specific recommendations for amendments that you will be submitting to us for consideration.

Dr. Mark MacLeod: I'm going to let Ada respond.

Ms. Ada Maxwell: In our written submission, there are suggested amendments. Not specific wording, but we also suggest that regulations could deal with some of the issues we've put forward.

The Chair (Mr. Shafiq Qaadri): Thank you, Ms. Elliott, and thanks to you, Professor MacLeod and Ms. Maxwell, for your deputation on behalf of the Ontario Medical Association.

ONTARIO COLLEGE OF SOCIAL WORKERS AND SOCIAL SERVICE WORKERS

The Chair (Mr. Shafiq Qaadri): I'd now invite our next presenters, Ms. McDonald, Ms. Birnbaum and Ms. Tarshis of the Ontario College of Social Workers and Social Service Workers. Welcome. I'd also ask you to just please introduce yourselves individually for the purpose of Hansard recording, and I'd invite you to please begin now.

Dr. Rachel Birnbaum: Good afternoon, Mr. Chairman, ladies and gentlemen. My name is Dr. Rachel Birnbaum. I'm the first vice-president of the Ontario College of Social Workers and Social Service Workers. With me today is the registrar of the college, Glenda McDonald, and the legal counsel for the college, Debbie Tarshis. I wish to thank the members of the committee for agreeing to hear our presentation this afternoon.

As you know, the college is the regulatory body for social workers and social service workers in Ontario and has approximately 15,000 members. The college will focus our presentation on the proposed amendments to the Regulated Health Professions Act, the Psychotherapy Act and the Social Work and Social Service Work Act, which will permit members of certain professions to use the title "psychotherapist" if certain conditions are met. The college strongly supports these amendments.

The college is particularly pleased that Bill 179 recognizes the key role that members of this college play in the delivery of psychotherapy services to Ontarians and enables them to continue making that contribution by being permitted to use the title "psychotherapist." These amendments are consistent with the college's submission to this committee on the Health System Improvements Act, which recommended that social workers be permitted to use the restricted title "psychotherapist," provided that this title is used in conjunction with the

restricted titles "social worker" or "registered social worker."

As members of the committee are aware, once the Health System Improvements Act is fully in force, psychotherapy services will be provided by qualified professionals belonging to a number of different regulated professions. The public associates the provision of psychotherapy services with the title "psychotherapist." The college strongly supports the government's initiative in Bill 171 to increase the protection of the public of Ontario by permitting the use of the title "psychotherapist" by members of those professions authorized to perform the controlled act related to psychotherapy, provided that the members also identify which profession they belong to.

However, the college requests that the committee consider a relatively minor technical amendment to Bill 179 as set out on page 3 of our written submission, which I believe you all have. The proposed section 47.2 of the Social Work and Social Service Work Act would read as follows:

"Despite section 8 of the Psychotherapy Act, 2007, a member of the college who is authorized to perform the controlled act of psychotherapy may use the abbreviated title 'psychotherapist' if the member complies with the following conditions, as applicable:

"1. When describing himself or herself orally as a psychotherapist, the member must also mention that he or she is a member of the Ontario College of Social Workers and Social Service Workers, or identify himself or herself using the title restricted to him or her as a member of the college.

"2. When identifying himself or herself in writing as a psychotherapist on a name tag, business card or any document, the member must set out his or her full name, immediately followed by the following, followed in turn by 'psychotherapist':

"i. the restricted title that the member may use under this act."

The college believes that the current option for members to place the name of the college after their name and before "psychotherapist" in written documentation will be cumbersome and potentially confusing to the public and proposes that this option be deleted. The college believes that the use in written documentation of the lengthy title of the college followed by "psychotherapist" may also lead a member of the public to believe that the member is employed by or holds an official position at the college. The amendment proposed by the college is also consistent with the registration regulation made under the Social Work and Social Service Work Act that the member be required to use the restricted title.

The college believes that the amendments we are recommending to Bill 179 will ensure that the public interest will continue to be protected by making it very clear which members of the Ontario College of Social Workers and Social Service Workers are authorized to call themselves psychotherapists in Ontario.

The college supports the important initiatives that the government has undertaken in Bill 179 to permit those regulated professionals qualified to provide psychotherapy to use the title "psychotherapist" and to hold themselves out as qualified to provide psychotherapy.

Thank you for the opportunity to make this submission to the standing committee and for your consideration of the college's recommendations.

The Chair (Mr. Shafiq Qaadri): Thank you very much. About two minutes or so per side, beginning with the government. Mrs. Mitchell.

Mrs. Carol Mitchell: Thank you for your presentation. I just have a quick question. You know that this bill is about increasing access to our health care professionals and collaboration and encouraging that. How do you see your role going forward in working with your members? How do you see the ability to enhance the collaboration from your association? Do you see that as part of your role, figuring out how you can improve the access to services?

Dr. Rachel Birnbaum: I'd like Glenda as the registrar to answer that, please.

Ms. Glenda McDonald: First of all, we're a regulatory body and not an association—

Mrs. Carol Mitchell: I know, I know.

Ms. Glenda McDonald: —so I just want to clarify that. We have been very involved in the government initiatives on inter-professional collaboration spearheaded by the Ministry of Health and Long-Term Care, although, as you probably realize, we're accountable to the Ministry of Community and Social Services. So we have been working very hard with our own ministry as well as with the Ministry of Health and Long-Term Care to ensure we are included as members of the inter-professional family, if you will, to enhance collaboration.

Without doing a commercial, inter-professional collaboration is something that's fundamental—

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

Mrs. Christine Elliott: Thank you very much for your presentation. I just want to confirm that the primary reason for advancing this sort of technical amendment is really to make it more clear to the public what they're dealing with.

Dr. Rachel Birnbaum: Absolutely.

Mrs. Christine Elliott: Okay—very reasonable. Thank you.

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

M^me^ France Gélinas: A very good presentation, and easy to understand. I find it's a relatively minor amendment that you're asking for and it will make things clearer, so you will have our support.

Dr. Rachel Birnbaum: Thank you very much.

The Chair (Mr. Shafiq Qaadri): Thank you, Madame Gélinas, and thanks to you, Ms. McDonald, Dr. Birnbaum and Ms. Tarshis, for your deputation and presence here today on behalf of the Ontario College of Social Workers and Social Service Workers.

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COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

The Chair (Mr. Shafiq Qaadri): I'd now like to invite Mr. Tulsiani of the College of Physicians and Surgeons of Ontario, known as the CPSO to its members and to its colleagues. Welcome, and I'd invite you to please begin now.

Dr. Rayudu Koka: Thank you, Mr. Chairman and the members of the committee, for this opportunity to appear before the committee. I am Ray Koka, president of the college. I am a psychiatrist practising in Sudbury and the surrounding areas. With me today are Rocco Gerace, our registrar; Maureen Boon, associate director of policy; and Norm Tulsiani, government relations adviser.

Overall, we are supportive of the legislation, particularly efforts to ensure greater inter-professional care. We do, however, have some very significant areas of concern. The first is the troubling and unexpected supervisor and audit provisions. The second is ensuring that inter-professional care is delivered in a coordinated fashion. I will also provide brief comments on some other aspects of the bill.

Supervisor and audit provisions: The college is very concerned about these provisions because they give the minister a broad discretion to take over a self-regulating body for virtually any reason. The college regulates the medical profession in the public interest and is committed to accountability. However, we believe these new powers are unnecessary because the minister already has wide power under section 5 of the RHPA. The minister has the authority, for example, to require health colleges to do anything that, in the minister's opinion, is necessary or advisable to carry out the intent of the RHPA, the health profession acts or the Drug and Pharmacies Regulation Act.

In addition, there are numerous oversight mechanisms in place to ensure accountability. These include, but are not limited to, reviews by the Fairness Commissioner of our registration policies; an appeals process for our registration and complaints decisions to HPARB; public consultations on all our regulations and policies; cabinet approval of all regulations; open council and discipline hearings; and the highest proportion of government-appointed members on our boards. Given the broad range of oversight tools already available to the minister, we recommend that this provision be removed from the bill.

If the committee chooses not to remove the supervisor provision, we recommend that it be amended to provide that this extraordinary power only be used in exceptional cases where a college does not comply with the minister's request under clause 5(1)(d) and the minister is satisfied that there is a risk to patient safety.

A decision to undertake such a dramatic intervention into the affairs of a regulatory body of a self-governing profession requires careful consideration. We are concerned, for instance, that extensive media coverage of a particular case could result in a rush to judgment and an inappropriate decision to appoint a supervisor or auditor. For this reason, we believe that including some procedural safeguards would be useful.

