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Monday 5 October 2009

**Journal
des débats
(Hansard)**

Lundi 5 octobre 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 Qadri
Clerk: Katch Koch

Président : Shafiq Qadri
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ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

STANDING COMMITTEE ON SOCIAL POLICY

COMITÉ PERMANENT DE LA POLITIQUE SOCIALE

Monday 5 October 2009

Lundi 5 octobre 2009

The committee met at 1415 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 Qadri): Chers collègues, j'appelle à l'ordre cette séance du Comité permanent de la politique sociale. Nous commençons avec nos premiers présentateurs.

Ladies and gentlemen and colleagues, I call to order this meeting of the Standing Committee on Social Policy. As you know, we're here to consider Bill 179.

The protocol for all of those who are listening and those who will be testifying today is: All presenters will have exactly 10 minutes to make their presentation, which will be militarily enforced. Any time remaining within those minutes will be distributed evenly among the parties for questions, comments and cross-examination.

ASSOCIATION OF ONTARIO HEALTH CENTRES

The Chair (Mr. Shafiq Qadri): I now invite our first presenters to please come forward: Mr. Davidson, Ms. McKenna and Ms. Goodine of the Association of Ontario Health Centres. I would respectfully invite you to begin now.

Mr. Bill Davidson: Good afternoon. My name is Bill Davidson. I'm the executive director of the Langs Farm Community Health Centre in Cambridge, Ontario. Today I'm speaking to you on behalf of the Association of Ontario Health Centres, along with my colleague Wendy Goodine, a nurse practitioner from the LAMP Community Health Centre.

We are speaking to you in our role as co-chairs of the Nurse Practitioners' Leadership Group of the Association

of Ontario Community Health Centres. Our membership consists of nurse practitioners from a variety of clinical settings, CHC executive director representatives from across the province and AOHC staff.

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Thank you for the opportunity to share very briefly with you highlights of our paper regarding Bill 179. Our response, entitled *On the Right Path*, which we have distributed, outlines the views of the AOHC as a whole and a perspective of our Nurse Practitioners' Leadership Group.

The Association of Ontario Health Centres has a variety of members, including community health centres, aboriginal health access centres and community family health teams. Our members deliver comprehensive primary care and health promotion services that focus on the social determinants of health in over 150 diverse communities throughout Ontario. Members employ inter-professional teams of health providers such as, but not limited to, nurse practitioners, social workers, dietitians, health promoters and physicians, who work collaboratively to provide high-quality, safe and accessible patient care for populations with barriers to access.

You may be aware that northern nursing stations and Ontario CHCs were among the first employers of nurse practitioners, and for more than 30 years have employed a significant majority of nurse practitioners in the province of Ontario.

We commend the government on its initiative to implement an act that expands the scope of practice of regulated health professionals in order to fully optimize the skills of interprofessional health care teams, and we appreciate the significant changes that have been proposed in Bill 179 that address the constraints placed on the scope and practice of nurse practitioners in particular.

We are pleased that Bill 179 enables various professional colleges to implement regulations governing their members with the authority to perform a broad range of acts—such as setting and casting fractures; dispensing, mixing and selling certain drugs; the application of specific forms of energy; and the ability to communicate a diagnosis to a patient—which I know is welcomed by nurse practitioners in Ontario.

We also welcome the proposed amendments that authorize various health care providers to administer, prescribe, mix, sell and dispense drugs and other substances. Proposed acts that broaden the role of other providers,

such as permitting dietitians to check a patient's blood readings and enabling midwives to communicate a diagnosis to a patient, will not only facilitate greater access for our patients in CHCs but will increase the quality and continuity of care for our patients as well.

As employers of a variety of primary care providers, we believe these changes to the legislation will not only result in improved care and better health outcomes for patients but will enable our providers to enhance their effectiveness by fully utilizing their skills and knowledge, thereby creating greater efficiencies in the health care system.

I'll now turn it over to Wendy, who will speak to you about some of the barriers that continue to exist with Bill 179 and provide some concluding remarks.

Ms. Wendy Goodine: The Association of Ontario Health Centres, on behalf of its more than 270 nurse practitioners working in a variety of settings across the province, shares the concerns of the Nurse Practitioners' Association of Ontario that some of Bill 179's provisions continue to place unnecessary limitations on nurse practitioner practice and the evolution of the role in Ontario.

The legislation in its current form appears to contradict HPRAC's and the government's repeated expressions of support for enhanced self-regulation for nurse practitioners and the elimination of unnecessary barriers to effective practice and high-quality patient care. While it takes some good steps in the right direction, it does not go far enough in addressing these barriers and utilizing the full skills and knowledge of all health professionals.

Nurse practitioners practising to their full capacity constitute a logical and effective solution for many of the concerns that face health policy decision-makers, including access to primary health care, improved collaboration and client-centred care. The development of one national standard of nurse practitioner education and practice, and a national standard for NP entry-to-practice examinations in Canada, ensures that NPs provide a high standard of care across the country. We believe that nurse practitioners are a key ingredient in the effective and efficient delivery of the second stage of medicare.

The Nurse Practitioners' Leadership Group of the AOHC has reviewed the HPRAC report and its recommendations and offers the following summary comments:

A commitment to legislating open prescribing would be consistent with the Ontario government's leadership role in regulating the nurse practitioner role in 1998. Studies clearly demonstrate that open prescribing enhances patient access to care, reduces wait times and lowers costs to the system. In addition, other jurisdictions, including five Canadian provinces, 48 US states and the United Kingdom, have open prescribing for nurse practitioners that is based on solid evidence and national standards of care. This decision would further the government's objective of providing high-quality, safe and accessible patient-centred care to all Ontarians.

It is critical that other pieces of legislation, including the Health Protection and Promotion Act, Immunization

of School Pupils Act, the Mental Health Act and the Highway Traffic Act, must be changed to reflect Bill 179. In order to function to their full potential, nurse practitioners need to be able to admit and treat patients in hospitals, be able to refer to specialists without the restrictions based on provider payments and be recognized as primary providers by the various agencies of the Ministry of Health and Long-Term Care.

Extensive research overwhelmingly supports the safe practice of NPs in a variety of health care settings. NPs have been practising safely in Ontario for more than 30 years, as evidenced by data from the Canadian Nurses Protective Society, which indicates no experience in claims awards for NPs practising in Canada or the US.

In conclusion, as a long-standing employer of nurse practitioners and interprofessional teams, the Association of Ontario Health Centres strongly supports open prescribing. Bill 179's intention to improve access to health care to the province of Ontario by better utilizing health care professionals and strengthening the health professional regulatory system will only be achieved by reducing barriers and expanding the prescribing rights of professionals, the opportunities for professional practice and the principles of self-regulation with the College of Nurses of Ontario.

The Chair (Mr. Shafiq Qadri): Thank you, Ms. Goodine. About 40 seconds each: the PC caucus. Ms. Elliott?

Mrs. Christine Elliott: Just a quick question. Thank you for your presentation. With respect to open prescribing, you mentioned that there were five other Canadian provinces which have adopted it. Could you just let me know which ones they are?

Ms. Wendy Goodine: When we put the legislation through in 1998, the choice to have lists was because of the necessities of the time. Many of the other provinces learned from Ontario, as we were the leading edge. They chose, when they integrated the nurse practitioner role, to go with open prescribing, recognizing the barriers that it created for NPs. So British Columbia, Newfoundland, Alberta, Nova Scotia—

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

M^{me} France Gélinas: Is there any evidence that it is safe for nurse practitioners to have open prescribing?

Ms. Wendy Goodine: Nurse practitioners have been overwhelmingly studied. Right now we have 12 randomized, controlled studies and over 1,200 papers demonstrating the safety of nurse practitioner practice. Currently, there are no randomized controlled studies that show that NPs are not safe and that open prescribing leads to any kind of endangerment of practice.

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

Mr. Bas Balkissoon: The legislation allows nurse practitioners to do the setting and casting of fractures. The OMA was here, and they showed concern with regard to that particular scope of practice. Can you shed

some light on when a nurse will actually set a fracture and when they would refer it?

Ms. Wendy Goodine: I think the setting of fractures is an example of the diverse practice settings of nurse practitioners. Some nurse practitioners work in very isolated communities or in areas where they may be one of the primary providers in small hospital settings. Many nurse practitioners work in emergency rooms—

The Chair (Mr. Shafiq Qaadri): Thank you, Mr. Balkissoon. Thanks to you, Ms. Goodine and Mr. Davidson, for your deputation and written submission on behalf of the Association of Ontario Health Centres.

REGISTERED NURSES' ASSOCIATION OF ONTARIO

The Chair (Mr. Shafiq Qaadri): I would now respectfully like to call our next presenter, who is Ms. Doris Grinspun, executive director of the RNAO, Registered Nurses' Association of Ontario, and colleague. I would invite you to please, first of all, introduce yourselves and to please begin.

Ms. Doris Grinspun: Thank you. Good afternoon. My name is Doris Grinspun and I'm the executive director of RNAO. RNAO is the professional organization for registered nurses, who practise in all roles and sectors across Ontario. Our mandate is to advocate for healthy public policy and for the role of registered nurses in shaping and delivering health services.

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I'm very proud to be joined today by Theresa Agnew, a nurse practitioner of excellence and member of RNAO's board of directors.

RNAO applauds the government's goal to enhance patient safety by increasing access to needed health care through expanding the scope of practice of health professionals within their education, knowledge and competencies.

Though there are a number of welcome changes contained in the bill that would significantly improve public access and reduce wait times, RNAO is deeply disappointed that without amendment, Bill 179 will continue to hamstring and underutilize health professionals and unnecessarily limit access—compromising, by that, the health of Ontarians.

We focus our response on three key concerns: lack of review of scope of practice for registered nurses; legislative limitations placed on nurse practitioners' practice, specifically in relationship to open prescribing of pharmaceuticals; and regulatory limitations placed on nurse practitioners' practice in relationship to admitting, treating and discharging clients to and from in-patient units in hospitals and other settings, the certification of death, and NP referral to specialists.

We also want to speak about advancing patient safety, a government agenda that is dear and central to the government, by strengthening interdisciplinary practice. For that, we ask that medical advisory committees,

MACs, be transformed into interdisciplinary advisory committees, IPACs, which already exist in the LHINs.

While we will speak to the need for legislative amendments to Bill 179, the RNAO also asks the committee to recommend regulatory changes to the minister that would be complementary to the objectives of Bill 179 and would improve patient safety.

Let me start with RNs. RNAO is gravely concerned with the blatant failure of Bill 179 to review the scope of practice of the nearly 100,000 registered nurses in Ontario and to recognize the RNs' high level of education, knowledge and competencies. The practice and role of RNs continuously evolves, with changes in work environments and technology, as well as educational and policy parameters. Bill 179, as it is currently written, represents a major lost opportunity to better serve Ontario's public by modernizing RNs' scope of practice.

RNAO calls for an amendment to Bill 179 authorizing registered nurses to dispense and compound drugs, communicate a diagnosis to a client and order simple X-rays and mammograms.

In a variety of contexts, RNs already dispense and compound medications, utilizing medical directives for patients who meet specific criteria or as a delegated act to respond to a particular client's situation. For example, RNs and RPNs dispense medications to sufficiently cover hospitalized clients or long-term-care residents who have been granted a leave of absence from the facility, like a weekend leave from a psychiatric or rehab unit or nursing home, but who need to continue with their medication treatment regime.

RNAO also calls for the authorization for RNs, with the appropriate education and knowledge, to order simple X-rays of the chest, ribs, arm, wrist, ankle and foot, as well as to use energy such as electro-coagulation and defibrillation. Authorizing an RN to order a chest X-ray early in the assessment of an infant in respiratory distress, for example, would aid in the swift assessment and treatment of pneumonia. RNs frequently take the lead in coordinating health promotion programs such as breast screening clinics, and authorizing an RN to order mammograms would promote early identification and risk reduction for the clients. It simply makes sense.

The regulation which governs the application of energy also needs updating as it has not kept pace with technological changes. While some acts are outside nursing scope, like nerve conduction studies or electroconvulsive shock therapy, similar acts are now in the public domain, like cardiac defibrillation in hockey arenas and shopping malls. RNs regularly perform acts under delegation or medical directive, and RN first assistants regularly perform electro-coagulation during surgery. We detail these in our submission.

I will pass it on to Theresa.

Ms. Theresa Agnew: I'd like to address the legislative limitations on nurse practitioners' scope of practice.

RNAO is deeply disappointed with the failure of the legislation to lift the onerous limits on nurse prac-

tioners' ability to make use of the most appropriate and current medications for their clients. Even the most efficient listing or delisting process cannot keep pace with rapid technological change, evolving pharmacological treatments and evidence-based practice, thus leading to real-time delays in client care.

It is not a regulated list of drugs or tests that ensures appropriate prescribing, ordering and monitoring by nurse practitioners; rather, it is the nurse practitioner's competencies in health assessment and diagnosis, health care management and therapeutic intervention, health promotion and prevention of illness, injury and complications. The professional role and responsibility: That is what promotes safe practice.

Here's one example which is both timely and compelling. With the imminent arrival of the 2009 flu season, nurse practitioners in the province are preparing for a surge of illness, which we can prevent by offering clients the influenza vaccine. However, if the H1N1 influenza virus remains the primary circulating virus, as is predicted, nurse practitioners will be unable to prescribe that specific vaccine to their clients, as it will not be placed on their designated list in time to be any good.

RNAO recommends that nurse practitioners be authorized to openly prescribe within their full scope of practice without having to refer to lists, as is already happening in most Canadian jurisdictions and certainly across the US. Ontario would be an isolated outlier if Bill 179 were passed with the proposed list-based approach. This is not the kind of leadership we expect from Ontario.

RNAO also notes the absence of authority for nurse practitioners to order MRI and CT scans and the anatomical limitations with respect to NP ordering of diagnostic ultrasound and X-rays. The level of assessment conducted by a nurse practitioner prior to the ordering of any diagnostic imaging or laboratory test is very thorough, and authorizing the ability to order these specialized images would not only increase the overall efficiency of nurse practitioner assessment and treatment but would also reduce costs to the system as a whole.

RNAO also strongly urges the committee to support regulatory amendments to regulation 965 of the Public Hospitals Act to authorize nurse practitioners to admit, treat and discharge hospital in-patients, to certify the death of a client and to refer clients to specialists on the same basis as physicians. We detail the latter two in our written submission.

Regulation 965 significantly limits nurse practitioners from opening access to the public by working to their full scope in a hospital in-patient setting. At present, they are only entitled to admit and discharge clients from an out-patient setting like clinics or hospital emergency rooms. They have not been granted privileges to admit a client from the emergency room to an in-patient unit or from one in-patient unit to another.

The Chair (Mr. Shafiq Qaadri): Less than a minute left.

Ms. Theresa Agnew: Okay. Similarly, the order for the client to be discharged can only be made by the

attending physician, midwife or dentist. There are substantive delays in patient flow, which are the direct result of physicians being unavailable to write admission and discharge orders. A clear, effective way to reduce wait times is to grant nurse practitioners expanded hospital privileges.