The college recommends that the supervisor provision be amended to require the minister to first turn to existing powers under section 5 to address any issues relating to a regulatory college. Only where the college does not fulfill the requirements set out in clause 5(1)(d), and where the minister is satisfied that patient safety is at risk, would the minister move to appoint a supervisor. Before doing so, the minister would be required to follow certain procedural steps:

—provide written notice to the affected college—not less than 60 days—which outlines the requirement that the college did not fulfill;

—give the college an opportunity to make written submissions;

—give the college an opportunity to comply with the ministerial directions and avoid the appointment of a supervisor; and

—ensure that the powers granted to the supervisor are consistent with those which are necessary to address the requirements outlined in the minister's notice and do not reach over into other areas.

The college's proposed amendments are attached as appendix A to our full submission.

We believe that the audit provision should be removed as health colleges are independent, self-funded bodies that do not rely on public funding. The Royal College of Dental Surgeons of Ontario, the College of Nurses of Ontario and the Ontario College of Pharmacists support this recommendation, and also the amendments that are contained in our submission.

Inter-professional care and scope expansions: The college has consistently supported inter-professional care as a way for all health care professionals to work collaboratively for the benefit of the patient. Care must be provided in a way that breaks down silos, ensures optimal care for patients and avoids duplication and higher costs. We caution that focusing on specific scope details while neglecting broader systemic issues may entrench professional silos and result in fragmented care.

The college supports the bill's proposed scope expansions in general, provided they are consistent with the knowledge, skill and judgment of the professionals involved, support a truly collaborative, team-based approach and are subject to rigorous regulatory structures. Our submission outlines some of the challenges and potential remedies.

Other areas, if I may touch upon them: On the issue of prescribing, the college believes prescribing must only be done in collaboration with a health professional who has the range of controlled acts that are essential to assessing the health of the patient as a whole, rather than a particular ailment or injury.

With respect to pharmacists, Bill 179 simply states that pharmacists are authorized to prescribe drugs. We note that this is inconsistent with the recommendations of

HPRAC and the substance of the PAPE; that is, the Pharmacist Authorization of Prescription Extensions agreement. The college believes that pharmacists have a key role to play in managing medication but this must occur in collaboration with a prescriber, and only after a diagnosis has been made. We believe that significant previous work in this area must be included in the regulation.

We endorse the requirement for a unique identifier for health professionals and support the use of MINC, the Medical Identification Number for Canada, for physicians. Bill 179 is not clear that MINC is the intended model for physicians and could be amended to state this explicitly.

The college believes that all professionals who dispense drugs should meet the same basic standards and that the standards in the Drug and Pharmacies Regulation Act should be the benchmark.

The college is also seeking two additional amendments to the RHPA that will allow us to fulfill our mandate to protect the public more efficiently:

(1) Amend the requirement that the college investigate every complaint received, and allow the college to decline to investigate a complaint if it does not relate to the professional misconduct, incompetence or incapacity of a member and does not raise a public safety issue; and

(2) Allow non-council members of the public to be counted towards a quorum for the ICRC and discipline committees, to avoid past situations where the college has not been able to achieve a quorum due to the unavailability of public council members.

Our written submission covers these and other issues in greater detail. Thank you very much for the opportunity to present to the committee.

The Chair (Mr. Shafiq Qaadri): Thank you, Dr. Koka, and your colleagues. We have about 40 seconds again, beginning with the PC side. Ms. Witmer.

Mrs. Elizabeth Witmer: Thank you very much for your presentation. I know that the issue of a supervisor has been of concern to yourselves and other colleges as well. I'd just like to ask you briefly: What would be the implications to public safety if a supervisor was appointed to take all of or part of the college's mandate?

Dr. Rayudu Koka: Maybe Rocco could answer that.

Dr. Rocco Gerace: The concern is whether or not there will be the ability to appreciate the practice of medicine. As you know, the profession has long taken that responsibility, understanding what doctors do and being able to adjudicate in areas of misconduct and incompetence. We're not sure that an independent individual would have that ability.

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

M^me^ France Gélinas: Following what you've just said, what already exists within your college to ensure the accountability of your college?

Dr. Rocco Gerace: There are a host of accountability frameworks that we have. For example, with public complaints, there exists the Health Professions Appeal and Review Board, which has the authority to review any complaint, whether it's appealed by a patient or a doctor.

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In respect to the discipline committee, there is the ability to appeal to Divisional Court or seek judicial review of decisions. Decisions of the registration committee, similarly, can be appealed to the Health Professions Appeal and Review Board. More generally, there is the activity of the Fairness Commissioner, doing audits on registration practices—

The Chair (Mr. Shafiq Qaadri): Thank you. The government side. Ms. Mitchell.

Mrs. Carol Mitchell: Thank you very much for your presentation. You certainly have made your position very clear on the supervisor's position, but you also have brought forward recommendations that you are proposing instead of the supervisor's position. So, as laid out in your presentation, you have about 30 seconds to expand.

Dr. Rocco Gerace: I think just very briefly, if the supervisor provision is going to stay in, there should be a more defined trigger and there should be a series of steps through which the minister has to proceed in order to order a supervisor. We've outlined those steps in our submission. There should just be some control—

The Chair (Mr. Shafiq Qaadri): Thank you, Ms. Mitchell. Thanks to you, Drs. Koka and Gerace, and to Mr. Tulsiani and your colleague for your deputation, written and by coming as well, on behalf of the College of Physicians and Surgeons of Ontario.

MARVIN SIEGEL

The Chair (Mr. Shafiq Qaadri): I would now like to invite our next presenter, Mr. Marvin Siegel, who I understand comes to us in a private capacity.

Mr. Marvin Siegel: What capacity, sir?

The Chair (Mr. Shafiq Qaadri): A private capacity as a citizen of Ontario, for which you are of course welcome.

Mr. Marvin Siegel: I have been called worse.

The Chair (Mr. Shafiq Qaadri): You may begin.

Mr. Marvin Siegel: Thank you for allowing me to appear here before you today. It is not my first time appearing before one of these committees or before HPRAC and making submissions to them.

I have not submitted a brief or a submission in the form submitted by everyone else. Unlike everyone else who has appeared before you today, I do not represent any regulated health profession, nor do I represent any organization. I totally represent myself.

Briefly as to background, I have experience in appearing before discipline committees of the College of Physicians and Surgeons of Ontario on motions. I have never represented anyone at that college; they're well-represented by the Canadian Medical Protective Association. I have brought motions under section 41.1 of the code, which I believe was the first one brought to any regulated health profession college since 1994, when the act came into effect. I have appeared on behalf of a

member of the college, a denturist. I have made motions before that college and also before the Ontario College of Pharmacists on numerous matters. I do believe I have reasonably extensive experience, over the last 14 years, in dealing with the Regulated Health Professions Act and the procedural code.

I will say this: I will not be making any submissions with regard to any of the other pieces of legislation that affect the health professions or the interaction between the various health professions. I appreciate that one can destroy one's credibility by making a slight joke, but the most attractive lady who's the pharmacist who provides me with my pharmaceuticals—I'd be most happy for her to inject me if she ever had to do so in the event of the swine flu epidemic.

If I may go on, I'm going to break down my submissions into various categories: Firstly, how did I get started on this business? A medical doctor was falsely billing OHIP on my behalf: billing OHIP for treating my family with family counselling, which did not exist; he did not ever meet any of my daughters when he started billing OHIP for family counselling. He allegedly was providing me, in billing, for individual in-patient psychotherapy which did never occur. I have never been an in-patient in a hospital until such time as I broke an arm playing hockey while at law school.

Very simply, I want to cover certain issues. Firstly, I would direct you people to read Jane Jacobs's book Dark Age Ahead, in which she deals specifically in a short, 13-page chapter with the issue of the learned professions, of which the clergy were the first. Some of you may not know, but in England, probates were not done by barristers or solicitors; they were done by the clergy, and all medical services at that time were free. Very simply, she anticipates, in the book entitled Dark Age Ahead, her last book, which came out in 2005—in May, I believe—that the lack of capacities of the learned professions are issues leading to the decline of our civilization.

I've got to get on with it, because those minutes go by so very quickly.

As to the fraud, which was my initial interest in health care, because there are provisions in the Health Insurance Act where any person can get one's own billings—I had vibes about the particular physician involved; I checked him out and found out the false billings. I did not go to the ministry; my connections were primarily with crown authorities. I went to the fraud squad. They said they couldn't handle it; it was too small a matter to prosecute a doctor for what amounted to a $1,250 fraud with regard to me. This doctor was billing OHIP excessively. He was billing when he wasn't there; he was billing when the patient wasn't there—all in breach.

The College of Physicians and Surgeons, to whom I provided my first complaint to the college on the matter of the fraudulent billing, which is covered by 856, the regulation under the Medicine Act, disposed of it, took no further action. "Billing disputes are not within the jurisdiction of the complaints committee." Whose jurisdiction are they within? I went to the health pro board, and I will deal with them on a very important matter in a moment. The health pro board upheld the dismissal of the claim. Dr. Gerace mentioned to you going to the health pro board, and this is very important, because he made representations—and I'm just going to digress for a minute—with regard to the interplay between the College of Physicians and Surgeons, and in my submission to you, in terms of who I was, I said I will restrict my comments primarily to the College of Physicians and Surgeons, which I believe is the reason for the proposed legislation.

I am not opposing that legislation and I'm not yet qualified to make a proper submission as to the proposal, but I do suggest, with respect, that it is most important. It recognizes the fact that the College of Physicians and Surgeons is not carrying out its statutory duty. I refer you to subsection 3(1) of the Regulated Health Professions Act's procedural code, which sets out the objects: to govern and regulate the profession according to the statutes, regulations and bylaws. I submit, with respect, that the College of Physicians and Surgeons has not done that. When you go down to subsection 3(2)—in carrying out its objects, the college shall serve and protect the public interest.

In my respectful submission, in the past 10 years, the College of Physicians and Surgeons has not carried out those objects in two important respects. One is with regard to the issue of enforcing the advertising regulation, which I'll deal with briefly. The second one, most importantly, which is the issue that Dr. Koka raised, was the one situation, obviously, of Dr. Yazdanfar and the tragic Stryland situation. That deals with Medicine Act regulation 865, subsection 2(5), which reads that "the holder of a certificate of registration shall only practise in those areas of medicine in which the holder is prepared by education and experience."

If I may deal with advertising—and I'd like to deal with one issue on fraud. I monitored every single OHIP fraud case that came down the pike, despite the zero tolerance in respect to health care fraud. Very quickly: a doctor, a psychiatrist, was over-billing OHIP. An OPP senior officer involved in that investigation informed me as an aside—and I will advise who it was when I appear on this matter before the Divisional Court, before whom I have appeared on other related matters—that the true amount of his fraud was $300,000.

I brought an application under the college's own rule 1203 to get production of documents in that matter. I was denied each and every single one—the notice of hearing, which is now publicly handed out, any documents filed; absolutely nothing. The college said that they had no legal obligation to provide me with any information. We are now getting notices of hearing on request. That flows from a Divisional Court decision in the matter of the Star versus Toronto city police.

I realize I'm running out of time.

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The College of Physicians and Surgeons talks constantly about openness, transparency and the rationale for

our decisions. I'll give you one simple example. I have been monitoring the College of Physicians and Surgeons for almost 15 years. I have material from each and every one of their council meetings over that period of time, going back to February of 1996. Very simply, on one occasion, a Dr. Hurst, a single, young doctor from Schreiber, Ontario, was charged with sexual abuse. Prosecutorial discretion: I appreciate the term and what it means. It applies to criminal prosecutions and it applies to discipline prosecutions. In that hearing, when you talk about openness, transparency and rationale for our decisions—when the report of that decision and any other was presented to council, a public member stood up and asked, "Why was this"—

The Chair (Mr. Shafiq Qaadri): One minute remaining, Mr. Siegel.

Mr. Marvin Siegel: "Why was this penalty so slight?" Dr. John Bonn, then the registrar of the college, advised, "Due to legal advice, I cannot say more." This is a member of council, a public member of council. Dr. Bonn said, "Due to legal advice, we can say no more."

The only other thing I want to say is this: I support totally the matter of the new bill. It would take too long to make submissions as to various ingredients of it. Very simply, in my brief documents that I put before you, I would ask you to consider two documents—and I'll be very quick. One is the three-page letter, dated September 23, 2009, from the Health Professions Appeal and Review Board, in which they do not give me proper—

The Chair (Mr. Shafiq Qaadri): With respect, Mr. Siegel, the time has now expired. I'd like to thank you on behalf of the committee for appearing today. I believe we did receive a written submission from you as well, did we not?

Mr. Marvin Siegel: You did not, sir. I presented documents which would be supporting some of my submissions. May I ask you this, sir?

The Chair (Mr. Shafiq Qaadri): That's what I'm referring to.

Mr. Marvin Siegel: May I ask you—

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

FEDERATION OF HEALTH REGULATORY COLLEGES OF ONTARIO

The Chair (Mr. Shafiq Qaadri): I now call our next presenters to please come forward: Ms. Coghlan, the president of the Federation of Health Regulatory Colleges of Ontario, and colleagues—

Ms. Anne Coghlan: Thank you very much.

The Chair (Mr. Shafiq Qaadri): First of all, as you've seen, the protocol is 10 minutes. Please do introduce yourselves individually. Go ahead.

Ms. Anne Coghlan: Thank you very much, and good afternoon. My name is Anne Coghlan, and I am president of the Federation of Health Regulatory Colleges of Ontario. With me today is Jan Robinson, our vice-president.

The federation is an umbrella organization for 22 health regulatory colleges, which govern health professions under the authority of the Regulated Health Professions Act. There are almost a quarter of a million regulated health professionals in Ontario.

The federation facilitates inter-professional collaboration, educational activities, common frameworks and implementation of strategic directions. It also serves as a vehicle for collective consultation with the ministry.

While the federation's submission on Bill 179 focuses on amendments to the RHPA and not on profession-specific issues, the federation supports, in principle, legislative changes that facilitate inter-professional collaboration.

The federation has a history of collaborative work with the ministry and with the Health Professions Regulatory Advisory Council to facilitate effective regulation of health professionals in the public interest. It therefore came as a complete surprise that there was no consultation with the federation in relation to provisions which appear in Bill 179, giving the minister powers to appoint a managerial supervisor and to mandate operational audits. The federation and the minister have developed an effective collaborative relationship over the years, which the proposals seem to disregard.

I wish to emphasize that we want to work with the government to make better use of the current section 5 of the RHPA, which we believe gives the minister the necessary powers to ensure that colleges are acting in accordance with the legislation. The federation recognizes that health colleges must be accountable to the Minister of Health and Long-Term Care and to the public. Accountability is a major theme of the RHPA and a focal point for our federation.

That accountability already includes, which you've heard earlier this afternoon, mandatory reporting; complying with minister's directives; the appointment of public members who serve on our councils and committees' providing the public with information about our members; a strict regulation and bylaw approval process; ensuring meetings are open to the public; appeals processes through a special tribunal and the courts for adjudicative decisions; and scrutiny by HPRAC, which acts as directed by the minister.

To further enhance accountability, the RHPA has been amended a number of times. Recent additions require colleges to file reports of registration practices with the Fairness Commissioner, expand information available to the public about our members, and add information on college websites. Recent legislation also increased the power of the minister to receive information from colleges. In addition, changes to the Ontario Human Rights Code and the Personal Health Information Protection Act have led to increased scrutiny of college actions by other external agencies.

Despite the fact that regulatory colleges are held to a high degree of accountability, the federation and its members go beyond the requirements enshrined in legislation. One example is the formation of our task force on

accountability, agreed to well before the introduction of Bill 179. The task force on accountability is exploring common mechanisms for an accountability framework. We have included the ministry as a key stakeholder in this important undertaking.

All existing accountability measures and legislative powers aside, Bill 179 has introduced new provisions that we believe are counter to the collaborative and transparent approach that the government professes. As written, Bill 179 adds provisions enabling the minister to appoint a supervisor to take over the administrative management of a college; the minister may also direct an operational audit. As I indicated at the outset, these provisions were introduced without any consultation with the federation and were not recommended by HPRAC.

Further to that, the federation has not been provided with any explanation as to why this additional power is needed or any example of where the existing powers of the minister are inadequate. Currently, section 5 of the RHPA gives the minister sweeping powers, including the right to require a council of a college to do anything that, in the minister's opinion, is necessary or advisable to carry out the intent of the legislation. The federation concludes that the need for new provisions is unclear and unnecessary.