RNAO strongly supports the development of a health care system utilizing a client-centred model, where Ontarians have access to continuity of care and continuity of caregiver from a primary health care provider.

In order to achieve the objective of improved, streamlined access for clients and full integration of nurse practitioners—

The Chair (Mr. Shafiq Qaadri): Thank you, Ms. Agnew, and thank you, Ms. Grinspun, for your deputiation and your presence and the written materials that you've left.

ONTARIO DENTAL ASSOCIATION

The Chair (Mr. Shafiq Qaadri): I would respectfully now invite our next presenters to please come forward: Ms. Samek of the ODA, the Ontario Dental Association, and any colleagues. Welcome, and I would invite you to please begin now.

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Ms. Linda Samek: Good afternoon. I'm Linda Samek, the director of professional affairs with the Ontario Dental Association. With me today is ODA's director of government relations, Mr. Frank Bevilacqua. The ODA is extremely interested in the legislative proposals outlined in Bill 179, the Regulated Health Professions Statute Law Amendment Act, and is pleased to have this opportunity to speak to the standing committee about this complex legislative initiative.

The ODA and its members remain committed to the delivery of quality oral health care within a clear accountability framework. Quite simply, we believe that the Regulated Health Professions Act, the Dentistry Act and related regulations establish a comprehensive accountability framework for the dental profession. This regulatory framework takes into account the interests and needs of the public.

Nearly one half of the members of college councils are appointed by the Lieutenant Governor in Council. This means that there is direct public representation on the college councils and college committees. In addition, the existing provisions of the RHPA grant the Minister of Health extensive authority to "require a council to make, amend or revoke a regulation under a health profession act" and "to do anything that, in the opinion of the minister, is necessary or advisable to carry out the intent" of the RHPA or a profession-specific act.

In our time with the committee today, we wish to comment on the following sections of Bill 179: the appointment of a college supervisor, expert committees and prescribing and use of drugs in dental hygiene.

The ODA was shocked to learn that those advising the ministry on the drafting of Bill 179 appear to have seri-

ous concerns about the accountability framework set out in the RHPA. As written, Bill 179 is an assault on the principle of self-regulation.

Under the RHPA, self-regulation takes a multi-pronged approach. Regulatory authorities must operate within a framework of the RHPA and profession-specific acts. Regulators hold individual practitioners accountable for maintaining the standards of care. There is a public complaint process. There is public representation on regulatory councils and college committees. Regulated practitioners must fund the governance and operation of the regulatory process. The minister retains substantive powers over regulatory colleges.

The proposal to appoint a college supervisor with the “exclusive right to exercise all the powers of a council and every person employed, retained or appointed for the purposes of the administration” of the RHPA and a profession-specific act sends a clear signal that there is a lack of confidence in the colleges to work within the accountability framework set out in the RHPA. The proposal for a supervisor undermines the concept of self-regulation in the minds of regulated health care providers and, perhaps more importantly, in the minds of the public. If implemented, this provision would send a chill over the regulators and regulated practitioners.

The bill provides no insight as to what would trigger the use of this clause. Equally important, there is no indication as to what would trigger the removal of the supervisor. In the event that a college council and/or staff, including the registrar, saw the appointment of a supervisor as a vote of non-confidence, causing them to resign, there are no clear provisions for a transition to the election or appointment of a new college council.

Without understanding the origins of this clause, the ODA is unable to suggest a solution that may address any underlying concerns. Notwithstanding this information vacuum surrounding the proposal to appoint a supervisor to act for a college, the ODA believes that the existing RHPA framework provides extensive powers to the minister. As noted, the minister already has the authority to require a council to do anything that the minister deems necessary or advisable. The minister has the legislative authority to act swiftly to address virtually any situation.

The ODA strongly urges that all references to the appointment of a college supervisor be deleted from the bill. Sufficient powers are granted to the minister to make the option of appointing a college supervisor completely unnecessary.

The ODA recommends that the expert committee be limited only to matters related to drugs and no other matters. This limitation still permits colleges and associations to work collaboratively through the formation of expert committees on an ad hoc basis without impeding the work of college councils. Again, we believe that an expert committee needs to look only at drugs.

Finally, we want to look at the Dental Hygiene Act. The bill proposes to add “prescribing, dispensing, compounding or selling a drug designated in the regulations”

to the Dental Hygiene Act. Without the corresponding regulations, the ODA cannot understand the full intent of this clause. However, the ODA acknowledges the thorough review of this matter undertaken in the development of HPRAC’s Critical Links report.

HPRAC’s drug review process included experts who took a comprehensive, balanced approach to the prescribing and use of drugs. Through the consultative process, the experts considered the education and training of dental hygienists in Ontario with (1) the need for dental hygienists to prescribe and use drugs related to their scope, and (2) the potential benefits and risks to the public in expanding the role of dental hygienists with respect to the prescribing and use of drugs.

The ODA supports the recommendation in HPRAC’s Critical Links report that would permit dental hygienists to prescribe and dispense chlorhexidine and topical fluoride as preventive treatments. In reviewing the education of dental hygienists, HPRAC found “that pharmacology courses in dental hygienists’ studies provide an overview of pharmacological actions and interactions.” However, as noted by HPRAC, it is important for dental hygiene students to have more education and training in areas of anatomy, biochemistry and physiology as well as a more in-depth understanding of pharmacotherapeutics before being permitted to prescribe and use additional drugs.

Despite the findings in the HPRAC report, the College of Dental Hygienists of Ontario continues to recommend that the “Dental Hygiene Act be amended to grant dental hygienists access to the controlled act of administering a substance by injection ... relating to the administration of local anaesthesia.” Based on the education and training of dental hygienists in Ontario, the Critical Links report noted that “HPRAC is not prepared to recommend that dental hygienists be authorized to independently administer substances by injection or inhalation.”

With specific reference to dental hygiene proposals to administer local anaesthetics, HPRAC wrote: “At the best of times, this is a delicate task, requiring significant training and skill. Pain management courses of limited duration do not prepare dental hygienists to perform this task. The dental hygienist is well qualified to identify the need for an anaesthetic and to make a referral to an appropriate health professional to perform the procedure.”

Like HPRAC, the ODA believes that any change to the prescribing and use of drugs by dental hygienists must be based on comprehensive education to ensure that appropriate theory and hands-on experience provide dental hygiene students with sufficient background to move this knowledge and training experience into practice.

The Chair (Mr. Shafiq Qaadri): Just under a minute, Ms. Samek.

Ms. Linda Samek: The ODA also supports a component of an undergraduate/graduate education program being in “academic facilities.” Accordingly, the ODA only supports permitting dental hygienists the authority to prescribe and use fluoride and chlorhexidine oral rinses for preventive purposes.

Finally, in keeping with the collaborative and consultative process envisioned in the RHPA and this bill, the ODA also recommends that dentists be on the collaborative committee formed to develop standards of practice for the prescribing, dispensing, selling and compounding of any drugs by dental hygienists.

The ODA is very grateful for this opportunity to present our comments, and if there's time, we'll certainly take questions.

The Chair (Mr. Shafiq Qaadri): We'd like to thank you, Ms. Samek, and your colleague for your precision-timed remarks.

1450

ONTARIO PHARMACISTS' ASSOCIATION

The Chair (Mr. Shafiq Qaadri): I now invite our next presenters, from the Ontario Pharmacists' Association, Mr. Darby, Mr. Miller and Mr. Malek, to please come forward. Gentlemen, welcome. I invite you to please begin.

Mr. Dennis Darby: Good afternoon. My name is Dennis Darby. I'm joined by Dean Miller, the chair of our board of directors, and Allan Malek, our vice-president of professional affairs. I am glad to be here to address Bill 179 and to share with you the views of the Ontario Pharmacists' Association, OPA.

OPA is the largest voluntary pharmacists' association in Ontario, and in fact in Canada, with more than 7,200 of the 10,000 registered pharmacists in the province as members.

A recent poll placed pharmacists and physicians as the two most respected and trusted professions in Canada. While physicians, nurses and nurse practitioners are, of course, the cornerstone of front-line patient care, pharmacists, particularly in community settings, are often the very first and most often consulted health care professionals for patients. So a tremendous opportunity exists to leverage both this high level of trust from the public and the practical and academic skills of pharmacists to enhance patient care.

We know that an aging population comes with increased reliance on medication and therapy. It's these medications that help Ontarians live independently and longer and, when combined with so many other stresses on our health care system, including pandemics of infectious diseases and escalation in chronic disease incidents, medication therapy contributes to a confluence of change and challenge that requires all of us to respond quickly, flexibly and with an open collegiality. The pharmacy community is ready to do so.

Bill 179 is clearly establishing the necessary conditions for such change. For us, it enables a number of key legislative tools that will allow pharmacists to strengthen the contribution they make to patient care in collaboration with our health care partners, and we are very pleased with this intent.

OPA is also committed to an interdisciplinary approach to the development of protocols and treatment

algorithms that ensure patient safety and introduce consistency in approach across all health care professions. Pharmacists, as you may know, are well accustomed to collaborating with prescribers when dispensing medications and caring for patients, and we see this only getting better.

We are, however, concerned about any broad-based changes to the Drug and Pharmacies Regulation Act, DPRA, that would permit dispensing without the physical presence of a pharmacist, regardless of location. This is a matter that needs further attention: certainly changes to the language of the bill and perhaps a pilot test of how changes will be implemented in rural and remote locations.

Furthermore, OPA recommends that if multiple regulated health professions are granted the ability to dispense, compound and sell drugs, the standards for these controlled acts should be developed and enforced by all professions at the highest level, which we believe is the standard that exists for pharmacists, as regulated by our own college and by the government.

A related issue leads to my next point. OPA requests that pharmacists be recognized in regulation 965 of the Public Hospitals Act, conferring to hospital-based pharmacists the same range of authorities granted to pharmacists within the community as part of an increased scope.

We believe there are further opportunities to do even more; for example, to provide routine immunization to patients, as occurs successfully in jurisdictions such as all 50 US states, the UK, Australia and parts of the EU, as well as Alberta and British Columbia. Ontario needs to keep pace. Especially in the event of a public health need like a pandemic, it would be useful to have all hands on deck, so to speak.

There are two issues related to oversight that I would like to comment on. First, Bill 179 proposes many changes to the Ontario Drug Benefit Act, ODBA, which could have a significant effect on Ontario's pharmacists. We believe that the executive officer of the public drug program currently has sufficient powers under that act and its regulations to ensure that the plan is judiciously administered. In addition, the proposed concept of different fees for different delivery settings needs to be further defined.

Secondly, on the issue of the college supervisor, OPA fully supports the College of Pharmacists in their position that this new role is unnecessary and would prove detrimental to the concept of self-regulation.

At this point, I'd prefer to use the last few minutes to make some comments on the larger context of change in which we find ourselves.

In all sectors—education, criminal justice, social development—there's a shift away from silo thinking towards more horizontal and integrated ways of delivering service: collaboration between and among professionals. It's not only the right thing to do; it's also the cost-benefit imperative for all of us.

As an appendix to our written submission—I thankfully will not read the whole thing for you today, if that's

okay—OPA has included a health economic analysis of the value of pharmacy services that should be of interest to this committee and to the government. It includes data on significant savings to the system when pharmacists practise in the new controlled access proposed in the bill. This in-depth analysis about how resources would be deployed or redeployed to provide the care and access Ontarians want and need from the health care system shows the true value of change.

As we contemplated what more pharmacists could provide in the face of a pandemic or emergency such as H1N1, we realized that we do have a role to play, one that was referenced in the September 2008 interim report from HPRAC that preceded Bill 179. I'd like to share with you what I think is a great example of things starting to come together.

HPRAC recommended that a number of professions should collaborate on the development of a minor ailments program for Ontario. This initiative would be led by the OPA and the college of pharmacists and would proceed in full collaboration with the ministry, the medical and nursing professions and their regulatory colleges and other health care professions. This program would see patients going to their pharmacist as the first point of contact to deal with a defined range of minor ailments, like athlete's foot, minor infections, poison ivy or cold sores, to name a few. Such a program, which is predicated on a defined set of protocols and treatment algorithms, including referrals, already exists in the UK. We would like to help make this a reality. The program would facilitate access to care, certainly decrease ER wait times, increase GP capacity for more important things and ultimately increase the overall efficiency, with some cost savings. This would be a first for Canada, and we look forward to expediting the initiative.

While not specifically related to this bill, we'd like to make a recommendation to the committee. In the face of the looming H1N1 pandemic, we propose that pharmacists should be tasked now to begin to assess and treat specific minor ailments. The government has the authority under subsection (4), paragraph 12, of the Emergency Management and Civil Protection Act to direct pharmacists to take this role. Such a step would surely take pressure off of doctors' offices, walk-in clinics and emergency rooms and allow them to focus on truly sick patients in the case of a pandemic. With some one-time funding to get pharmacists training, we could execute this plan relatively quickly. It's a small step and it certainly won't alleviate congestion of the system during a pandemic, but it's one way that pharmacists could step up and play a contributing role.

In conclusion, I'd like to remind the committee that pharmacists by their nature and practice are conservative, detail-oriented professionals who have the confidence of the public and have unique skills and knowledge. Before entering the four-year bachelor degree program, almost all students have at least two years of university experience, and more and more students—in fact, over 60% of the incoming class at the University of Waterloo this

year—have at least a bachelor's degree in science prior to entering pharmacy school. During their training, they practise alongside physicians and nurses.

The changes in scope of practice in Ontario will begin to bring us in line with the most modern jurisdictions. We are ready to work with our regulatory colleges to put protocols in place and begin the transition towards more defined community and institutional health care for patients by pharmacists.

Henry Thoreau said, "Things do not change; we do." I think it is true today. While it may be disruptive and somewhat uncomfortable, we don't have a choice. It's easy to keep things as they are, but if we don't change, we won't rise to the challenge, and we will fail to provide the level of care Ontarians need and deserve from the system. We are ready to do our part to make a stronger contribution to the health care of Ontario.

The Chair (Mr. Shafiq Qadri): Thank you. Ms. Elliott, 40 seconds.

Mrs. Christine Elliott: I'm interested in the minor ailments program that you were discussing. Do you know where it is right now in the mix and why it hasn't come along sooner than one would have hoped?

Mr. Dennis Darby: The minor ailments program was in the HPRAC report but was not included in the bill per se. Granting the legislative ability for pharmacists to prescribe certain schedule 1 drugs is in the bill, but right now, it's limited just to drugs for smoking cessation. This would require them to go a little bit further than they are today.

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

M^{me} France Gélinas: Would you have examples of where pharmacists actually do routine immunization? What happened with the record-keeping of all of that?

Mr. Dennis Darby: Routine immunizations are done in Alberta now. There is record-keeping that goes back to the physician. In other states in the US, their regulations vary—in all 50, the regulations exist where the pharmacist is required to keep a record and to share the record with the primary care provider.

The Chair (Mr. Shafiq Qadri): Mr. Balkissoon?