Rather than relating to the appropriate level of accountability, the proposed provisions appear to relate to the operations and management of colleges. This runs contrary to the minister's role of oversight to ensure good governance of colleges. If there is a problem, the current provisions in section 5 give the minister the power to ensure that appropriate governance is restored.

Regulatory colleges differ from hospitals and school boards. Colleges are funded by members. The supervisor model that now exists for publicly funded organizations is a poor fit in the regulatory college model.

Bill 179 also lacks clarity. For example, there are no criteria identifying when appointing a supervisor might be appropriate. There is no requirement that the minister first make a finding that the college is failing to fulfill its essential public interest objects. In addition, procedural safeguards in the provisions are inadequate. There is no requirement to use section 5 of the RHPA first and to only use supervisor or managerial audit powers if that intervention fails. There is no due process. There is no maximum term for the intervention and no appeal or review mechanism.

Further, the powers of the supervisor and auditor do not have the expected constraints. There is no protection to prevent confidential or privileged information being disclosed. There is also no discussion of financial accountability, including who pays for the supervisor's or auditor's work, how reasonable remuneration would be managed and how to preserve the college's assets from being appropriated by the supervisor.

If it is felt that section 5 of the RHPA needs to be more explicit, the addition of specifying that the minister may direct the attendance by college representatives at a meeting called by the minister to discuss concerns or an alternate dispute resolution mechanism could be considered. If additional enforcement mechanisms are needed for non-compliance by a college, this can also be addressed through amendments to section 5. Adding a mandatory injunction provision to require a college to comply with a minister's directive or a power to appoint, with suitable safeguards, a supervisor to implement a minister's direction under section 5, if a college failed to comply with that direction, could also be considered.

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The federation supports strong public accountability by regulatory health colleges. Extensive accountability, in fact, already exists. We recommend that the supervisor and audit provisions be removed. They do not achieve greater accountability beyond what is already available in the current statute.

We reiterate that we would be pleased to work together with the minister and HPRAC to review the issue of accountability and to develop appropriate and effective solutions to any concerns that might exist. While there is always room for improvement, in the absence of specific areas of concern, the proposed changes imply a lack of confidence in colleges' accountability. The federation would welcome frank dialogue with the government and an opportunity to collaborate on solutions that meet our joint commitment to effective regulation in the public interest.

The Chair (Mr. Shafiq Qaadri): Thank you, Ms. Coghlan. Thirty seconds; to the government, Mr. Balkissoon.

Mr. Bas Balkissoon: I just wondered if you listened to the alternative suggested by the CPSO. Would you agree to that alternative?

Ms. Anne Coghlan: The federation's submission is very similar and does support the recommendation of CPSO.

Mr. Bas Balkissoon: Is the college of optometrists a member of your federation?

Ms. Anne Coghlan: The federation is made up of all of the current health—

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

Mrs. Christine Elliott: Thank you very much for your presentation—very clear and very reasonable.

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

M^me^ France Gélinas: You presented very valid arguments as to why there shouldn't be that provision for a supervisor. Do you know where this idea came from?

Ms. Anne Coghlan: No. We have not been given any indication of what the source of the recommendation is.

The Chair (Mr. Shafiq Qaadri): Thank you, Madame Gélinas, and thanks to you, Ms. Coghlan and your colleague, for your deputation on behalf of the Federation of Health Regulatory Colleges of Ontario.

ONTARIO CHIROPRACTIC ASSOCIATION

The Chair (Mr. Shafiq Qaadri): I would now invite our next presenters to please come forward: Dr.

Brunarski, president, and Dr. Haig, executive director of the Ontario Chiropractic Association. Welcome, gentlemen. Please introduce yourselves individually and begin.

Dr. David Brunarski: Good afternoon. My name is Dr. Dave Brunarski, and I am the president of the Ontario Chiropractic Association. Joining me today is OCA executive director Dr. Bob Haig. We would like to thank you for this opportunity to present our views on Bill 179. We will take just a few minutes to allow time for questions.

The OCA is the voluntary professional organization that has represented the chiropractic profession since 1929. Just over 80% of Ontario chiropractors are OCA members.

Dr. Haig?

Dr. Bob Haig: Good afternoon. The Ontario Chiropractic Association is highly supportive of the government's resolve to remove barriers that limit practitioners' ability to practise to the extent of their education, training and competence and to effectively participate on interprofessional collaborative teams. It is for these two important reasons that we're here today.

In Ontario, the chiropractic profession is supported by three bodies: the Ontario Chiropractic Association, the College of Chiropractors of Ontario and the Canadian Memorial Chiropractic College, which is the educational institution. Obviously, while each has their own mandate and responsibilities, you will hear today from each organization why we are united in recommending the same single, straightforward amendment to Bill 179.

The musculoskeletal conditions that chiropractors manage are among the most costly and burdensome both to society and to the health care system. In Ontario, the estimated direct and indirect cost of back pain alone is $2.4 billion a year. Chiropractors provide diagnosis and treatments to more than a million patients with these conditions every year.

The recent HPRAC recommendations, Bill 179—which is under consideration here—and the regulation-making process to follow are all intended to enhance scopes of practice where that's necessary and to provide the tools for practitioners to practise fully within their scope. In the current form, Bill 179 makes recommendations for a number of professions but not with respect to chiropractic.

We are not seeking an expanded scope of practice. Rather, we are seeking the diagnostic tools to improve our ability to practise within the existing scope. Specifically, those tools are magnetic resonance imaging and diagnostic ultrasound—and it's the ability to order those, not to actually perform them.

Let me give you an example of how things work currently. A patient consults a chiropractor for back pain. It's one of those few cases where, to arrive at an accurate diagnosis and ensure that the correct treatment approach is applied, the patient requires an MRI. Currently, the chiropractor refers that patient to a family physician or a medical specialist, the physician orders the test, the test is performed, the results go back to the physician, the patient goes back to the physician and then finally the results are conveyed to the chiropractor. Given that the chiropractor is fully trained and competent, this convoluted route is unnecessary and inefficient, and contributes to increased wait times, the burden on physicians and the added cost on the system. So it's important to recognize that chiropractors already "order" these tests. It happens in Ontario every day, but they're ordered through a physician. The OCA is simply asking that chiropractors be permitted to directly order these tests.

Attached to our brief you will find a number of letters from front-line family physicians and other health care professionals who work with chiropractors in multidisciplinary settings and who support this amendment. For example, a Hamilton physician who is part of the Hamilton family health team has written directly to you to say, "Chiropractors will be able to care for patients in a more appropriate manner, thereby avoiding time-consuming and costly referrals to other disciplines. This will serve to alleviate an inconvenience to the patient and expedite recovery."

In the past few weeks we've met with most of you and many of your colleagues. The reaction we have received is that this request is logical, it's simple and simply makes sense. If this is not implemented, it will be years before there's another opportunity to do so. Implementing it now will avoid years of inefficiency, unnecessary costs, compromised patient care and barriers to interprofessional collaboration. Implementing it now will enable chiropractors to better lend their training and expertise to delivering health care in a variety of collaborative and integrative health care settings. Specifically, and consistent with provisions already in Bill 179 for some other professions, we ask the committee to amend Bill 179 to amend section 4 of the Chiropractic Act in order to include the authorized act of ordering the application of a prescribed form of energy. The proposed legislative amendment is documented in detail on page 7 of our brief, which you have in front of you. This amendment will provide for the development of regulations to permit chiropractors to order MRIs and diagnostic ultrasounds.

Chiropractors are deeply committed to the health of Ontarians and to the Ontario health care system. We hope to work with you, as we are working with other health care professions, to create a better, stronger and healthier Ontario. Again, thank you for the opportunity to present our views, and we'll be happy to answer any questions.

The Chair (Mr. Shafiq Qaadri): We have about two minutes per side, beginning with the PCs. Ms. Elliott.

Mrs. Christine Elliott: Thank you very much for your presentation. It is very clear; I just want to confirm, though, that there is only the one amendment that you're suggesting, specifically the one that's on page 8 of your presentation. Is that correct?

Dr. Bob Haig: That's correct. It's on page 7. The Chiropractic Act is being opened. There's a change with respect to the appointment of public members. We're suggesting this other one-line addition to that amendment.

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

M^me^ France Gélinas: There have been a number of presentations—I lost track, actually—but some of them saw limiting the number of providers who could order MRIs as a way to limit the use of expensive technology and basically lobby against anybody gaining access to requesting MRIs. What would you answer to that?

Dr. Bob Haig: The largest research study that's been done that would address this is in a patient population of 1.7 million in a very large HMO. For those patients who had access to chiropractic services, the cost for musculoskeletal treatment was substantially lower. One of the reasons was because of reduced use of advanced expensive imaging. This is what chiropractors do. They're very diligent in their use of it. So if anything, we could anticipate a reduction.

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

Mr. Bas Balkissoon: I want to thank you for being here and presenting to us. I think your presentation is very clear and well understood.

The Chair (Mr. Shafiq Qaadri): Thanks to you, Dr. Haig and Mr. Brunarski, for your deputation on behalf of the Ontario Chiropractic Association.

Just before I call our next presenter I would once again, on behalf of the committee, like to recognize the presence of Ms. Barbara Sullivan, former member of provincial Parliament, in the government of Ontario. Welcome.

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DIETITIANS OF CANADA

The Chair (Mr. Shafiq Qaadri): I'd now invite Ms. Leslie Whittington-Carter of the Dietitians of Canada to please come forward. Welcome, and please begin.

Ms. Leslie Whittington-Carter: Good afternoon. I'm Leslie Whittington-Carter and I'm the Ontario government relations coordinator for Dietitians of Canada. Thank you for the opportunity to speak with you today about Bill 179.

Dietitians of Canada is the professional association representing registered dietitians in Ontario. We have over 6,000 members nationally, and about 3,000 of our members are here in Ontario. Dietitians of Canada is committed to excellence in patient care, and we support regulatory mechanisms that ensure public safety. We're also a strong supporter of inter-professional care, and we're in favour of initiatives that enhance the ability of health care professionals to work together in the best interests of the patient.

We're pleased to provide comment today on this bill, which represents a significant impact on the practice of health care professionals in the province. We have five main recommendations for the committee, which are found on the first page of our submission, just after the cover page. The first is that we ask the committee to support the amendment that has been written into Bill 179 to the Dietetics Act, which will allow dietitians to take blood samples by skin pricking. The ability to perform this simple aspect of the controlled act will make it much easier for dietitians to effectively provide care for their patients, particularly patients suffering from diabetes, by testing blood-glucose levels, so we ask for your support to leave that as it is.

The second recommendation is actually for an addition to the bill regarding the scope-of-practice statement for dietetics. The scope-of-practice statement currently set out in the Dietetics Act does not clearly reflect the activities of our profession. A request was made to HPRAC in our original scope-of-practice review application, which was a joint application by Dietitians of Canada and the College of Dietitians of Ontario, and that was not put forth as a recommendation to the minister in HPRAC's Critical Links report. The main reason given was that the changes we requested did not directly affect the practice of controlled acts for our profession. However, we feel that that does not fully recognize the purpose of a scope-of-practice statement and that, in particular, the inclusion of the health promotion aspect of our practice is very important and is also found in a number of other regulated health professions' scope-of-practice statements, as outlined on the submission.

Our proposed scope-of-practice statement was crafted with the input of our members, as well as the regulatory body and other stakeholders. We've given the revision that we would recommend on page 2, along with a detailed rationale on pages 2 and 3 for our changes.

The third request that we would make of this committee is actually for a regulatory amendment. While we realize that you do not deal directly with changes to the regulations, we feel that this is directly related to Bill 179 and that it's of sufficient importance to the health care system that the members of this committee need to be made aware of it. Currently, registered dietitians cannot directly order nutrition therapy within a hospital due to the provisions of the Public Hospitals Act, which specify which professions can order diagnostics or treatments within a public hospital. That means that the experts in foods and nutrition—the registered dietitians—can only recommend a diet order or a nutritional therapy, but the actual order has to be written either by the physician or co-signed by the physician or the nurse practitioner. The delays that result from this are very detrimental to patient care and a very poor use of health practitioners' time. We feel that, with the current shortage of all health professions, it's very important that regulatory requirements support the provision of safe, effective and efficient care. You'll find a full description of this issue within our submission, and we ask that you consider forwarding this request to the minister to amend the regulation under the Public Hospitals Act to allow dietitians to directly order nutritional therapy within public hospitals.

Our final two recommendations to the committee are also found in submissions of other professional associations belonging to CORHPA, the Coalition of Regulated Health Professional Associations. The first is that the provisions within Bill 179 concerning the appointment of

a college supervisor be removed or substantially amended. As you've heard from other presentations yesterday and today, we feel that the minister has adequate powers under the current RHPA to compel a college to act, and that the ramifications of a supervisor's appointment would have very negative effects on the regulatory body and hence on the professionals that are its members, who support the regulatory body through their registration fees.

Finally, concerning the professional liability insurance reference in Bill 179, although we've been verbally assured by ministry staff that the intent is not to have regulatory bodies actually provide professional liability insurance or professional practice insurance, it is important that the wording in section 24 be changed to ensure that that is clearly laid out.

Thank you very much for the opportunity to present our recommendations to you. I'd be happy to answer any questions.

The Chair (Mr. Shafiq Qaadri): Thank you, Ms. Whittington-Carter. We have about a minute or so per side, beginning with M^me^ Gélinas.

M^me^ France Gélinas: I would say, very well done. There are five; I understand them all, and I found them all in the bill. That's a miracle right there.

The one that is a little bit tricky is the one that has to do with the Public Hospitals Act. You suggest that we include this in Bill 179?

Ms. Leslie Whittington-Carter: My understanding is that because it is a regulatory amendment, we are just asking for your support to the minister's office and to the relevant ministry staff to update the regulations.

M^me^ France Gélinas: Okay.

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

Mrs. Carol Mitchell: Thank you very much for your presentation. Just to add further, you know that this bill is about further allowing collaboration and expanding our health services. How do you see that the amendment you're asking for in the hospitals act would enhance your role? And specifically, could you give me an example directly related to diabetes?

Ms. Leslie Whittington-Carter: The amendment that we're asking for under the Public Hospitals Act we feel would enhance collaboration by allowing the time that's currently spent, or I'll say wasted, in chasing a physician's co-signature on a diet order to be spent in meaningful patient care collaboration, actual discussion between health professionals on complex patient care cases.

Mrs. Carol Mitchell: So specifically, if a diabetic strategy was developed for a patient, do you have the authority to initiate a nutritional plan with that client?

Ms. Leslie Whittington-Carter: At this point, no. We would make the recommendations, for example, for the number of calories or carbohydrates or the diet order or plan. At this point, our order would then need to be co-signed by the physician or nurse practitioner.

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

Mrs. Christine Elliott: I just have a quick follow-up question on the same subject. As things stand now, are you the one who actually writes it and it's the physicians who just sign off on it? Is that how it works?

Ms. Leslie Whittington-Carter: It depends on facility policy. That certainly happens in some instances. The dietitian will actually write the order and the physician will just sign it. In other facilities, they won't allow the actual writing of the order, so then you have to ask the nurse to get the physician to actually write the order.

Mrs. Christine Elliott: But the input is essentially always from the dietitian?

Ms. Leslie Whittington-Carter: Yes, definitely. And according to surveys of our members, almost 100% of their recommendations for nutrition therapy are straightaway signed off by the physician. So it's not affecting patient care except to delay it.

Mrs. Christine Elliott: Thank you.

The Chair (Mr. Shafiq Qaadri): Thank you, Ms. Whittington-Carter, for your deputation on behalf of the Dietitians of Canada.

CANADIAN MEMORIAL CHIROPRACTIC COLLEGE

The Chair (Mr. Shafiq Qaadri): I now invite our next presenter, Dr. Moss, president of Canadian Memorial Chiropractic College, and colleagues. I invite you to begin now, please.

Dr. Jean Moss: Good afternoon, Mr. Chairman and members of the committee. We thank you for the opportunity to speak to you today with regard to Bill 179. I am Dr. Jean Moss, president of the Canadian Memorial Chiropractic College, commonly referred to as CMCC. With me today are two of my colleagues: Dr. Silvano Mior, special assistant to the president, and Dr. Deborah Kopansky-Giles, coordinator, integrated care research.

Established in 1945, CMCC is the only English-speaking chiropractic educational institution in Canada. Students enter CMCC after a minimum of three years of university-level education. They then complete four years of intensive study, leading to the doctor of chiropractic degree, offered under the written consent of the Ontario Ministry of Training, Colleges and Universities.

In addition, CMCC is accredited by the Canadian Federation of Chiropractic Regulatory and Educational Accrediting Boards and is recognized by regulatory bodies in each province and territory.