Mr. Bas Balkissoon: Just to say thank you very much for coming forward and presenting to us.

The Chair (Mr. Shafiq Qadri): Thanks to you, Mr. Darby, Mr. Miller and Mr. Malek, for your deputation on behalf of the Ontario Pharmacists' Association.

PHARMATRUST

The Chair (Mr. Shafiq Qadri): I'd now invite Mr. Jim Gay of Patient Care Automation Services to please come forward.

Interjection.

The Chair (Mr. Shafiq Qadri): We'll be happy to distribute that. And to your colleague, I'd invite you to please begin.

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Mr. Peter Suma: Good afternoon. My name is Peter Suma and I'm the president of PharmaTrust. I have with

me our chief director of pharmacy, Ms. Sandra Tadros, who is a pharmacist.

PharmaTrust strongly supports Bill 179. We understand the aims of Bill 179 to increase access and inter-professional collaboration. We believe the bill, as drafted, achieves many of these objectives. But we wish to speak particularly about remote dispensing.

Remote dispensing allows pharmacists to potentially be available whenever and wherever and dramatically extends the footprint of pharmacy services in the province of Ontario. As an example, we are deploying, under hospital and clinic law, remote dispensing systems in the province. They have been up and operating, actually, for five years under northern projects undertaken by Northern Pharmacy, and we have been in production for two years at Sunnybrook hospital, Albany clinic, Cambridge Memorial Hospital, and the list is growing. And we are looking to deploy a trial project in an extremely remote location with an aboriginal community, which would see the first and only 24-hour available health care in that particular jurisdiction. Technologies commonly available and commonly used by Ontarians in this province every day, now freely, easily and economically affordable, can and should be brought to the practice of pharmacy.

Canada has long been a pioneer in the development of new infrastructure and distance technology—the telephone, cellphone, television etc. This is an opportunity to once again lead. We hope to see the day when every parent in Ontario, in any Ontario community, can receive a pharmacist’s counselling, and when the pharmacist plays a larger role in the health care of Ontarians. That role should be available at any hour of the day at any point in this province, where, in the middle of the night, a parent could receive, in any town, regardless of size, dispensing and pharmacy counselling.

At the touch of a screen or the lifting of a phone, an Ontarian should be able to speak to a pharmacist, or a physician, for that matter, whenever they need to. Such things are available today with the simple leveraging of existing and ubiquitous technologies.

The day when all of our complex health records, deployed over the same infrastructure, could be confidentially transmitted and explained by a live health care professional is here, should we will it to be. The day when we’re prepared for the next pandemic, with a primary care infrastructure system able to service at least two or three times the throughput of the existing health care system, with no additional cost, is here. We simply have to choose to use it. The day when this infrastructure is available, with no additional capital cost to the government—simply utilizing the existing fees that are paid, in the billions of dollars, into the drug budget in Ontario—is here.

The changes we are asking for in the wording of Bill 179: Despite all of these changes, we understand that these are big changes for the pharmacy system and pharmacy legislation. While the hospital act and the physicians’ act both permit this and are the basis upon which

the existing systems deployed by us and others in the province have been utilized, the Pharmacy Act is approaching it with all the depth of consideration that pharmacy is known for, and with an eye to safety.

However, fundamentally, the safety of any of these systems, be it the telephone, a remote dispensing station, robotics, which exist in pharmacies and hospitals across this province—the existing systems rest upon one thing: the professional judgment of a pharmacist. We ask that Bill 179 be modified so that it too rests upon that professional judgment of the pharmacist, and that the regulations that fall from Bill 179 not be unduly limited so that the benefits of these technologies are, in fact, made available and the spirit and intent of the legislation is actually brought to life in the industry and in the community for the benefit of Ontarians and pharmacists.

In pursuit of such, we propose two definitional changes: One is to incorporate a definition of remote dispensing, and another to incorporate a definition of a remote dispensing location—“remote dispensing” meaning dispensing at a remote dispensing location under the authority of a pharmacist or other authorized person through technological means; and “remote dispensing location” meaning a place where drugs may be dispensed remotely, pursuant to the authority of a pharmacist or another authorized person and subject to the approval of the college of pharmacy.

To clarify what remote dispensing is about, it is about Ontarians catching up to a trend that is sweeping across regulated pharmacy professions in western, socialized-medicine countries. I just came back from the UK. Our company has been given full approval to go ahead and deploy remote dispensing stations in hospitals and clinics in the United Kingdom, something we expected to take two more years, although it has been publicly announced to be the United Kingdom government’s priority. We are also in the late final stages of a discussion with a jurisdiction and a large partner in the United States, and we expect both of those to come to fruition in 2010.

Remote dispensing is also about taking the leadership position for Ontario and not waiting the three years to watch it be proven safe somewhere else, proven to extend pharmacy benefits, increase systematic capacity and lower costs, and turn around and find out that we could have, and should have, been the first. It is safe. It has been five years in trial in Ontario. The time now is to deploy it and make it available to everyone.

Remote dispensing is not about compromising safety. It is not about compromising selection. The machines and the technology have advanced dramatically. It is not about accepting fraudulent scrips; it actually, in my opinion, is superior in terms of audit trail and fraud identification. But fundamentally, no machine and no handwriting recognition exists in this world to replace the judgment of a pharmacist. That’s why our systems and those that have been deployed are fundamentally based on the human pharmacist’s professional judgment.

For remote dispensing, the legislative and regulatory process should not be about creating barriers to the

attainment of these efficiencies and gains for Ontarians and the profession even if they are quite shocking to the status quo. It should be about preserving the spirit and intent of the legislation and the efforts that have been three years in the making, and going forward and seeing that spirit and intent implemented under the guidance and control of the Ontario College of Pharmacists, but with an intent not to limit the spirit and intent of the legislation and render the proceedings of Bill 179 invalid by virtue of limiting commercial operational efficiencies and economic viability.

We are not choosing here to enable anything new. It has already existed for years in this province. Tele-pharmacy, as some call it, brings significant advantages. Imagine. One retailer alone that we have spoken to, if deployed, would increase the number of pharmacist-available hours in the province of Ontario by 16% without a single dollar spent by the government. If you don't believe this is an issue, google it, the Sudbury Star website. There was a great debate about the fact there are no 24-hour pharmacies, save one, available in the outlying areas, let alone in Sudbury. The public is blogging about these things. It would bring 24-hour health care to all of these communities. What a great gift of the Legislature.

In conclusion, we would like to see the spirit of Bill 179 implemented. We look forward excitedly—our pharmacists, 10 of them, who have been using this technology consider it to be a platform and an opportunity and a tool that does not replace them in any way, shape or form. It can do nothing without their guidance, care, consideration and counselling of the patient.

I thank you for having us comment today.

Le Président (M. Shafiq Qadri): Le plancher est à vous, madame Gélinas. Thirty seconds.

M^{me} France Gélinas: Merci. Which First Nation are you doing your pilot in?

Mr. Peter Suma: The discussions are currently ongoing and not finalized, but it is Christian Island. The Beausoleil First Nation is the current discussion. It is not concluded as yet.

M^{me} France Gélinas: Where is that?

Mr. Peter Suma: It's in the middle of Georgian Bay on an island.

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

Mrs. Carol Mitchell: Thank you for your presentation. I just wanted to bring forward very quickly that there have been concerns raised about safety. I wanted to give you the opportunity very quickly to talk about the five years in trial and what you found from the information that was gathered during those five years.

Mr. Peter Suma: In short, I would conclude that many people call for, let's say—the reasons being that every dispense is weight, expiry, lot, storage temperature, UPC bar code image, cross-validated at the machine and the supply chain going through—

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

Mrs. Christine Elliott: No questions. Thank you for your presentation.

The Chair (Mr. Shafiq Qadri): Thanks to you, Mr. Suma, and to your colleague for your deputation and written submission on behalf of Patient Care Automation Services.

1510

LYME ACTION GROUP

The Chair (Mr. Shafiq Qadri): I would now invite our next presenters to please come forward: Dr. Wilson and Mr. Manten of the Lyme Action Group. Welcome. I'd invite you to please begin.

Mr. Robert Manten: Good afternoon. My name is Robert Manten. I'm a Lyme disease patient and represent the Lyme Action Group, which supports patients with both acute and chronic forms of Lyme disease.

Dr. Douglas Wilson, also a Lyme patient, sends his regrets. I'm speaking in his place today.

With me is another Lyme patient, actually a recovered Lyme patient, whose name is Ms. Karin Kiouman. We gratefully present to you today.

You may be wondering why a Lyme disease advocacy group would want to address the subject of Bill 179. There have been occasions in the history of medicine in our province where, to be frank, things have gone terribly wrong. Regrettably, Lyme disease is today one of those cases. However, we are optimistic that Bill 179 provides an opportunity to address some of our concerns. To explain how, I need to give you some background and context.

Presently in Ontario, it is very difficult to get a timely diagnosis of Lyme disease, yet a timely diagnosis is essential in order to avoid the serious chronic illness that results from undiagnosed Lyme disease. There are several contributing factors to the difficulties we now face.

First, a lack of reliable testing: The two-tier testing protocol used throughout North America, and also here in Ontario, has been shown in medical literature to give overwhelmingly false negative results. While there are more reliable tests available through certain labs in the US and Europe, the seriously flawed two-tier protocol remains the only OHIP-funded tool available to Ontario doctors today.

Second, a lack of experienced doctors: Presently in Ontario—in fact, across the country—there is only a handful of doctors experienced in the diagnosis and treatment of Lyme and chronic Lyme disease. Increasingly, patients are forced to seek treatment in the US or Europe at great personal expense.

Third, a lack of awareness: The most recent surveillance data from the US shows that in 2008 there were more than 35,000 new cases of Lyme disease reported to the CDC. The vast majority of these cases are in close proximity to Ontario's border with the US. The public health branch has kindly shared with us Ontario's surveillance data. In the last two years, reported cases of Lyme disease in Ontario have more than doubled,

according to public health. This information is not being effectively communicated to either the public or the medical community.

While it is outside of the scope of our discussion today, I would also mention that Canada is one of the few western nations that does not currently screen its blood supply for Lyme disease. Clearly, this is a disaster waiting to happen.

There is divergent opinion in the medical community about Lyme disease, and chronic Lyme in particular. The two schools of thought are represented by the Infectious Diseases Society of America, IDSA, and the International Lyme and Associated Diseases Society or ILADS. The IDSA takes the position that chronic Lyme does not exist, with obvious implications for patient access to treatment, while ILADS has done extensive research demonstrating not only the existence of a chronic form of the disease, but has also developed long-term antibiotic treatment protocols that have restored the health of many chronic Lyme patients.

In 2008, the Attorney General of Connecticut concluded an antitrust investigation of how the IDSA developed its Lyme treatment guidelines. Many procedural flaws were identified, including a failure to consider the extensive body of research supporting chronic Lyme, as well as several of the guideline panelists having had undeclared conflicts of interest. As a result of that investigation, the IDSA agreed to a complete review of its guidelines, a review currently in progress. But in spite of the validity of the existing guidelines having been seriously called into question, they continue to be the mandated standard of care in Ontario, to the exclusion of any others. The Journal of Medical Ethics has recently covered this subject matter, outlining issues of systemic bias in the guideline development process, and documentation from the journal and the Attorney General is included in our package today.

To give a real-life example of these issues, currently in Ontario, there is a doctor trained and accredited by ILADS who is being investigated by the CPSO. There has not been one single patient complaint against him, yet the disciplinary proceedings are moving forward. The actions of the CPSO in this case have neglected to consider important legal precedents, such as the 2003 Supreme Court definition of a "true peer" for the purposes of one doctor providing an unbiased assessment of another, nor has it considered a 1993 Ontario Court Brett decision, which ruled that a doctor cannot be found guilty of misconduct solely because a disciplinary panel prefers a certain standard of practice, even one supported by the majority of the profession, as long as there exists a responsible and competent body of professional opinion that supports the doctor's actions. Clearly, ILADS meets the criteria of such a responsible and competent body. Nor has the CPSO considered the 2000 Kwinter amendment to the Medicine Act, which allows for doctors to use therapies that are non-traditional or that depart from the prevailing medical practice.

Perhaps the most disturbing aspect of such disciplinary actions is that patient outcome is considered ir-

relevant. Despite the government-ordered review in 2000 by KPMG, which noted that, "The health care delivery system is moving from a physician-centred model to a patient-centred model. To ensure public accountability, the CPSO decision-making model must follow in that direction," the CPSO still appears to ignore these recommendations. Speaking as a patient, that doesn't sit well.

The disciplinary proceeding against ILADS Lyme doctors is prevalent throughout the United States and, as in Canada, such medical politics interfere with the doctor-patient relationship. As American cases of Lyme disease have risen dramatically in the last quarter-century, some jurisdictions have recently taken legislative action to protect Lyme doctors, ensuring their ability to practise their protocol of choice and patient access to treatment. Such legislation recognizes that, while the debate is ongoing in the medical community, it is unacceptable that Lyme patients should be denied treatment, as is frequently the case.

Three states have now passed such Lyme doctor protection legislation. A fourth has achieved the same protection through the co-operation of its state medical authority, and, just last month, two more states have introduced similar doctor protection legislation.

In this context, Bill 179 provides a rare opportunity to introduce Lyme doctor protection to the RHPA, and we strongly recommend that it be added. Such protection clearly comes down on the side of patients to ensure access to treatment and would serve as a model for other emerging illnesses.

The current proposed amendments of Bill 179, particularly section 5.0.1, are timely indeed. Given the shortcomings described in the application of existing college disciplinary procedures, we believe that additional oversight of the CPSO is warranted. We, therefore, support the bill's provisions for a college supervisor and additional audits. These provisions will better enable the minister to fulfill his obligations to regulate and coordinate in the public interest by, first, protecting a diversity of responsible medical opinion; second, using supervision and audits to ensure colleges utilize their extensive powers in the public interest; third, eliminating systemic bias and emphasizing the importance of positive patient outcome; and, last, ensuring appropriate application of current legal protections.

These changes will only serve to enhance the regulatory process, to the benefit of all involved. Our written submission goes into greater detail of our recommendations with relevant references.

Patient outcome does matter, and we trust this will be a consideration for you as you deliberate over the details of Bill 179. Thank you very much.

The Chair (Mr. Shafiq Qadri): Thank you. We'll start with the government side, under 30 seconds. Mr. Balkissoon.

Mr. Bas Balkissoon: Thank you very much for making your presentation and the input into the bill.

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

Mrs. Christine Elliott: Just a quick clarification: It's only the one recommendation for amendment that you're asking for, then, just Lyme doctor protection?

Mr. Robert Manten: That is something we would really like to see, in addition to supporting the additional oversight of colleges such as the CPSO, yes.

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

M^{me} France Gélinas: Am I to understand that you would like the part that talks about oversight be clarified to include the four points?

Mr. Robert Manten: Yes, that would be correct. Yes.

The Chair (Mr. Shafiq Qaadri): Thanks to you, Mr. Manten and your colleague, on behalf of the Lyme Action Group.