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We support the government's initiatives to promote and facilitate inter-professional education and collaboration among health care professionals for the benefit of all Ontarians. In order to achieve this, CMCC, together with the College of Chiropractors of Ontario and the Ontario Chiropractic Association, requests that the committee consider a minor amendment to the current Chiropractic Act to allow chiropractors to order diagnostic

tests such as MRI and diagnostic ultrasound. This would be consistent with the intent of Bill 179.

As you may be aware, the Health Professions Regulatory Advisory Council noted that enabling health care providers to perform tasks consistent with their competence will not only enhance their working with others but will potentially allow them to take on new or altered roles in collaborative environments. Interprofessional education plays a critical role in achieving this goal.

CMCC is recognized internationally for advancing interprofessional education by introducing ground-breaking clinical experiences for its students within multidisciplinary settings. We educate our interns and graduate students to participate as members of multidisciplinary health care teams within partner health care institutions; for example, Anishnawbe Health Toronto, South Riverdale Community Health Centre, Sherbourne Health Centre, St. John's Rehabilitation Hospital, and St. Michael's Hospital. CMCC has also been involved in the delivery of several award-winning interprofessional educational programs in collaboration with St. Michael's Hospital and the University of Toronto.

Our faculty has conducted research assessing the role of chiropractic in inter-professional care consistent with the government's vision of team-based community primary care. This research, our experience and that of our collaborators suggest that collaborative care can benefit patients, improve efficiencies in the delivery of care to patients with musculoskeletal conditions, reduce repeat visits to physicians and provide timely patient access to much-needed care.

Chiropractors are well educated in determining when to order and in interpreting imaging tests appropriate to their scope of practice. The principles of diagnostic imaging at CMCC are integrated throughout the majority of the courses in the doctor of chiropractic degree program. Courses range from radiation physics to specific pathologies to advanced imaging technologies, such as MRI and diagnostic ultrasound. Students use these skills in diagnostic imaging in the development of differential diagnosis to advance the clinical decision-making skills essential to success in clinical practice.

The CMCC curriculum, based on core clinical competencies, national clinical guidelines and standardized learning outcomes, provides CMCC graduates with the ability to judiciously order and interpret relevant clinical diagnostic tests in order to accurately communicate a diagnosis to patients.

It is important that all health care professionals be enabled to practise to their level of training and education in order to achieve effectiveness in inter-professional collaborative care. Being able to directly order advanced diagnostic tests would enhance the ability of chiropractors to make efficient and effective clinical decisions, reduce potential duplication of already-limited services and assure safe and quality patient-centred care for all Ontarians.

A minor regulatory amendment, as noted above, would enhance chiropractors' ability to provide health care within their full scope of practice as members of an integrative, collaborative team contributing to a stronger and healthier Ontario.

We appreciate the opportunity to present to this committee today. We are happy to respond to any questions from the committee.

The Chair (Mr. Shafiq Qaadri): Thank you very much, Dr. Moss, for your presentation. We have about 90 seconds per side, and we'll lead off with the government. Mr. Balkissoon.

Mr. Bas Balkissoon: Thank you, Mr. Chair. Are your graduates currently trained in MRI and ultrasound?

Dr. Jean Moss: Yes, they're currently trained in ordering and interpreting.

Mr. Bas Balkissoon: Thank you very much.

The Chair (Mr. Shafiq Qaadri): Ms. Elliott.

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

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

M^me^ France Gélinas: How does the training in MRI that your students get compare to the training of a physician?

Dr. Jean Moss: I couldn't answer that question for you, but for the majority, the average family physician doesn't have much training in the interpretation of MRIs; that's usually done for them by radiologists. But I haven't got those facts with me.

M^me^ France Gélinas: Thank you.

The Chair (Mr. Shafiq Qaadri): Thank you, Dr. Moss, and your colleagues Dr. Kopansky-Giles and Dr. Mior, for your presentation on behalf of the Canadian Memorial Chiropractic College, commonly known as the CMCC, as you rightly said.

ROYAL COLLEGE OF DENTAL SURGEONS OF ONTARIO

The Chair (Mr. Shafiq Qaadri): I now invite President Fefergrad of the Royal College of Dental Surgeons of Ontario to please come forward. Welcome, and please begin.

Mr. Irwin Fefergrad: You've elevated me in the position I hold; I'm the registrar at the college. I aspire to be president one day, but I don't think that's going to happen soon. Thank you for inviting me and for accepting my invitation to be here. I know it has been a long afternoon for you.

I should tell you, by way of background, that I'm not a dentist; I'm a lawyer. I'm the only lawyer in the province of Ontario who has a double specialty in health law and in civil litigation. I tell you that so that what I share with you might perhaps have a little more weight than otherwise.

You've heard from many of my colleagues, and will continue to hear, about the concerns around the drafting and the provisions of Bill 179, and of course you've got a joint letter we submitted on September 25. I don't propose to repeat what you've already heard. I want to

chat with you a bit about the message you give when there is a bill of this sort that has awesome authority and power in the hands of a minister to insert a supervisor. What is the message that a council gets? By the way, as you know, government appoints 49% of most of the councils, and certainly mine. What is the message that this council receives?

Let me tell you a little bit, in context, about what we have been doing in the last year to support government initiatives and government activities. There has been, from the Royal College of Dental Surgeons of Ontario, full, total and unqualified support of the initiatives around the amendments to the RHPA—at no small expense, by the way, to the dentists of Ontario; and full, complete and total support of the initiative of this government—and indeed, every government in the country, the federal government included—on the agreement on internal trade, such that in order to have permit-to-permit registration, we have negotiated a national agreement that includes every regulator in dentistry from Newfoundland to British Columbia and every university that teaches dentistry, and that was at no small expense.

When the government passed the fairness legislation, we not only supported it; we asked to be the first one to be audited. As you will remember, the audit provisions under the FARPA legislation have the cost borne by the colleges and by the individual members. I'm delighted to report to you that we were audited and came up with a sterling report, complying with all the provisions of fairness. There's comment in the report about the efforts dentistry is making to reduce barriers to internationally trained dentists.

We've been fully supportive of the ministry around human resource database initiatives, also at no small expense. Around pandemic, we've not only been supportive; we've lent some of our staff resources to assist different committees of the government to try to help out in any way we can, and that's just in the last year or so.

So, in the face of a piece of legislation that says the minister has this awesome authority, almost without really outlining the rationale, and frankly, there isn't a clear indication in the legislation what would be the trigger—that is not a message that I think is healthy to give to regulators that are compliant and that want to regulate with one purpose; that is, in the public interest.

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I would urge you to ask yourselves, if you were sitting on the council of any college—but particularly my own, where these activities have taken place—how would you feel if you were faced with Bill 179, which says that the minister shall, at his or her discretion, impose a supervisor? I don't think you'd feel particularly good about what you've done, and you might ask yourself, "What more do I need to do? What else do I have to do to prove myself, to establish that we can regulate in the public interest and protect public safety?"

As you look at this bill, I would ask that you consider the existing section 5 authority, and if more is needed, I would urge you not to trash out section 5 but have it as a precedent so that at least there are some trigger points, at least there is some notice so colleges can understand what the ministry or the minister may be concerned about. Give the colleges an opportunity to rectify it, so that the good faith that has been shown can continue to be demonstrated. Absent that, the message that goes out is not a healthy one and not an encouraging one, especially to the many people you yourselves appoint to sit on these councils.

One last point, and then I'll stop, is the power to request an audit. As you know, we are obligated to provide audited statements, which we do; you've heard that before. I don't know how one answers the question to a profession that doesn't look to government for one nickel—not one nickel—in its operations. So they wonder why a minister would want the authority that is contemplated in this statute.

Those are my submissions. I know that you have a difficult time; it's a difficult statute, and there are many features to it. I thank you for your time, and I'm happy to receive any questions.

The Chair (Mr. Shafiq Qaadri): Thank you, Mr. Fefergrad. We'll start with the PC side for a minute or so. Ms. Elliott.

Mrs. Christine Elliott: Thank you very much, Mr. Fefergrad. I think you have been listening to some of the other presentations, and you know that a number of other groups have similar concerns to those you have expressed.

I think it's troubling on several levels. First, a number of groups have indicated that these provisions are being brought forward without any meaningful consultation; and secondly, the lack of limits on the circumstances under which this power can be exercised. Thank you for bringing that forward in such a cogent fashion, and we certainly are listening and considering very closely.

Mr. Irwin Fefergrad: In the interest of answering your question, may I say that this is a college that actually welcomes accountability. You'll note—I'm not going to read the whole report I brought, but Barbara Sullivan chairs HPRAC, a wonderful organization. There are some quotes there from our college, which actually endorses and asks for accountability, but in a meaningful and fair way.

Mrs. Christine Elliott: Thank you very much.

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

M^me^ France Gélinas: I certainly agree with the comments that my colleague just made, and you are not the first representative to talk about the provision of a supervisor. Do you have any idea where it came from and what it's trying to do?

Mr. Irwin Fefergrad: I don't. In fact, I asked that question at briefings, and I'm no clearer as to where it comes from. My assumption is that it comes from a very good place: government trying to do the best it can to address a problem. I'm not sure what the problem is, but I know the solution can't be appropriate to whatever the problem is. The self-regulation we have in this province is envied across the world. This kind of provision is not a healthy message to give.

M^me^ France Gélinas: Thank you.

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

Mr. Bas Balkissoon: Thank you, Mr. Chair, and thank you very much for your input. The College of Physicians and Surgeons of Ontario made a submission for an alternative to the wording in the bill with regard to the supervisor. Have you had a chance to read it, and do you support it?

Mr. Irwin Fefergrad: We, I think, jointly wrote a letter on September 25: ourselves, the college of nurses, the college of pharmacists and CPSO. I haven't changed my mind since September 25.

Mr. Bas Balkissoon: Okay, thanks.

The Chair (Mr. Shafiq Qaadri): Thank you, Mr. Fefergrad, for your presentation on behalf of the Royal College of Dental Surgeons of Ontario.

COLLEGE OF NURSES OF ONTARIO

The Chair (Mr. Shafiq Qaadri): I'd now like to invite Mr. Fieber, president, and—welcome back—Ms. Coghlan, CEO of the College of Nurses of Ontario. Welcome, and please begin.

Mr. Georges Fieber: Hello. My name is George Fieber; I'm a registered nurse. I'm the director of professional practice at Thunder Bay Regional Health Sciences Centre, and I'm president of the College of Nurses of Ontario. With me today is Anne Coghlan, executive director of the college of nurses.

I'm pleased to be speaking to you today on behalf of the College of Nurses of Ontario, the regulatory body for the nursing profession in Ontario. Many of the changes related to the nursing practice proposed in Bill 179 were recommended by the college back in 2006. We recommended the changes to improve public access to quality health services and to improve transparency regarding who's accountable for what in Ontario's health system. We're pleased to see that many of our recommendations were adopted in Bill 179.

The College of Nurses of Ontario has provided a written submission to the standing committee, which discusses five areas of concern with the bill. My comments today will elaborate on one issue, and that is nurse practitioner prescribing.

There are about 1,400 nurse practitioners, also known as NPs, registered in Ontario. They work in every corner of the province: large urban cities, rural communities and remote areas. They work collaboratively with the other health professions and they also work independently; it is possible to do both. They provide health services to people of all ages from all walks of life, with all sorts of health care needs: from those who are healthy and well to those who are terminally ill, and everyone in between. This means people with diabetes, cancer, heart disease and dementia, to name a few, and of course it includes people who are living with more than one chronic disease. Nurse practitioners work in every imaginable setting: emergency rooms, intensive care units, long-term-care homes, public health units, hospital wards and community health centres, to name a few. They work in a number of different clinical specialties, including oncology, cardiology, mental health, sexual health—you name it. Again, this list could go on. I could probably find you an NP who works with just about any patient population you could think of.

This diversity in NP practice is the reason why the College of Nurses of Ontario does not support a list of drugs for nurse practitioner prescribing and why we believe the drug list is not in the public interest. We would like Bill 179 amended to enable broad prescriptive authority for nurse practitioners.

I don't think anyone is challenging that NPs are competent to prescribe drugs. It is part of their education, it's well reflected in their core competencies and it is a common part of their practice. The college sets standards for safe and ethical nurse practitioner practice, including standards for prescribing drugs. Nurse practitioners currently have access to the controlled act of prescribing, because they are competent to prescribe drugs.

Let me expand on what I mean when I say that nurse practitioners are competent to prescribe drugs. Prescribing is not a discrete and isolated event; it's an integrated part of a process of providing health care services to patients. For example, before prescribing a drug, the nurse practitioner conducts a health assessment, a history and a physical examination. The nurse practitioner formulates a differential diagnosis, which is a systematic process of elimination through which the NP analyzes clinical findings and symptoms to narrow down the list of potential diagnoses. The NP takes inventory of all medications the patient is taking to reduce the risk of interactions and potential errors. After writing the prescription, the NP documents it in the patient's health record and monitors the patient's response to the medication.

These are just a few highlights to illustrate to you that prescribing is part of a continuum. You can see how critical that entire process is. Patients are at risk if something goes wrong at any step of the process. Nurse practitioner education covers that entire continuum: health assessment, diagnosis and therapeutics. The college's registration exams, practice standards and quality assurance program also cover that continuum, from assessment to diagnosis to treatment.

So now let me talk about the list and some of the issues.

First and foremost, there is absolutely no connection between a list of drugs and safe prescribing. There are currently close to 300 drugs on the NP drug list. Any one of those drugs can cause harm if prescribed incorrectly. There is nothing magical about the list that prompts a nurse practitioner to select the right drug or choose the right dose to treat the right condition. Rather, it is the nurse practitioner competencies and the college's practice standards in the areas of health assessment, diagnosis and treatment that promote and guide safe prescribing.

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Second, given the diversity in nurse practitioner practice and the variety of patient populations, it would

be impossible to predict and list every drug that an NP may be required to prescribe in order to meet patient care needs in a timely fashion. Although there are 300 drugs on the list right now, not all 1,400 nurse practitioners are prescribing all 300 drugs, and there are hundreds of other drugs that are not on the list that some of the 1,400 nurse practitioners need to prescribe.

An NP only prescribes those drugs that she or he is competent to prescribe and that are relevant to the patient population with whom she or he works. This is a standard of practice set by the college of nurses. What this means is that the individual nurse practitioner is familiar with the specific drug and understands the particular patient's condition and symptoms. The NP understands how and why the specific drug is used to treat this patient's condition and also whether there are specific patient factors that may alter the medication's desired effect. This means the NP understands the potential side effects and interactions the drug may cause and whether this particular patient may be at increased risk for such effects. It means promoting optimal therapy for the patient, including education to encourage compliance. Finally, it means the NP understands how to monitor the patient taking the medication to ensure it is having the desired effect and taking the necessary steps to follow up if the treatment is not working.

So knowing this, I ask: What added value is there for the patient in requiring the nurse practitioner to check the list of drugs? A list of drugs is not in the public interest because there will always be an unnecessary delay from when a nurse practitioner may need to prescribe a drug to when the drug is added to the list. The list imposes an artificial barrier between the NP's competency to prescribe a drug and the patient's right to timely access to treatment. I can't tell you how many times this happens with the drug list, and each and every time it does, patient care in Ontario is undermined.

Finally, the college has a 10-year history of using the NP drug list. We'd like to share with you our experience with that list.

The list is rigid. A drug is either on it or it's not. There is no in-between. If the drug is not on the list, then the NP cannot prescribe it. While the list is rigid, patient care needs are not. I'd like to close with a few real-life examples of the negative effect this list has on patient care.

Twinrix is a combination vaccine that offers dual protection for both hepatitis A and hepatitis B. According to the drug list, a nurse practitioner can prescribe the hepatitis A vaccine and/or the hepatitis B vaccine, but not the combined agent because this drug is not on the list. Does this make sense? For Ontarians travelling over the winter season, nurse practitioners cannot prescribe the vaccine of choice.

Another example would be ciprofloxacin HC ear drops. These were used to treat certain types of ear infections. The college of nurses first asked for this drug to be added to the list in 2002. It was finally added in 2004. Then in 2007, the drug was discontinued. It is no longer available in Canada. Although there are suitable alternatives, NPs cannot prescribe them until they are added to the list.

I already described how NPs provide health services to a wide variety of people. Nurse practitioners work in community outreach programs, providing health services to the homeless, a marginalized and vulnerable population. I can tell you that there's a short window of opportunity to get health care services to people who are homeless. If you miss that window, the complications can be severe.

One of the nurse practitioners in Thunder Bay recently told me that she needed to prescribe Ventolin to such a patient. He wasn't in severe distress, but he needed puffers to keep it that way. The list only allows her to renew the Ventolin—that is, it must first be prescribed by a physician—and then the list permits her to order the repeats.