ONTARIO SOCIETY OF PHYSICIANS FOR COMPLEMENTARY MEDICINE

The Chair (Mr. Shafiq Qaadri): I now invite our next presenters to please come forward: Dr. Rapson and Mr. Yazbeck of the Ontario Society of Physicians for Complementary Medicine. I'd invite you to please begin.

Dr. Linda Rapson: The Ontario Society of Physicians for Complementary Medicine, OSPCM, is an organization founded in 1997 and incorporated in 2006 as a not-for-profit medical society to serve as an umbrella body for physicians practising a variety of time-tested or innovative, evidence-informed health care approaches and techniques that complement and integrate with those taught in western allopathic medical schools. Such approaches and techniques are important to assist patients with chronic or emerging conditions who are not well served by, or who do not choose, prevailing methods and might otherwise have to go out of province or out of country for care.

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The Ontario Medical Association has a complementary medicine section to which OSPCM members generally belong. In addition, OSPCM members commonly belong to and have been trained by a variety of recognized, credible organizations in Ontario or other jurisdictions. These organizations sponsor courses and conferences in the focused-practice areas which are approved for continuing medical education credits in Canada, the US and internationally, and have respected faculty who are frequently university-based. For example, in addition to my medical training, I was trained by the Acupuncture Foundation of Canada, beginning in 1974, and earned a certificate of proficiency from them. The Acupuncture Foundation of Canada Institute is part of an international medical acupuncture organization which meets every four years for educational purposes. I have successfully integrated my skills in acupuncture into my chronic pain medical practice and now teach those skills nationally and internationally.

To summarize, members of the OSPCM are conscientious physicians who have spent time, money and effort to learn safe and effective treatments for chronic pain and conditions that ruin quality of life. Our case-

loads consist almost completely of patients who seek us out because their health problems have not responded to prevailing allopathic methods.

The OSPCM has worked to create greater knowledge and proficiency in various complementary medical approaches through education of regulated health professionals in Ontario. For example, the society currently hosts a two-part continuing education program accredited through the University of Toronto by the College of Family Physicians of Canada, the Royal College of Physicians and Surgeons of Canada and the American Medical Association. This program deals with nutrition, a long-neglected topic in most undergraduate and continuing medical education programs yet a vital determinant of health.

The OSPCM welcomes this opportunity to contribute to the government of Ontario's initiative to improve health care for Ontarians by presenting our perspectives on portions of Bill 179. Many of our members have grave concerns about the manner in which the College of Physicians and Surgeons of Ontario continues to treat our members under the current legislation.

Our main goal is to help the government meet its goals for Bill 179 by focusing on potential amendments to address needs for peer evaluation and procedural safeguards for both health professionals and their colleges.

We have invited Mr. David Yazbeck to summarize and focus on stated government goals for this legislation and to outline possible solutions to deal with some unintended consequences of amendments to the RHPA, which are explained in more detail in appendix A. Mr. Yazbeck is a partner in Raven, Cameron, Ballantyne and Yazbeck LLP, a prominent Ottawa legal firm specializing in human rights, employment and labour law, constitutional law and judicial review of government action.

Mr. David Yazbeck: Mr. Chair, members of the committee, Mr. Clerk, I know I don't need to tell you how important quality health care is to the citizens of this province. I do need to tell you that there are several serious legal impediments to the development of effective and innovative medical practices that are crucial to that quality, particularly for those who suffer from chronic pain or chronic diseases. I know that one of the goals of the Legislature in reviewing this bill is to alleviate their concerns.

The chief difficulty is that professional groups, especially those in the fast-changing world of medicine, often fail to accept what are legitimate and effective medical developments solely because they are different from the majority's practice. Yet we know that many significant and effective medical practices have developed in exactly this way, and acupuncture is one classic example. Many of these practices are crucial as well for chronic disease.

Unfortunately, the law provides insufficient protections for practitioners in these areas. Fortunately, you have an opportunity to change that. I stress that this is not a new concern. A previous presenter, for example, referred to the Medicine Act, and it's worth stressing that the Medicine Act states, "A member shall not be found

guilty of professional misconduct or of incompetence ... solely on the basis that the member practises a therapy that is non-traditional or that departs from the prevailing medical practice unless there is evidence that proves that the therapy poses a greater risk to a patient's health than the traditional or prevailing practice." That is a recognition by the Legislature of the importance of non-traditional practices.

Similarly in the Brett case, which the previous presenter referred to, Justice O'Leary stated, "If it be misconduct (or incompetence) to use methods and techniques that are foreign to or disapproved of by the vast majority in the profession, the profession might never progress. In the case of medicine, for example, acupuncture would probably not have become a method of treatment in Ontario."

What we are urging the committee to do is look at that policy that does exist here in Ontario and look at the manner in which medical professionals, especially those who practise complementary medicine, are regulated by law. The reality is that the law is not sufficient, and it has the effect of stifling innovation in medicine. This is because of the failure to assess physicians by true peers and by insufficient legal protections to ensure that physicians actually know how they're being dealt with by their college.

For this reason we urge the committee to seriously consider the comments in our brief. It's fairly lengthy. There are detailed comments in there to restructure the law to better protect these physicians and ultimately to improve health care in Ontario.

In the brief, I'll just refer you to the key passages, although I'd urge you to review the whole of the brief. Pages 4 and 5 deal with the question of "true peer" and how important that is to assessing physicians. Pages 7 to 9 deal with mandatory reporting and the significant negative effects that could result. Appendix A deals with that as well. Then pages 10 to 14 offer some concrete solutions for addressing these problems and ensuring that all Ontarians are entitled to the benefit of innovative medical practices.

Members of the committee, our proposals are designed to ensure not only legal fairness but medical thoroughness in the assessment of physicians in the province of Ontario, which would ultimately, of course, improve the health of Ontarians by improving its health care system.

To summarize, without adequate peer evaluation and procedural safeguards to ensure this fairness, we see a number of unintended adverse consequences, particularly as a result of mandatory reporting.

First, there would be loss of access for Ontarians to innovative health professionals and new methodologies, especially for those with emerging or chronic complex recalcitrant conditions.

Secondly, there would be a loss of ability to attract and keep health professionals because of a prevailing atmosphere of suspicion and distrust.

Thirdly, there would be deterrence of ongoing thoughtful, respectful interprofessional discourse and co-

operation to continually improve health care for the well-being of patients.

Without removing these barriers, efficiency as well as professional and public confidence in the health care system are likely to be seriously undermined.

By providing an initial opportunity for health professionals to respond to inquiries, complaints or reports, as well as to decisions to order broader investigations with a review of their responses by appropriate peers, many concerns may be addressed swiftly at the outset. Unwarranted expansion into time-consuming and costly investigation and discipline processes may delay colleges from addressing truly serious concerns in other—

The Chair (Mr. Shafiq Qadri): You have under a minute left, Mr. Yazbeck.

Mr. David Yazbeck: Thank you—members' practices, in the public interest.

We believe, members of the committee, that peer evaluation and these procedural protections can and should be available at the initial assessment stage, through to completion, of any regulatory college evaluation process by amending the Regulated Health Professions Act in Bill 179. Such changes would be consistent with the government's changes in Bill 171, schedule D, to enhance the fairness of the medical audit process.

Members of the committee, many physicians are subject to review by their governing college in a way that does not provide them with a fair opportunity to know the case against them and to actually address it in a way that's fair and also consistent with health practice here in Ontario. We urge these changes to be made so that these physicians will be treated fairly and so that ultimately they will help in adapting and developing innovative medical practices which will benefit all of Ontario.

The Chair (Mr. Shafiq Qadri): Thank you, Dr. Rapson and Mr. Yazbeck, for your deputation on behalf of the Ontario Society of Physicians for Complementary Medicine.

1530

SHOPPERS DRUG MART

The Chair (Mr. Shafiq Qadri): I'd now invite our next presenter to please come forward again: Mr. Miller of Shoppers Drug Mart and colleagues. I'd invite you to please begin now, and do introduce yourselves as well, please.

Mr. Dean Miller: Thank you. Good afternoon. My name is Dean Miller. I am the director of pharmacy in Ontario for Shoppers Drug Mart. I was introduced earlier on as the chair of the Ontario Pharmacists' Association, but these remarks are on behalf of Shoppers Drug Mart. Joining me today is Jeff May, our senior vice-president of pharmacy professional affairs and pharmacy business.

On behalf of Shoppers Drug Mart, I welcome the opportunity to participate in the public hearings on Bill 179. Shoppers Drug Mart is supportive of the recommendations being proposed in Bill 179 as they relate to pharmacists' professional services. We also believe that

an increased scope of practice for all regulated health professions is a bold and progressive step forward to better serve the people of Ontario.

Pharmacists have the knowledge, skills and professional judgment to perform any of the new controlled acts in the proposed legislation. And after all, many of the current acts give them regulatory authority to do the things that pharmacists have been doing for years. Enhancing the role of pharmacists will no doubt lower wait times and improve the overall efficiency of our health care system. We do, however, have a few concerns and recommendations which I will touch upon later on in my presentation.

What I thought I would do today is provide a practical viewpoint of the kinds of services that our pharmacists provide to Ontarians on a daily basis, based upon my experience. This will demonstrate the value pharmacists add to the health care system and how expanding the scope of practice would improve the health care of Ontarians.

About our company: Shoppers Drug Mart has 1,100 locations across Canada, 570 of those in Ontario. Our head office is located here in Toronto, and we employ approximately 2,100 pharmacists, both part-time and full-time, and over 30,000 people total across the province. Capital spending in 2008 was approximately \$750 million for infrastructure across Canada, the majority of it here in Ontario. And most uniquely, every one of our pharmacies is owned by an associate owner who is a pharmacist.

Pharmacists provide a whole range of vital services across the province—everything from advising on life-threatening situations like a Telehealth nurse phoning a pharmacist with a poisoning situation related to medication or educating a mum on how to use an EpiPen injector save a child's life at school or when away from home, to minor situations like blister-packing medications for a senior or even how to treat a blister for that same senior. All of these services keep people out of doctors' offices and hospitals and allow many vulnerable Ontarians to live independently.

Access to health care is frustrating. Visiting a pharmacist takes some of that away because you don't need an appointment to see us. We are conveniently located and often open for extended hours to serve our patients. Shoppers Drug Mart now provides almost 50 locations in Ontario where people can access pharmacy services 24 hours a day.

I'd like to point out a number of specific examples that routinely occur on a daily basis in our pharmacies. Some of these are directly related to Bill 179, and others just illustrate enhanced services that pharmacists already provide. Medication compliance programs like compliance packaging occurs in almost all of our stores. These are complex medication regimens, sometimes containing 10 or more medications per package. Dosage adjustments and medication modifications with these patients can occur on a weekly basis. Pharmacists manage these patients and help them stay in their homes. Giving pharmacists the authority to extend their refills, make dosage

adjustments and in some cases initiate and suggest new therapy keeps them in their homes and out of mainstream health care—a very good idea.

Pharmacists take an active role in monitoring patients who need dosage adjustments of their medication to control their blood clots, thus getting better control of their condition and preventing strokes and cardiovascular incidents. If allowed to actually pierce the patient's skin, the pharmacist can better manage a patient and minimize return visits back to the health care system—another very good idea.

Before attaining over-the-counter status, plan B, or emergency contraception, was initiated by a pharmacist in discussion with a patient. Patients benefited from easy access and proper advice and counselling from a pharmacist. Drugs for smoking cessation is a great beginning, but many other drugs and conditions exist where a patient could easily access these medications at the pharmacy level.

These are some of the services that we already provide every day and in every community across the province. I'd also like to share a few specific examples of how Shoppers Drug Mart pharmacists save the health care system significant dollars.

Our store in Scarborough, number 826, is a 24-hour store. It answered 632 Telehealth nursing calls in November 2008 between 11 p.m. and 8 a.m. That's 20 a night. These were drug-related calls related to medication issues with patients. It is highly likely that many of those 632 patients who reached a Telehealth nurse would have sought access to the health care system if that pharmacy had not been open through the night.

As a national pharmacy organization, our experience in British Columbia, Alberta and New Brunswick has our pharmacists already extending refills of maintenance medications and adapting prescriptions for patients. It's our view that in those provinces with escalating activity, citizens benefit from uninterrupted medication therapy, physicians' offices are more efficient, and pharmacies are more efficient—three very positive outcomes. Reports from patients are incredibly positive, particularly in communities where access to a family physician is limited or non-existent.

In Alberta, 68 of our pharmacists have received accreditation from the Alberta College of Pharmacists to administer medications by injection and, to date, have administered 1,650 medications by injection, mainly travel vaccinations. Again, patients benefit from the convenient access to a health care service, creating additional capacity in physicians' offices for patients who may not have access to physicians.

In a time of crisis, all health care professionals will be asked to do a little more. As the most accessible point of entry into the health care system, pharmacists offer many benefits to public health in Ontario.

Finally, three of our pharmacists have already received advance prescribing certification from the Alberta College of Pharmacists. They provide prescribing support, working collaboratively with physicians in their community.

We encourage the Ontario government to adopt these regulatory changes in Ontario and, as such, support the Ontario Pharmacists' Association's proposal. These examples are consistent with the government's priorities: lowering wait times, chronic disease management and mental health and addictions. Allowing pharmacists to do more, like refill extensions and therapeutic modifications, would not only save the system money but, more importantly, it will mean better health care for Ontarians.

We do have one concern: remote dispensing. Best pharmacy care for patients is always face to face with a pharmacist. We are encouraged by the regulations around remote dispensing as proposed by the Ontario College of Pharmacists and believe strongly that technology or a machine could never replace a pharmacist.

We do agree that there are appropriate uses for technology in remote areas where convenient access to traditional service does exist to support optimal face-to-face care. Regulatory regimens exist in the United States that address this matter. As the Ontario Pharmacists' Association has pointed out, it may require some further review of this part of the legislation.

Pharmacy is currently working collaboratively with the ministry to modernize the current drug system in Ontario to provide cost savings and better value for money. Pharmacy has developed a framework that does this, but it's contingent on Bill 179 changes.

Shoppers Drug Mart has seen the future of pharmacy in Canada. Pharmacists in other Canadian jurisdictions are already initiating prescriptions, immunizing patients, extending refills and adapting prescriptions.

Shoppers Drug Mart looks forward to working with the government in continuing to deliver the kind of health care that Ontarians deserve.

Le Président (M. Shafiq Qaadri): Merci. Je passe la parole à madame Gélinas; 40 secondes.

M^{me} France Gélinas: Very well done; easy to understand; easy to follow. When you talk about remote dispensing, you wouldn't see every hospital having a remote dispenser?

Mr. Jeff May: The hospital perspective is a little bit different because it currently falls under a different regulatory regime. I think outpatient dispensing is something that is of benefit. Our focus in our submission is really to look at community-based non-hospital remote dispensing in remote communities where there isn't access to traditional community pharmacy services.

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

Mr. Bas Balkissoon: These remote dispensing machines: If Shoppers Drug Mart was able to own them and have them remote from their own pharmacist, don't you see this as an improvement to patient access to prescription drugs?

Mr. Jeff May: Again, I think the issue is ensuring appropriate access in remote areas. We strongly believe that the nature of pharmacy services, particularly with the role this particular bill will put in place, requires face-to-face dialogue between pharmacist and patient. The

opportunity to have dispensing units to improve access in communities where pharmacies do not exist—

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

Mrs. Christine Elliott: That was very clear. Thank you for your presentation.

The Chair (Mr. Shafiq Qaadri): Thanks to you, Mr. May and Mr. Miller, for your deputation and presence on behalf of Shoppers Drug Mart Canada.

ONTARIO ASSOCIATION FOR MARRIAGE AND FAMILY THERAPY

The Chair (Mr. Shafiq Qaadri): I now invite our next presenter, Mr. Stafford of the Ontario Association for Marriage and Family Therapy. Welcome, Mr. Stafford. I invite you to please begin now.

Mr. Dexter Higgins: I am taking the place of him today. My name is Dexter Higgins and I am the secretary of the Ontario Association for Marriage and Family Therapy. I hold a bachelor's degree, two master's degrees, a doctorate and approximately four years of post-doctoral training. As a member of the Christian clergy, I pastor churches in Newfoundland and here in Ontario. I was a program coordinator in the Newfoundland school system developing and implementing curriculum. I am a registered social worker and a member of the Ontario College of Social Workers and Social Service Workers since 2004. Since 1988, I've engaged in marriage and family therapy and became a registered marriage and family therapist in 1995.

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The Ontario Association for Marriage and Family Therapy, commonly called OAMFT, is a self-regulated organization founded in 1972 that maintains marriage and family therapist guidelines as the professional organization for over 800 members here in Ontario, 500 of whom are registered marriage and family therapists. The majority of the other 300 are in the process of becoming registered. Registered marriage and family therapists strive to honour diversity in ability, age, culture, ethnicity, gender, race, sexual orientation, spirituality and socio-economical status.

However, what all our MFTs have in common is that they are among the highest and most rigorously trained of any mental health professional in Ontario, and they have completed a minimum of a master's degree in marriage and family therapy or in fields such as medicine, education, nursing, psychology, social work or theology. They have completed 12 additional courses that are geared to marriage and family therapy. There has been the completion of a 300-hour supervised practicum and 1,000 hours of direct clinical contact, of which 50% must involve more than one person in therapy. There are 200 hours of clinical supervision, of which 50% must involve individual supervision. The actual ratio of clinical hours to supervision is one hour of supervision for every five hours of therapy. Our MFTs are uniquely qualified to provide mental health services and do so in community

mental health centres, hospitals, schools, employee assistance programs, family counselling agencies, children's health centres, universities and research centres and in private practice.

At the outset, we wish to make it clear that the OAMFT is very pleased with the creation of the College of Psychotherapists and Registered Mental Health Therapists of Ontario. We are pleased with the addition of the term "registered" to the psychotherapist title, which now makes the title "registered psychotherapist." We are pleased with the exclusive use of the title "registered psychotherapist" by members of the College of Psychotherapists and Registered Mental Health Therapists of Ontario. We are pleased with the requirement that other colleges must cite their college membership in conjunction with the use of the title "psychotherapist." We strongly support the requirement that all regulated health professionals hold minimum professional liability insurance.

However, the OAMFT respectfully submits that Bill 179 be further amended by adding the following: Section 5 of the bill should be amended and the name of the college be changed by moving the term "registered" so that the college would henceforth be known as the College of Registered Psychotherapists and Mental Health Therapists of Ontario. We make this request for the following reasons: The term "registered" is already being used to describe mental health therapists in the name of the college. In our view, moving the term "registered" to appear before the term "psychotherapists" is both more reflective of the college's mandate to regulate both psychotherapists and mental health therapists and makes it clear to the public that this college only governs registered psychotherapists.

The second reason for changing the name to the "College of Registered Psychotherapists and Mental Health Therapists" is that section 23 of the bill allows other professionals, such as physicians and psychologists etc., to use the title "psychotherapist," but only if they use it in conjunction with their other title, such as physician-psychotherapist, psychologist-psychotherapist etc. It is very important to maintain a clear distinction between a registered psychotherapist and a hyphenated psychotherapist. This is a matter of public protection and clarity. The public needs to know where to seek accountability should a complaint against a professional performing psychotherapy be raised. It needs to be made clear that only registered psychotherapists are regulated by the college and that if a complaint is raised, for example, against a physician who practises psychotherapy, redress is available at the College of Physicians and Surgeons.

While the proposed amendments to the act create a clearer distinction between registered psychotherapists and hyphenated psychotherapists, the name of the new college does not. In keeping with our public protection concern and our desire to afford the public as much clarity as possible on this issue, we believe that the term "registered" in the name of the college should be moved

so that the college becomes the College of Registered Psychotherapists and Mental Health Therapists.

The OAMFT wholeheartedly supports the legislation's provision that requires that all regulated health professionals hold minimal professional liability insurance. We would, however, submit an additional requirement. The OAMFT makes the submission that regulated health professionals should be required to hold registration in their relevant college and membership in the professional association in order to be eligible to purchase liability insurance.

We believe that membership in a professional association, particularly one that requires ongoing continuing education, would be in the public interest, in part because it enhances professionalism and professional development and thus can result in fewer claims due to unethical conduct or incompetence. Requiring both college registration and association membership would highlight for professionals the relevance of professional association membership to college registration.

Thank you for allowing me to present my association's views on Bill 171.

The Chair (Mr. Shafiq Qadri): Thank you, Mr. Higgins. We have about 30 seconds or so per side, beginning with Mr. Balkissoon of the government.

Mr. Bas Balkissoon: I just wanted to say thank you very much for coming forward and making your presentation. I think your point has been well made.

The Chair (Mr. Shafiq Qadri): The PC side.

Mrs. Christine Elliott: I would agree with Mr. Balkissoon. Thank you very much. Very clear.

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

M^{me} France Gélinas: We all agree. Clear and concise.

The Chair (Mr. Shafiq Qadri): Thanks to you, Mr. Higgins, for coming forward.

ONTARIO SOCIETY OF DIAGNOSTIC MEDICAL SONOGRAPHERS

The Chair (Mr. Shafiq Qadri): I would now invite our next presenter, Mr. Jozkow of the Ontario Society of Diagnostic Medical Sonographers and colleagues. Sorry—Kim Jozkow; Madame Jozkow. I would invite you to please come forward. Please begin.

Ms. Kim Jozkow: Ms. or Mrs. is fine. Good afternoon. My name is Kim Jozkow. I'm here today representing the over 700 members of the Ontario Society of Diagnostic Medical Sonographers, and I would like to thank you all for allowing us to present today.

Bill 179 presents an opportunity to provide much-needed improvements to many areas of health care. The OSDMS supports many of the facets of this bill. However, today I would like to speak to a very specific point that is raised within the bill. It is in regard to the request of nurse practitioners to be able to apply ultrasound energy for the purpose of a diagnosis.

In part, this issue arises with respect to what constitutes a diagnostic ultrasound. According to the Regu-

lated Health Professions Act, a diagnostic ultrasound means “ultrasound that produces an image or other data.” This leaves a large spectrum of what can be considered a diagnostic ultrasound, and I can refer you as well to the handout that I have provided today. At one end of the spectrum you have ultrasound in the form of a Doptone. This piece of equipment is relatively straightforward and it would require minimal training to become competent in its use. At the very other end of the spectrum, however, you would have an example of an echocardiogram. An echocardiogram is an ultrasound that fully evaluates heart structure and function, among other things. This type of ultrasound requires a high degree of skill, knowledge and judgment to perform. What the NPs—nurse practitioners—have requested and what would be permitted by the passing of this bill is that they would be allowed to perform diagnostic ultrasound. This, by definition, would include the entire spectrum of these exams.

1550

Based on their standards of practice with nursing as a self-regulated profession, we can accept that nurse practitioners only perform procedures within their personal level of knowledge, skills and judgment. According to the decision tree in their standards, they must ask themselves, “Do I have the knowledge, skills and judgment to perform and manage all possible outcomes of performing this procedure?” If the answer to this question is yes, then they perform the task. If the answer is no, then they refrain from performing that task.

However, what happens if the nurse practitioner believes that they have the appropriate knowledge, skills and judgment but in fact they have been misguided in this respect? In the submission by the College of Nurses of Ontario to HPRAC for their request for the extended scope of practice, there were many inappropriate terms and misinformation around the use of ultrasound. In that document, the CNO made reference to using only low-frequency ultrasound and performing only bedside ultrasound. The OSDMS questioned the use of these terms as we felt they were quite misleading. Ultrasound is by definition high-frequency, and virtually any ultrasound examination can be performed at the bedside. From the point of view of sonographers, these terms demonstrated a lack of understanding around this technology.

We expressed these concerns to the CNO, the Ministry of Health and Long-Term Care and HPRAC. HPRAC did find in their report on the extended scope of practice for nurse practitioners that nurse practitioners should be granted access to this controlled act. It was suggested by HPRAC that the nurse practitioners could take on these additional tasks with the proposed environment of mentoring and with the use of interprofessional collaboration to guide them.

The OSDMS would like very much to work with the CNO on this issue; however, we were never asked before the submission that was made to HPRAC, nor were we identified as stakeholders.

The OSDMS is also aware that the ultrasound content within the current training programs for nurse prac-

tioners is cursory at best. So more questions arise: Who will be mentoring the nurse practitioners in this field? Who will the CNO be collaborating with to create a scenario where nurse practitioners are fully trained in the application of ultrasound? Who will ensure that the nurse practitioners are performing these tests appropriately? With the lack of understanding that has already been demonstrated by the College of Nurses of Ontario, it is with concern for patient safety that the OSDMS felt compelled to present to you today.

When HPRAC was holding its public hearings into the extended scope of practice for nurse practitioners, a few scenarios were presented as potential situations where a nurse practitioner could perform an ultrasound to benefit the patient. One of these scenarios is that of a long-term-care facility where a nurse practitioner could perform a venous leg Doppler on an immobile patient to determine the presence of a DVT without transporting them. Certainly a nurse practitioner with the appropriate knowledge, skills and judgment could perform that exam, but then that nurse practitioner would be trained to the same level as a sonographer.

A sonographer, under that scenario, would perform this potentially very difficult exam, then give those images to a radiologist to report to the patient’s physician, who would then treat on its findings. Unfortunately, Bill 179 also gives nurse practitioners further extension to their scope of practice. So, potentially, you could have a scenario where a nurse practitioner identifies the need for the exam, performs the exam, interprets the results, informs the patient of their findings and then goes on to treat the patient based on those results. None of the usual checks and balances that are found in the health care system currently would be present if that scenario were allowed to unfold. But again, that would only be if the nurse practitioner felt that he or she were working within their knowledge, skills and judgment.

While the OSDMS recognizes that nurse practitioners, as a self-regulated profession, would likely not encounter this situation commonly, there is, however, a potential for a significant risk of harm to Ontarians. This seems especially true if one considers that the body that is safeguarding the public from the nursing profession seems to be the one misguided in its facts. It is for this potential risk of harm to Ontario patients that the OSDMS would like to request that with the passing of this bill, a strong suggestion be made to the CNO that parameters need to be set to provide guidelines as to what types of ultrasounds can be performed and with what training.

We also would like to encourage interprofessional collaboration with the appropriate groups that represent the profession of sonography, and that limitations be set as to which types of diagnostic ultrasounds are appropriate for the nurse practitioners to perform. With simpler point-of-care ultrasounds, the training required would be significantly less than the training for full, complete ultrasound exams. It is our hope that the OSDMS and similar societies will be allowed to help the CNO sort out the details of these types of exams.

I’d like to thank you once again for your time.

The Chair (Mr. Shafiq Qaadri): Thank you, Ms. Joskow. About a minute or so per side, beginning with Ms. Elliott.

Mrs. Christine Elliott: Thank you very much for your presentation. I wonder if I could just clarify whether the society is against nurse practitioners being involved in any kind of ultrasound.

Ms. Kim Jozkow: No.

Mrs. Christine Elliott: You want to have a consultation with respect to what can be done.

Ms. Kim Jozkow: That's exactly it, because there's such a broad range of potential exams. The Doptone exams, because the equipment is quite simple to use and it's quite straightforward, would take very minimal training to work with. The problem that the OSDMS has is, at the other end of the spectrum, you have these very complex exams. Currently, training in Ontario—there is a spectrum because sonography is an unregulated profession at the moment. The minimum amount of training for someone is a postgraduate program and it's about 18 months to be able to do a full-complement ultrasound exam, a full exam.

With that said, what concerned us about the conversations between HPRAC and CNO is that there never seemed to be any fleshing out, and I understand that—

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

M^{me} France Gélinas: Well, maybe continue. I was interested in what you were saying.

Ms. Kim Jozkow: Our concern was simply that because the nurse practitioners haven't fleshed out what exactly is going to be incorporated in the education programs, the recommendations from HPRAC were quite limited and suggested only this environment of mentoring.

Our concern was, if the nurse practitioners are the ones doing the mentoring, without any consultation with sonographers, perhaps that's not going to allow for an appropriate education for them.

M^{me} France Gélinas: Thank you.

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

Mr. Bas Balkissoon: Someone else raised the same issue last week. I went back and read the legislation itself. It actually says that they're allowed to practise based on "the terms and conditions and limitations imposed on his or her certification of registration to perform the following..." So if they're trained and registered by their own college, would you have an objection?

Ms. Kim Jozkow: If they're trained appropriately by the college, that is completely sufficient with us. That's really all that we're asking to have happen. The issue we're raising is—because the CNO identified themselves as having a misunderstanding of the profession of ultrasound and the application of ultrasound, that was where our concerns stood.

Mr. Bas Balkissoon: So if the minister takes the step to clarify this in his regulations, your organization will be happy.

Ms. Kim Jozkow: Absolutely.

Mr. Bas Balkissoon: Thank you very much.

The Chair (Mr. Shafiq Qaadri): Thanks to you, Ms. Joskow, for your deputation on behalf of the diagnostic medical sonographers.

JOZEF KROP

The Chair (Mr. Shafiq Qaadri): I'd now invite Dr. Krop to please come forward. I understand you'll be speaking in your capacity as a private citizen. I would invite you to please begin.

Dr. Jozef Krop: Yes. I might even speak as a person who has dual citizenship. I am Polish and I'm also Canadian. I am proud to be Canadian.

The Chair (Mr. Shafiq Qaadri): Gin Dobriye.

Dr. Jozef Krop: Gin Dobriye.

Mr. Chairman and committee members, my name is Jozef Krop. I am a medical doctor, a Fellow of the American Academy of Environmental Medicine, practising environmental, preventive and orthomolecular medicine in Mississauga.

Thank you for allowing me to speak to you in support of Bill 179, specifically the amendment to appoint a college supervisor, which would provide an important first step enabling the government to support and protect patients with new and emerging medical conditions who fall between the cracks of a medical system which is unable to provide adequate solutions for them.