The patient is homeless. He does not have a physician. Although this NP is perfectly capable of prescribing Ventolin, her best available option that day was to send him to the emergency department to get that first puffer. And by the way, the ER in Thunder Bay saw 125,000 people last year—one of the busiest in the country. That was her critical window of opportunity to provide that patient with the medication he needed.

Not only do we see the drug list interfere with appropriate patient care, it also contributes to the waste of system resources.

My last example will be quick. As I said, the drug list is rigid. A drug is either on it or it's not, and if it's not on the list, an NP cannot prescribe it. Currently, seasonal influenza vaccine is on the NP drug list. However, the pandemic H1N1 vaccine is not.

These are just a few of the multitude of problems faced by nurse practitioners and their patients every day. This is why the college's position is that the list of drugs is more harmful to patient care than helpful.

This concludes my remarks. We have provided more information in the college's written submission. In addition, I'll leave copies of the oral presentation.

The Chair (Mr. Shafiq Qaadri): Fifteen seconds, Madame Gélinas.

M^me^ France Gélinas: Some people say it would be dangerous. Do you agree?

Mr. Georges Fieber: No. Nurse practitioners have the training to prescribe medication safely, and they only prescribe medications to the appropriate patient. A list is not going to change that. If anything—

The Chair (Mr. Shafiq Qaadri): Mr. Balkissoon.

Mr. Bas Balkissoon: Thank you very much for being here and presenting to us today.

The Chair (Mr. Shafiq Qaadri): Mrs. Elliott.

Mrs. Christine Elliott: Thank you very much for being here. A very clear presentation.

The Chair (Mr. Shafiq Qaadri): Thanks to you, Mr. Fieber and Ms. Coghlan, for your deputation on behalf of the College of Nurses of Ontario.

COLLEGE OF CHIROPRACTORS OF ONTARIO

The Chair (Mr. Shafiq Qaadri): I would now call our final presenters of the day, Mr. Amlinger, president, and Ms. Willson, registrar, of the College of Chiropractors of Ontario. Welcome, and I'd ask you to please begin now.

Ms. Jo-Ann Willson: Good afternoon—almost good evening. My name is Jo-Ann Willson. I am the registrar and general counsel for the College of Chiropractors of Ontario. I am not a chiropractor by training; I am a lawyer and social worker by training. You will be relieved to know we're going to be very brief and we're going to give you an opportunity to ask questions.

CCO is the regulatory body for approximately 39,000 chiropractors in the province. It has a public interest mandate—you've heard that from other regulators. The way in which the public interest mandate is exercised is through complaints and discipline, and quality assurance; those are the two main mechanisms.

Why our CCO submission is different from some of the submissions that you have heard over the past two days: They are different because we are not recommending an expanded scope of practice; we are not recommending a scope-of-practice review. Chiropractors already have a very broad scope of practice: They have the doctor title; they have the responsibility to diagnose; they have the authority to order and interpret x-rays under HARP legislation; they have a very broad scope of practice that benefits patients in Ontario. There is only one amendment that is being recommended and that is on page 10 of our written submission. That amendment takes advantage of the fact that the Chiropractic Act is being opened up, and that amendment is to allow that the authorized acts for chiropractors include ordering the application of a prescribed form of energy. I note for you that it is not interpreting; it is not applying; it is ordering.

I should tell you that CCO specifically chose not to comment on some of the other professions' suggested expanded scope-of-practice requests etc., specifically because our view is that regulators should be trusted to develop standards of practice consistent with the public interest and should be able to know what is within the competency of their members. So we did not comment on those. I should tell you in terms of follow-through that if the amendment was accepted and included in the legislative amendments, CCO would of course work very closely with the ministry in developing appropriate regulations. Also, I will tell you that we would develop standards of practice to which members of the profession would be required to comply.

There is a somewhat analogous situation: When the legislation relating to acupuncture was before committee, the amendment was that members of professions of certain colleges that have standards of practice in acupuncture would be permitted—and that is, in fact, what we did. We developed a standard of practice on acupuncture, and chiropractors now perform acupuncture in accordance with that standard.

There is an opportunity here to make an amendment that is consistent with the policy thrust of the legislation, which supports inter-professional collaboration and also allows members of a profession to act within the full range of their competency and training. I just note parenthetically that CCO was one of the signatories to the federation's submission on the issue of supervisors, and we support that submission. I know there have been some questions about that, so I just wanted to acknowledge that.

The RHPA has been used as a model in many parts of the world, and Ontario has been viewed as a leader in health care regulation.

We just want to thank you for the opportunity to make a few brief comments. I am going to turn it over to Dr. Peter Amlinger to talk about the public-interest rationale for the amendment that we are suggesting.

Dr. Peter Amlinger: Thank you. I'm Dr. Amlinger. I'm a chiropractor with 24 years' experience in Mississauga practising chiropractic and I'm the president of the college, as Jo-Ann noted.

We are here today because we do believe there is a public interest in this amendment to the proposed legislation. Our scope of practice, simply stated, is that chiropractors assess, diagnose and safely care for people with disorders of the spine and nervous system and their impact on health.

As Jo-Ann stated, we are not asking for an expanded or enhanced scope of practice. We're simply asking for access to new technology, to current, up-to-date technology so we can better serve our patients and our scope of practice. Our scope of practice is quite sufficient in caring for the people who present to us and we simply need access to this technology to serve them better.

Basically, it will help, as Jo-Ann said, the policy direction of health care right now. It will improve efficiency, it can decrease costs to the system, and it will enhance patient care and patient safety. It will decrease risk to patients because they won't have to wait so long for tests.

Basically, in my office, there are three types of patients who come to see me—in any chiropractor's office. One type of person comes in and they have a health complaint that is clearly in the domain of chiropractic and I can manage them single-handedly. Some of those patients—a few of them; not very many—would benefit if I could order an MRI to further investigate their problem and help me care for them.

Another group of patients present and they're in a health crisis and they need immediate attention from a physician or another health provider, and we make an immediate referral to either an emergency ward or their attending physician. Those patients need MRI scans, and if we could expedite the process, it would really help them along. There have been instances where patients have been caught in the merry-go-round of going back to their family physician to get the requisition for the MRI or a diagnostic ultrasound and get the result, and they have a tumour and it has cost them their leg and, in some

cases, it has cost them their life. If we could eliminate that, it would be a huge benefit to the public of Ontario.

Then the third type of patient who comes to see us is a type of person with multiple health problems. They are a chiropractic case, but they need to be co-managed by a number of health care providers. Some of those people need MRI scans as well. We could order the MRI scan or the diagnostic ultrasound; we are trained to order the tests, for sure. We could order the tests and then we could enter into a collaborative care agreement with other health providers and serve the patient's needs.

In doing that in jurisdictions where it is available, as Dr. Haig mentioned, it's been shown that chiropractors, because of our training, tend to be more judicious in the ordering of these tests, which means we order them less and save the system money. Other research shows that people get well and they can avoid surgery, and we decrease wait times and we take a burden off the health care system. So we clearly see that it will increase efficiencies and cost savings in the system and, most importantly, it will enhance the quality of chiropractic care and health care in general for the people of Ontario.

I'd like to thank you for giving us your time this afternoon. That concludes my remarks, and I'll open the floor to any questions.

The Chair (Mr. Shafiq Qaadri): Thank you. Thirty seconds per side. Mr. Balkissoon.

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

The Chair (Mr. Shafiq Qaadri): Ms. Elliott?

Mrs. Christine Elliott: Thank you very much for joining us today. A very good presentation.

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

M^me^ France Gélinas: How do you reassure yourself that your members are competent to do this?

Ms. Jo-Ann Willson: We have a number of mechanisms. For example, these would be the quality assurance initiatives, the peer assessment program where we have peers go out and assess members' practices in their own practice. We have the development of standards of practice relating to each of the authorized acts—commuicating a diagnosis, and this one would also require the development of a standard of practice. Those would be the proactive approaches. Of course, there is also the reactive, which is the complaints and discipline.

I don't know if that—

M^me^ France Gélinas: Yes.

Ms. Jo-Ann Willson: Okay.

M^me^ France Gélinas: Thank you.

The Chair (Mr. Shafiq Qaadri): Thank you, Ms. Willson and Dr. Amlinger.

If there is no further business before the committee, that concludes today's presentations. The committee is adjourned till Monday, October 5, 2 p.m. in this room. Thank you.

The committee adjourned at 1750.

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