My submission is a vivisection of a case illustrating the pitfalls of power in the hands of a regulatory body without adequate checks and balances.

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It is a documented fact that doctors in Ontario who want to help patients suffering from chronic degenerative diseases with newly emerging understanding of their causes and available treatments that do not fit the existing paradigm risk professional suicide. There is a systemic bias in the laws regulating health professions because standards of medical practice can be arbitrarily enforced through the sledgehammer method of disciplinary investigations instead of being established by scientific and collegial discussion and resolutions for the benefit of the patient.

I have practised medicine in Ontario for over 30 years. In the 1970s, I became interested in the new health problems, both physical and mental, caused by nutritional deficiencies as well as by toxins in our food, water and air, of which pesticides are one of the biggest causative factors. I express my gratitude to this government for passing the most comprehensive pesticide reduction law in Canada, which will reduce a great deal of human suffering as well as health care costs.

In recent years, I learned that many symptoms associated with new diseases such as multiple chemical sensitivity, chronic fatigue and fibromyalgia as well as traditional conditions such as multiple sclerosis, rheumatoid arthritis, Parkinson's, Alzheimer's and certain types of childhood autism often are caused by borrelia

infections, which commonly cause Lyme disease. This is the fastest-growing vector-borne infectious disease in North America and in Europe. It should also rapidly become a priority for governments everywhere because borrelia and associated infections are transmissible by blood transfusion, as reported by the Canadian Medical Association Journal in 2001.

After training and certification in the International Lyme and Associated Diseases Society, I began to treat many chronically ill patients diagnosed with some of the above-mentioned conditions for Lyme. Surprisingly, most tested positive and responded dramatically to antibiotic treatment protocols developed internationally.

From 1989, I was under disciplinary proceedings by the CPSO, which lasted 13 years without patient complaint or evidence of harm, and I was charged with diagnosing and treating environmental allergies and sensitivities, including multiple chemical sensitivity. The CPSO opined that MCS was not yet a valid diagnosis and, therefore, could not yet be treated in Ontario. The charges included recommending to my patients water and air filtration, sauna therapy for detoxification, organic food, nutritional supplements and avoiding pesticides. In 1999, I was found guilty of failing to maintain the standard of practice of the profession.

Last year in June, the CPSO once again commenced an investigation of my practice, this time for diagnosing and treating chronic Lyme disease. Again, CPSO investigators did not consider this to be a real disease, relying on the advice of their medical “experts” who, in this case as in other complementary doctors’ cases, are not true peers and are biased against both the diagnosis and treatment. Again, it was not patient complaint or harm that triggered this process.

When doctors are subjected to protracted disciplinary proceedings simply for practising in a new and emerging field, the whole society suffers, because medicine, as a science and as a practice, is then no longer patient-centred. Indeed, at many disciplinary trials, CPSO policies take precedence over patient outcome. I refer you to the glasnost report that I provided in the binder for you, and this is on the disc.

It is grossly unfair to allow doctors in Ontario, during disciplinary proceedings, to be forced to defend not only their own practice but an entire emerging field of medicine which is in the formative stage. The doctor’s expert witnesses are disregarded, good patient outcome is irrelevant and doesn’t count, and the doctor-patient relationship is grossly interrupted. What counts and remains on the record is overzealous prosecutorial activity to find you guilty. Much of the process is hidden from public scrutiny.

In a press conference here in Queen’s Park on May 10, 2000, criminal and constitutional lawyer Michael Code, now an Ontario judge, reviewed such CPSO discipline cases and stated:

“The documents that I saw showed that college officials took a very severe view of doctors practising in innovative areas ... the overall pattern that emerged was

an alarming one and one that clearly—in the public interest—bears close scrutiny. I would certainly invite the responsible government officials to look closely at whether the college is exercising its powers appropriately; whether this is the kind of Ontario, and the kind of medical climate, and medical community that we would like to live in, whether it is appropriate that doctors are treated in this fashion.... What is remarkable is the absence of harm by what they are doing. I think what they are asking for is that they be treated fairly. What I have seen is that they have not been treated fairly.”

I understand that the CPSO has the responsibility to regulate the practice of medicine and to serve and protect the public interest. However, it is absolutely essential that government should have the power to make medical administrative law bodies accountable to the public.

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

Mr. Jozef Krop: None of the currently existing supposed safeguards, not the CPSO’s own policy on complementary medicine, nor the Kwinter bill, nor the Supreme Court description of the qualities of the “true peers,” nor the Ontario Divisional Court judgment in the Brett case, have worked to prevent what so many doctors in Ontario have experienced and what their patients are forced to accept. These safeguards, if written in the RHPA, would also serve to improve patients’ access to the health care of their choice.

In summary, I respectfully offer my support of a supervisor for the colleges, because it shows the government’s recognition that regulatory bodies must operate more transparently and be held fully accountable to the public. Self-regulation is no less a privilege than is the licence to practise medicine.

The Chair (Mr. Shafiq Qaadri): Thank you, Dr. Krop, for your deputation and the submission that you’ve left with us. Do Svidanya.

ONTARIO MEDICAL ASSOCIATION—SECTION ON GENERAL AND FAMILY PRACTICE

The Chair (Mr. Shafiq Qaadri): I would now invite our next presenter to please come forward: Dr. Bridgeo, chair of the Ontario Medical Association—Section on General and Family Practice, and entourage. Welcome, gentlemen. Please begin.

Dr. David Bridgeo: Good afternoon. My name is Dr. David Bridgeo and it’s my privilege to serve as the chair of the Section on General and Family Practice of the Ontario Medical Association. I’d also like to introduce my chair of health policy, Dr. Jan Lusic.

Before I start, I would like to tell you a little bit about our organization. We represent the largest group of physicians within the Ontario Medical Association. Our members include over 9,000 physicians who practise as family and general practitioners, walk-in doctors and focused-practice physicians in various areas, including

psychotherapy, orthopaedics, addiction medicine, sports medicine and others.

The goals that Bill 179 might seek to address are laudable: to make more services easier for patients to access and to ensure accountability of health care professions. Our presentation will speak to how well this bill addresses these goals and at what cost. Our concerns are about patient safety, optimization of care and maintaining a culture of care that protects the rights and dignity of both the patients and the providers of that care. We encourage those who craft such legislation to take advantage of the experience of those on the front lines in its provision.

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Dr. Jan Lusic: We think that some of the provisions of Bill 179 do not help the goals that it purports to seek. Why? Let us return to the basics of medical practice.

History; physical examination, including the appropriate ordering and interpretation of tests; the development of a diagnosis and then the creation of a treatment plan are the building blocks of effective patient care. This includes the weighing of multiple pieces and types of information, the development of diagnoses with associated differential diagnoses, which are weighed in and out during the process of information-gathering and test-ordering, whilst communicating with and counselling the patient during the process and after the process.

History, examination, diagnosis, treatment: This is what we, as family doctors, live by.

History-taking and physical examination: In our understanding, the writing of a prescription or other treatment must include those steps to give optimum treatment to our patients, the citizens of this province. We appreciate the concern of the members of Parliament that more treatments be given more conveniently, but we would like to preserve, in this process, that which is essential to success and safety in treating patients. We are concerned that those who do not have the training or the experience are going to be thrust into what family physicians do, at the expense of patient safety.

History, examination, diagnosis, treatment: All of our training has prepared us to carry out this sequence. We think that those who are to be empowered to prescribe and treat must be equally able and trained to carry this out. We encourage you to consider this with respect to every health provider group that is to be empowered to prescribe under this act. Can they do an appropriate history, including other medical and psychological problems that affect the patient? Can they do an adequate physical examination, including other parts of the body that might be affected or are affecting the area in question? Can they appropriately interpret tests? Can they form an adequate diagnosis, including other conditions that might beset the patient? Will the treatments thus be informed? Will they know what the scope and breadth of the treatments may be?

We appreciate the opportunity to present to this committee. We would have liked to present also to the HPRAC committee, whose proposals preceded this bill.

We have a commitment to good primary care in this province. We think it is appropriate that we be included in any discussions regarding changes in the provision of primary care.

Bill 179 empowers the minister to make further extensive changes by regulation and without parliamentary oversight. We believe that both you, as representatives of the people of Ontario, and we on the front lines of primary care should be consulted about such further changes. We trust that you will provide for this.

The era of independent, self-regulating health care professions is past. Both this bill and previous legislation give the minister increasing power over the various colleges, fee schedules and regulations. Anything can be changed at the minister's discretion. This, of course, gives you, the members of the Legislature, increased direct responsibility for the outcome of the provision of health care in all the ways that it's provided. You will be responsible for the good outcomes and the bad. We trust you will carry out this oversight with suitable industry and vigilance. We recommend the engagement of practising physicians who are independent of the politics of the ministry in the creation of health policy and the legislation to effect this.

Primary care is changing. Care by family doctors is equally or less expensive than care by midwives, pharmacists and nurse practitioners. The ministry finds value in these forms of care despite the lack of any evidence of positive cost benefit. We do argue that the increased expense should buy sufficient expertise to ensure safe treatment for our patients as the area of operation of the various health care providers is expanded.

We, too, have to expand our scope of practice as our consultant colleagues cannot fully cover the needs of our communities. If there is a shortage of family doctors, then get more family doctors, especially comprehensive-care family doctors who can provide the continuity of care that is necessary for optimal health results and who need to function in a supportive and sustainable environment. Fractionating care, as is entertained in this bill, is at best a stop-gap measure and will not lead to comprehensive care.

History, examination, diagnosis and treatment: Can the pharmacists do this? They certainly can do some of it, and we do appreciate the limitations to pharmacists prescribing in this bill. Also, this should be asked of the others who will be taking on prescribing and treatment. But who will ask? With the passage of this bill, these questions will have to be addressed by ministry personnel with more or less clinical knowledge of medical process. We hope it will be more knowledge. We hope that decisions in this area will be carried out in a non-partisan way for non-political ends. We trust that you will ensure this.

The provision of health care to the citizens of this province depends on a culture of caring. We, as do other health providers, actively care about our patients. This culture of caring must be fostered and sustained. This bill and its predecessors constrain this culture. How does one

maintain a culture of caring in the presence of draconian measures that attack the rights and dignity of providers? Presuming somebody guilty of misconduct and subjecting that person to penalties before he or she can hear and answer the complaint do not contribute to a favourable climate. Presumption of guilt is not the basis of our laws or tradition. Spying on our colleagues, incrimination by complaint without proof and a requirement to co-operate with a prosecutor do not contribute to an atmosphere of trust and goodwill on which a free society must depend. An adversarial stance toward family doctors will not foster the trust and caring that is essential to our endeavours.

The Chair (Mr. Shafiq Qadri): Just under a minute left.

Dr. David Bridgeo: We from the Section on General and Family Practice recognize the intent of this bill for taking on the oversight of this very important area, which will affect every citizen of Ontario. We have our paradigm: history, examination, diagnosis and then treatment. We present to you our commitment to optimum primary care for the citizens of Ontario.

We appreciate the opportunity to present to this committee. We think that including the Section on General and Family Practice at an earlier stage would have been helpful to the development of policies and legislation that best serve the citizens of this province. You have our commitment. We trust we will be able to exercise it in this way.

The Chair (Mr. Shafiq Qadri): Thank you, Drs. Bridgeo and Lusic, for your deputation on behalf of the OMA—Section on General and Family Practice.

COLLEGE OF OPTICIANS OF ONTARIO

The Chair (Mr. Shafiq Qadri): I would now respectfully like to invite our next presenters, Mr. Fernandes and Ms. MacIsaac-Power of the College of Opticians of Ontario. Welcome, and please begin.

Mr. Jeffrey Fernandes: Good afternoon. My name is Jeffrey Fernandes. I am the president of the College of Opticians of Ontario. I am here with the registrar of the college, Caroline MacIsaac-Power. We would both like to thank you for the opportunity to speak to you today on Bill 179.

The College of Opticians of Ontario is the registering and regulating body for opticians in Ontario. The main function of the COO, as it's known, is to regulate opticians in the public interest. This includes ensuring that anyone who receives a certificate of registration as an optician in Ontario has the skills and training to practise opticianry safely and effectively.

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Opticians provide, fit and adjust contact lenses and eyeglasses as well as a range of subnormal vision devices. They are authorized to perform the controlled act of dispensing subnormal vision devices, contact lenses and eyeglasses on the prescription of an optometrist or a physician. For those who are unaware, subnormal vision

devices assist individuals who have less-than-normal vision even with the most accurate prescriptions. Low vision can be congenital or age-related, such as macular degeneration.

The college maintains among the most rigorous registration requirements in Canada, and Ontario's opticians have enjoyed an excellent track record of providing the highest level of vision care safely and effectively for several decades.

Our 2,500 members complete accredited two-year programs and a minimum of 1,000 hours of dispensing as registered intern opticians before they are allowed to sit for national examination. Only once they pass these exams can they be registered as registered opticians.

The college is encouraged by the government's decision to advance interprofessional care and collaboration and make it the provincial standard. As HPRAC has noted, interprofessional care takes place at the clinical level. It is about teamwork amongst health care professionals from different disciplines providing comprehensive quality care to patients whether in hospitals or within the community.

A significant barrier to collaboration is the lack of knowledge amongst professionals as to the skill sets that other health professionals possess. Encouraging joint continuing education programs within teaching institutes and collaborative care teams comprised of diverse health professionals would not only increase their awareness of other professionals with similar scopes of practice but allow for an environment that encourages the sharing of knowledge, skills and best practices. Interprofessional collaboration, as distinct from interprofessional care, refers to co-operation, not only among practitioners but also among the health regulatory colleges.

In the vision care sector, the College of Opticians of Ontario strongly believes that the public would be best served by a collaborative approach that facilitates seamless services and patient-centred care. Establishing a clear expectation that colleges with common controlled acts would work together to develop common standards of knowledge, skills and judgment will help ensure that their members perform these acts safely and appropriately. To that end, the college continues to work toward mutually beneficial arrangements with its colleagues in the vision care sector to advance such collaboration.

The college aspires to a vision care system in Ontario founded on mutual professional respect and interprofessional equality, as well as increased public access to services. While the bill does not amend the scope of practice for opticians, the college supports the government's decision to expand the authorized acts and scopes of practice of other health care professionals regulated under the RHPA.

The College of Opticians strongly believes that all health professionals should be able to utilize their knowledge and training to their fullest competencies.

Historically, some members of regulated health professions have not fully understood or had the appreciation of other regulated health professionals and their respective roles within the health care system.

As health care delivery evolves, so too must the system and its stakeholders. We all have a role to play in eliminating barriers to collaboration.

In closing, we commend the government for these reforms and would now entertain any questions that you may have.

The Chair (Mr. Shafiq Qaadri): Thank you, Mr. Fernandes. We have about 90 seconds per side, beginning with Ms. Elliott.

Mrs. Christine Elliott: Just to clarify that you are happy with the legislation as drafted and have no suggestions for amendments?

Ms. Caroline MacIsaac-Power: Other than signing on to the federation response regarding the supervisor, we would have no requests for amendments.

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

M^{me} France Gélinas: I'm good. Thank you. Good presentation.

The Chair (Mr. Shafiq Qaadri): To you, Mr. Balkissoon.

Mr. Bas Balkissoon: You've suggested collaboration but you didn't suggest how we solve the problem where it's not taking place.

Ms. Caroline MacIsaac-Power: We were hoping to look to you for that solution.

Mr. Bas Balkissoon: I'm not in the profession; you are.

Ms. Caroline MacIsaac-Power: Absolutely. It needs to start with working together, absolutely, coming together at the same table and defining some ground rules, how we're going to work together for the patient.

Mr. Bas Balkissoon: Has your association made any initiatives toward that?

Ms. Caroline MacIsaac-Power: Our regulatory college has, for a number of years, initiated discussions and held conversations and has been very clear, I think, in wanting to collaborate.

Mr. Bas Balkissoon: Would you say that this is a role the supervisor can play to help the two parties come together?

Ms. Caroline MacIsaac-Power: No, I would not.

The Chair (Mr. Shafiq Qaadri): Thanks to you, Ms. MacIsaac-Power and Mr. Fernandes, for your deputation on behalf of the College of Opticians of Ontario.

COLLEGE OF DIETITIANS OF ONTARIO

The Chair (Mr. Shafiq Qaadri): I'd now invite Ms. Gignac of the College of Dietitians of Ontario and any colleagues to please come forward. I invite you to please begin now.

Ms. Mary Lou Gignac: My name is Mary Lou Gignac. I appreciate having the opportunity to speak with you on behalf of the College of Dietitians.

The college regulates over 3,000 dietitians. Our regulatory philosophy is prevention. I think that's a theme that you might consider in the consideration of changes to the RHPA.

I'm a bit unique in the regulatory field because I've worked on three sides of the regulatory table. I've worked as the Ministry of Health coordinator of health professions, as the executive coordinator for the Health Professions Regulatory Advisory Council and now as registrar and executive director. I am not a regulated health professional, and it's a bit too late in my life to consider doing that.

The college has two issues it wishes to address: the supervisory powers and the dietetic scope of practice with reference to one particular issue. The college supports the strong and effective accountability of colleges to make sure that they regulate in the public interest—we think that's important—and, in addition, to be seen as regulating in the interest of the public. I note to you the existing 16-point accountability system that was referenced in the Federation of Health Regulatory Colleges of Ontario submission. In addition, I note the additional section 5 powers that the minister has.

I know of no other type of organization that is subject to so many varied external accountability instruments, and I have to ask, "Why more?" because that question has not been answered by the ministry or the minister. Even with all of these accountability instruments, I really believe that government of health professions regulation is not particularly well done.

There are two key reasons. I have more, but I'll stick to two. The ministry and the minister do not have the benefit of key indicators for regulatory effectiveness in the public interest. There is a vacuum there. If the reason for the new supervisory power is to instill public trust, I think we need to look at improved accountability mechanisms, including the basic criteria that make it very clear what the expectations are and what some of the pitfalls to be avoided are.

The other reason I don't think oversight is done particularly well is that ministers in the past have not used section 5 powers effectively. They are there, but ministers have shied away from using them. I ask: If section 5 powers are so rarely used, even for things like making formal inquiries into things, why are we now moving to yet more, and more severe, powers? I think this question has to be answered.

If the objective of the supervisory provisions is to instill public trust, I think we have to be a lot more thoughtful about how we do this. Maybe what needs to be addressed is how to get better accountability with fewer or more effective accountability instruments, including the indicators and the actual processes, because if we want the public to trust what we have, what we're developing is a lot more transparency based on something that gives them the message of effectiveness or not.

Another way to improve is simply to make more and better use of the section 5 powers that are currently in place.

If the media is correct and the supervisory provisions are here to stay, then the CDO, as the federation does, asks you to consider introducing better safeguards right in the RHPA. You have to appreciate that the conse-

quences for an appointment of the supervisor are profound for the individual college, as well as the network of colleges. These effects will last beyond the term of any supervisor. We ask that these safeguards include things like transparency of the criteria and the process used by the minister to fairly judge when a college is not performing well enough.

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The criteria ought to be restricted to public interest. The ministerial authority should relate explicitly and only to public interest. The safeguards should also introduce a transparent process set out in the legislation to cover things like what issues need to be addressed, any attempts or requirements for collaborative resolution, notice periods and the publication of information. This should all be in place and transparent before a supervisor is appointed. Not to introduce such safeguards will subject the college to political expediency. This has actually been the case and challenge of the past.

I would like to ask you to consider one additional point, and that is that colleges really are starting to feel as though they are being treated like transfer payment agencies. Colleges are not transfer payment agencies. That is not the model of profession self-governance that was established with the RHPA. To introduce supervisory powers dealing with operational and financial management clearly confuses the intent of the model of profession self-governance, and any changes to the RHPA should reinforce, not take away from, professional self-governance, with the addition of effective ministerial oversight for public protection and the public interest.

I'd like now to talk about the scope of practice of dietitians. The college, in conjunction with the professional association, Dietitians of Canada, advocates for a change in the Public Hospitals Act regulation to enable dietitians to order nutrition therapy in public hospitals. This is highly complementary with the planned regulation change to enable dietitians to order lab tests to monitor nutrition issues. We were told by the ministry that your recommendation could be very helpful in this regard, even though it doesn't involve the legislation.

Dietitians are the experts in nutrition, especially in clinical nutrition. They receive five years' post-secondary school education, including one year of an internship, a lot of this taking place in public hospitals. The scope-of-practice reviews were motivated in part by a desire to ensure that legislation and regulation does not impede interprofessional collaboration. Interprofessional collaboration is a valued way to improve client care.

Our written submission shows that the requirement to chase the orders, chase the signatures, interferes with collaboration in many ways. It confuses authority with collaboration, two very different concepts. It confuses who has authority with who has the expertise. It steals time away from meaningful collaboration, like dialoguing. It leads to workarounds that, as a registrar of a college, I am particularly concerned about. We have orders that say, "Diet per RD." That's fine. But we also have orders like, "Diet is tolerated." I'm not sure what that means and I'm

the registrar of the college. We also have orders that say "RD to see," where in fact—

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

Ms. Mary Lou Gignac: Thanks. Our research shows that this requirement is simply not needed. Recommended orders from dietitians are followed without question. We need to create the time and the mechanisms for real collaboration.

I welcome your consideration of this request. RDs do collaborate and are really trying to create more time to do it more and to do it more effectively, and this is in the way. Thank you for your consideration.

The Chair (Mr. Shafiq Qaadri): Thank you. You have time for pleasantries. Ms. Gélinas.

M^{me} France Gélinas: The change that you want is a change that we need to happen in the hospitals act, is it not?

The Chair (Mr. Shafiq Qaadri): Time is now expired, Madame Gélinas. To the government side.

Ms. Mary Lou Gignac: Regulation under the Public Hospitals Act.

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

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

Mrs. Christine Elliott: Thank you very much. It makes perfect sense to me.

The Chair (Mr. Shafiq Qaadri): Thank you, Ms. Gignac, for your deputation on behalf of the dietitians of Ontario.

ENVIRONMENTAL HEALTH ASSOCIATION OF ONTARIO

The Chair (Mr. Shafiq Qaadri): I would now invite our next presenter, Ms. Grist of the Environmental Health Association of Ontario, to please come forward. I'd invite you to please begin now.

Ms. Lin Grist: If you don't mind, I'd like to get a glass of water first. It's quite dry in here.

Good afternoon, ladies and gentlemen. Thank you for giving me the time to present to you.

Let's start from the beginning. My name is Lin Grist and I am a board member of the Environmental Health Association of Ontario. The EHAO has been in business for some 20 years. We are, of course, not-for-profit, and we are a member organization with our headquarters in Ottawa, Ontario.

EHAO works with and for people who have multiple chemical sensitivities. You may also know this condition as environmental sensitivities, although in the health care systems across the European Union, in the USA, in Japan and in the World Health Organization, the condition is known as multiple chemical sensitivities. It is a disease of toxic injury, and people with this debilitating and chronic condition are highly sensitive to the many chemicals that we are all exposed to in the course of our everyday lives.

I do not have MCS, which is why I am able to speak with you today in this room without fear of a chemical exposure. This is why those with this condition are often called the “invisible cripples.” If you are unable to engage in public life by going into public buildings, shopping malls, shops, government buildings—including hospitals—health clinics and doctors’ offices because they contain an array of chemicals to which you are highly sensitive, it is difficult to inform, educate or advocate for necessary services on your own behalf. It is also why there is so little public knowledge of this condition.

The EHAO has read the submissions of the Ontario Society of Physicians for Complementary Medicine and that of the Lyme Action Group and supports the principles outlined in their submissions. People with multiple chemical sensitivities may also be afflicted with Lyme disease. Their compromised immune, endocrine and nervous systems make it much more difficult to fight such opportunistic bacterial infections.

The EHAO approaches this issue from the lens of the patient, and our focus today is to provide input into the discussion of Bill 179 and what we are concerned might be the unintended consequences of some aspects of the bill. Our goal, like yours, is to ensure that this legislation and related regulation support the necessary medical care of all Ontarians served by our publicly funded health care system. In particular, we are apprehensive that this bill will inadvertently interfere with the delivery of medically necessary services to patients with multiple chemical sensitivities.

As you may be aware, the condition of multiple chemical sensitivities has been labelled the disease of the 21st century, in part because of the plethora of new chemicals which have been developed and become an integral part of our daily lives since the 1950s. While the development of these thousands of new chemicals was designed to be benign, there has been a growing awareness among health care professionals and government agencies at all levels of the toxicity to humans and other life forms of some of these chemicals and the concomitant need for a more measured approach to the use of chemicals.

Our own provincial government has led the way in this area with the Toxics Use Reduction Act, 2009. Our publicly funded health units across the province have adopted the precautionary principle with regard to the use of chemicals in order to protect public health in the areas of air quality and illnesses related to chemical emissions.

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We applaud the provincial government’s position to identify health human resources requirements to increase patient access, improve chronic disease management and meet new emerging health care needs by better utilizing regulated health professionals and reducing barriers to their practice. Increasing patient access to appropriate medical care, improving chronic disease management and meeting new emerging health care needs is at the heart of the work that EHAO has been involved with over the past 20 years at both the federal and provincial levels of government.

Our concern, as I mentioned earlier in this brief, centres around what we believe to be an unintended consequence of a desire on the part of the provincial government and the Ontario College of Physicians and Surgeons to ensure the provision of high-quality, peer-evaluated medical services to all Ontarians.

Our practical suggestions to ensure that these unintended consequences do not compromise the current level of care and the evolving practices of those physicians with the body of knowledge and expertise to treat people with multiple chemical sensitivities are—and I refer you to page 2 of our submission.

I should tell you that I’m not a lawyer, and I am enormously grateful for the pro bono legal counsel that actually translated legal language into something that was accessible to me. So I am going to give you an overview but I’m not going to go through the details because I’m sure, members of the panel, you know it much better than I do.

Evolving practices and peer evaluation: We propose that the concepts of evolving practices and peer evaluation be enshrined in all areas of regulatory colleges’ assessment and investigation processes in accordance with the objective that health professions legislation be fair and also be seen to be fair.

I refer you to page 3 of our submission. Quality assurance impacts: Plans are in place to increase assessments in the College of Physicians and Surgeons of Ontario quality assurance program—peer assessment, practice assessment, physician review program and specialties assessment program. If a physician using a complementary or innovative method is assessed by someone who does not have the relevant expertise, there is considerable risk of being judged to have deficient clinical ability. A health professional must comply with a quality assurance assessor and committee. The quality assurance committee can order remedial education or impose terms and conditions on the member’s certificate of registration. I would suggest that you look at this particular section, learned members of the committee, with great care.

I refer you to page 3 of our submission, “Procedural safeguards,” and again to what we believe to be the unintended consequences of Bill 179 that concern us.

I would stress that what matters most to Ontarians—and I’m talking now as a member of the public who actually uses health care services and of an organization that works with people who use those publicly funded services—are positive outcomes of health care intervention. Hence, the object for health care legislation to be considered first must be “the well-being of the patient,” and I quote the Canadian Medical Association code of ethics, 2004.

Ontario’s few environmental physicians are a very precious resource to the group of people that I work with. They have done further training in new medical modalities, some of which have been labelled “complementary.” They have joined OSPCM and the OMA complementary medicine section to interact collegially with other innovative physicians as physicians who use

innovative and complementary techniques and modalities. But their special knowledge of how to help the chemically sensitive is rare in this province, and I would say to you, ladies and gentlemen, that it is irreplaceable.

The Environmental Health Association of Ontario therefore urges this standing committee to consider both our concerns and our recommendations for amendments prior to presenting its deliberations and recommendations to the Ontario Legislature on this important piece of legislation. Thank you for your time.

The Chair (Mr. Shafiq Qadri): We have about 20 seconds a side. Mr. Balkissoon.

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

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

Mrs. Christine Elliott: Thank you as well from us.

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

M^{me} France Gélinas: I think I'm learning. Thank you very much.

The Chair (Mr. Shafiq Qadri): Thank you, Ms. Grist, for your deputation on behalf of the Environmental Health Association of Ontario.

ONTARIO ASSOCIATION OF
CONSULTANTS, COUNSELLORS,
PSYCHOMETRISTS AND
PSYCHOTHERAPISTS

The Chair (Mr. Shafiq Qadri): I would now invite Ms. Siddiqui and Mr. Marai of the Ontario Association of Consultants, Counsellors, Psychometrists and Psychotherapists. Welcome. Please be seated. I'd invite you to please begin now.

Ms. Naseema Siddiqui: Good afternoon, Mr. Chairman and members of the standing committee. My name is Naseema Siddiqui, and I'm president of the Ontario Association of Consultants, Counsellors, Psychometrists and Psychotherapists. With me is my colleague and chair of the OACCPP board of directors, Mr. John Marai. OACCPP is the affectionate name used by our colleagues and members of the OACCPP.

The Ontario Association of Consultants, Counsellors, Psychometrists and Psychotherapists, as the name indicates, is an umbrella organization which represents approximately 1,800 psychotherapists and counsellors and other mental health service providers in this province. We are an incorporated, self-regulating professional association formed in 1978 to represent providers of mental health services. OACCPP has been advocating for the statutory regulation of mental health professionals for many years. We have been very supportive of the Psychotherapy Act of 2007 and welcome the opportunity to speak to this committee regarding the Regulated Health Professions Statute Law Amendment Act, 2009; that is, Bill 179. Most specifically, we will be addressing the amendment pertaining to the Psychotherapy Act of 2007.

OACCPP has previously supported the principle that members of the regulatory colleges who already have access to the controlled act of psychotherapy should not have to undergo dual registration in order to continue to provide psychotherapy services and to access the controlled act of psychotherapy. Additionally, we support that such members could also have access to the title of "psychotherapist" when used in conjunction with their college affiliation, as described in the proposed amendment to Bill 179.

OACCPP supports the proposed title revision to the original Psychotherapy Act to include the new title "registered psychotherapist" as this construction is consistent with "registered mental health therapist," a consistency which helps the public identify members of the new College of Psychotherapists and Registered Mental Health Therapists. We feel that this title clarification and distinction is extremely important for public information and education. So we are supporting many of the amendments. However, this is in principle. OACCPP supports most of the amendments, but we require some further clarification, and I will ask my colleague, John Marai, to speak to those clarifications.

Mr. John Marai: As indicated, we strongly suggest that the full title "registered psychotherapist" be incorporated in the title of the new college, thus changing it to the College of Registered Psychotherapists and Mental Health Therapists of Ontario. This again provides the public with a clearer distinction between the members of the new college and other regulated professionals providing psychotherapy services in discipline-specific domains.

We draw your attention to an important fact that no other regulated college shares the protected titles of their members with other colleges. For example, physicians do not share their title with nurses. We at OACCPP feel that adding the term "registered" both to the title of the college and the title of psychotherapist helps afford members of the new college access to their own exclusive title, which will be protected under the regulatory status of the new college. This would again add further clarification to the public.

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OACCPP would also like you to review the holding-out clause. Many members of OACCPP hold a master's degree in psychology. We feel it is imperative that the Psychology Act should include a new provision, namely, that members of the College of Registered Psychotherapists and Mental Health Therapists be able to identify the discipline leading to the degree that they have legally earned.

With respect to members of the new college, we ask that restrictions cited below not be considered a contravention to the Psychology Act, 1991, subsections 8(2) and (3). In other words, we ask that members of the new college holding a master's degree in psychology be given the right to indicate their field of training to their clients, the public and other mental health professionals. We feel strongly that prohibiting such communication of a

truthful fact to the client is not in the best interests of the client. Since the primary intent of the Regulated Health Professions Act is to protect the public, how would this prohibition protect the public?

I made some references to the restrictions, and I will share them with you. Subsection 8(2) states, “No person other than a member shall hold himself or herself out as a person who is qualified to practise in Ontario as a psychologist or psychological associate or in a specialty of psychology.” Subsection 8(3) states, “A person who is not a member contravenes subsection (2) if he or she uses the word ‘psychology’ or ‘psychological,’ an abbreviation or an equivalent in another language in any title or designation or in any description of services offered or provided.”

In conclusion, again, on behalf of the Ontario Association of Consultants, Counsellors, Psychometrists and Psychotherapists, we would like to thank the committee for the opportunity to present our concerns and issues for your consideration.

The Chair (Mr. Shafiq Qaadri): Thank you, Mr. Marai. A minute per side, beginning with Ms. Elliott.

Mrs. Christine Elliott: No questions. Thank you very much.

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

M^{me} France Gélinas: I think your request is reasonable, clear and easy to understand.

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

Mr. Bas Balkissoon: I have no questions. Thank you very much for your presentation.

The Chair (Mr. Shafiq Qaadri): Thanks to you, Ms. Siddiqui and Mr. Marai, for your deputation on behalf of the Ontario Association of Consultants, Counsellors, Psychometrists and Psychotherapists.

BEST MEDICINES COALITION

The Chair (Mr. Shafiq Qaadri): I’d now invite Ms. Binder and Ms. Eddy to please come forward on behalf of the Best Medicines Coalition. I would invite you to please be seated and begin.

Ms. Louise Binder: Good afternoon. Thank you very much for the opportunity for the Best Medicines Coalition and the Canadian Treatment Action Council to present to you today. My name is Louise Binder. Just as background, I am an HIV-positive woman, probably infected more than 20 years ago. So I’ve had a very long, intense history with the medical profession and all of the other related health care professions. I have with me Paulette Eddy, who’s the executive director of the Best Medicines Coalition.

Our two organizations are both national, non-governmental organizations. The former—that’s the Best Medicines Coalition—represents numerous patient groups across the country of different disabilities and diseases, while the Canadian Treatment Action Council represents primarily people with HIV/AIDS and people co-infected with hepatitis and HIV as well. Both share a commitment to ensuring safe and timely access to evidence-based

medicines for people in Canada. They are both funded by governments, both provincial and federal, the pharmaceutical industry and the members of the organizations.

We have analyzed Bill 179, and there are two areas that we would like to discuss with you today for a few moments. First I’d like to say that in general, in principle, both of our organizations very strongly support the appropriate full use of all health care professionals to the fullest of their training and skills, but we submit that all regulatory frameworks that define the scope of practice—and in this case, I’m speaking of pharmacists—must clearly outline the process and collaborative interface that those pharmacists will have within a health care team, specifically with the physicians who are treating their patients, including family doctors and specialists. In fact, ideally, the pharmacist is part of an interdisciplinary health team, thereby ensuring that pharmacists’ decisions are known to the doctor and to the other members of the health care team who are treating. Unfortunately, in our view, the way Bill 179 is presently worded doesn’t offer this protection to patients.

In addition, pharmacists who are prescribing should only do so where it is acceptable for patient safety. In our view, that’s in limited cases and where the goal is to address immediate patient needs and to improve treatment outcomes for previously diagnosed conditions.

Pharmacists should not be permitted, in our view, to order tests, to interpret results or to diagnose ailments unilaterally, as this is not part of their training and skill sets, and there is nothing in this legislation to explain to us how they are going to be trained such that they would be able to do so. Only in limited cases, where there is strong justification, should pharmacists be involved in changing or adjusting medications. In those cases, any pharmacist’s adjustment regarding dosing or formulation should be accompanied by patient consent and immediate notification to the physician or physicians caring for the patient.

Best Medicines Coalition and CTAC recognize that Ontario faces huge human resource challenges, and, as I say, we strongly believe that health care professionals should certainly be pursued to take advantage of the full range of their skills and knowledge. We are concerned, however, that there is so little outlined in this legislation about the limits of pharmacists’ powers to prescribe and so much left to regulation, which is not required to come before the Legislature, that we really have no clear idea of what the pharmacists are going to be permitted to do or the training they’re going to receive. In our submission, the legislators have left so much in for these regulations and out of this legislation that there will definitely be a possibility for court challenge, that we have not in fact retained our jurisdiction as legislators in matters of substance and that we have left matters of substance to the regulations, which are only supposed to provide process and form but not substantive legal provisions.

Specifically, if we look at subsection 21(2), this act defines what types of drugs the pharmacist can prescribe

and it really should define, but does not, what drugs the pharmacist should prescribe. It should also state clearly what injections the pharmacist can administer and what types of inhalations can be administered. What procedures are the regulations going to require for the pharmacist to do this prescribing? These procedures are not at all clear. An error in prescribing a drug or administering an injection or inhalant can be life-threatening for a patient. Thus, the act itself should outline specifically the “what” and the “how” of such prescribing and not leave it for the regulations, which do not undergo the same scrutiny as legislation and which can indeed be amended much more easily. This is a great worry to our communities.

In our submission, the act is so lacking in definition of which ailments or types of ailments should be included as part of broader pharmacists’ prescribing powers, it’s so lacking in explaining the skills that will be provided to the pharmacists and training that the pharmacists will be required to have, as to be unworkable. Details about mandated communications between the pharmacists and the primary care physicians are lacking, details about levels of authority within a health care team are lacking, and clarity on patient confidentiality and privacy issues, which I can assure you in our communities are profound, is also lacking.

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Our organizations support the role of pharmacists as patient educators and counsellors and in having limited prescribing powers—for instance, to permit someone a few pills or some sort of medication until their doctor can be reached—but they do not support the authority of pharmacists to be involved independently in medication therapy management, even in smoking cessation or in travel prophylaxis drugs. The concerns that arise in these situations relate to the possibility of anaphylactic or other serious reactions in an environment where equipment to deal with them is not available.

Another profoundly important issue is the relationship of compensation for community pharmacists. There are numerous conflict-of-interest issues that arise when a pharmacist is also running a business from which revenue from prescriptions is a part of their business, rather than those who work in a health team setting—it’s critical that all health professionals in an environment work in an environment of integrity, transparency and public trust, which I must say is frankly quite lacking for us in a lot of the large pharmacies where there’s business being done.

Before expanding the scope of practice, those issues must be resolved completely. This should be done not only in tandem with, but also integrated with the work presently being undertaken by the Ontario Ministry of Health and Long-Term Care to consult on—

The Chair (Mr. Shafiq Qadri): Just under a minute, Ms. Binder.

Ms. Louise Binder: Sorry?

The Chair (Mr. Shafiq Qadri): Just under one minute left.

Ms. Louise Binder: Oh, thank you. And review—so to work with them on this.

The last point I would like to make is about the decision to appoint a supervisor of a college. We’re sure that there are egregious situations in which this is the thing to do, but we would suggest an addition as well. We’re now dealing with a situation with the Ontario College of Physicians and Surgeons where they are mandating mandatory HIV and hepatitis testing for their doctors who are doing certain types of surgery. This has been found by lawyers to be contrary to the Charter of Rights and Freedoms and it also limits the rights of patients and doctors to do their work. So what we would propose to you is, in addition to your legislation, to provide some sort of objective adviser to the ministry so that if a complaint comes in about a particular rule or regulation, there can be an objective—

The Chair (Mr. Shafiq Qadri): I’ll need to intervene there, Ms. Binder. I’d like to thank you and Ms. Eddy for your deputation and written materials on behalf of the Best Medicines Coalition.

COALITION OF FAMILY PHYSICIANS OF ONTARIO

The Chair (Mr. Shafiq Qadri): I would now like to invite, on behalf of the committee, our next presenter of the afternoon, and that is Dr. Doug Mark of the Coalition of Family Physicians of Ontario, and any colleagues he may have. Welcome, gentlemen. I invite you to please be seated and please begin.

Dr. Douglas Mark: Thank you, Mr. Qadri, for this opportunity to appear before you today at the committee. My name is Dr. Douglas Mark, and it’s my privilege to serve as the president of the Coalition of Family Physicians of Ontario. Founded in July 1996, the coalition is a voluntary, member-driven, grassroots organization representing over 3,000 family physicians. It is dedicated to protecting the rights and independence of family physicians across the province. We advocate, on behalf of our patients and members, solutions to improve health care delivery to the people of Ontario.

Joining me today is board member Dr. Felix Klajner, who will present our main concerns today. Dr. Klajner?

Dr. Felix Klajner: Thank you, Dr. Mark, and thank you for this opportunity to address you. What I’d like to do first is to give you a brief background—our view of it—which led up to Bill 179. I’m beginning to see that a lot of our concerns are being echoed by other people as well, so obviously there’s some consensus.

Virtually no decision involving one area of health care can be made without affecting some other area, either within or beyond the health care system. For this reason, very thorough and thoughtful research and decision-making is required.

What is the past? In the early 1990s there were significant reductions to medical training positions in Ontario, following the recommendations of the Barer-Stoddart report at that time, which was viewed as state-of-the-art knowledge. Ontario, and in fact all of Canada, are still feeling the effects of this ill-fated decision as our health

care system struggles to provide access to patients in the face of severe shortages of physicians as well as nurses and other health care professionals and resources. Now, almost 20 years later, Ontario has made significant increases in medical training positions in a sharp but commendable reversal of previous government policy. However, large gaps still remain, especially access to primary care physicians, specialists and diagnostic testing, not to mention certain cancer medications.

Although industrialized Ontario experienced favourable economic conditions during a good part of the time, the present worldwide decline is likely to profoundly affect Ontario in the foreseeable future—it's not going to go away quickly. The Coalition of Family Physicians of Ontario fully understands the importance of using human health resources in the most effective and cost-efficient manner. However, Bill 179 has several provisions that are of major concern to us. Three major areas:

(1) The actual increased costs associated with increased scopes of practice of many providers are not really known. However, what is known is that increasing scopes of practice and the resulting increased access and usage of resources will definitely involve a significant cost—not how much, but it definitely will. Cost containment was the major reason that physician numbers were sharply curtailed in the past. The previously created shortage of physicians is now leading to expand the scopes of practice of other health care providers, but is likely to increase costs again. The coalition is concerned that expanding the scopes of other providers is not a solution, but rather a desperate stop-gap measure to address the effects of previous decisions regarding physician numbers, and now it will bring on further problems of its own. Rather than simply expanding scopes of practice, a much more detailed study of our human health resources is needed before haphazardly proceeding.

(2) Ontario is significantly lagging behind other provinces in the adoption of electronic medical records and health information technology, and only a minority of physicians and other providers have managed to incorporate such technology into their practice. The present \$1-billion eHealth Ontario fiasco will now only further exacerbate this problem. Merely expanding the scopes of practice of other providers to order imaging or other laboratory investigations without providing the ability to share these electronically, or in other words to engage in real-time collaboration, has the troubling potential to lead to significantly increased duplication of services and expenses. Expanding scopes of practice before having widespread modern information-sharing tools for providers appears to be like putting the cart before the horse.

(3) Expanding the scope of practice of other providers as a response to physician shortages may be seen by some as necessary at this time. However, patient safety must always remain paramount, and mechanisms must first be put in place to evaluate the effects of such a move in order to ensure that the resulting care is safe, effective and appropriate. Indeed, this is the coalition's most important area of concern with the proposed legislation.

Physicians clearly receive the most intensive and lengthy education of any health care provider concerning diagnosis and treatment. Is such training really necessary? We believe that it is, and this is underscored by the present trend in family medicine to an even lengthier education as medical knowledge advances. Moreover, even seemingly simple things are often not so simple. There are many examples that come to mind. Here are some of them.

If pharmacists renew an antibiotic, asthma medication or blood pressure medication, are they trained to evaluate whether the drug is in fact effective or whether it has notable side effects for the patient? Such evaluation is critical, requires a thorough medical knowledge base and, if not performed, can lead to disastrous consequences. Should we then train pharmacists in diagnosis, record-keeping and treatment? If so, for how long? Should they be allowed to diagnose and treat without such training? Should they be compelled to carry malpractice insurance? These are all unanswered questions. In Alberta, where pharmacists can now apply for prescribing rights, pharmacists themselves recognize their own limitations and very few have actually applied for these rights.

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Moreover, physicians are not allowed to dispense medications that they prescribe, due to an obvious conflict of interest. It puzzles us why this same conflict of interest should now become acceptable for pharmacists and for nurse practitioners. Is it because they, unlike physicians, would ostensibly not be paid an explicit OHIP fee for the prescribing process? If so, then this extension of the scope of their practice might cynically be seen by some as saving costs at the expense of patient welfare.

The diagnosis and setting of a broken bone by a nurse practitioner acting independently without physician supervision is another potential pitfall. Orthopaedic surgeons have among the highest rates of malpractice suits, many coming from the treatment of fractures, a seemingly simple procedure. Although we acknowledge that remote locations could require a nurse acting relatively independently out of sheer necessity, modern telecommunication with a supervising physician should and must be used, but as we've pointed out earlier, Ontario suffers from a chronic lack of such information technology.

While Ontario works towards improving access to the health care system and patient outcome and satisfaction, patient safety and treatment effectiveness must remain the paramount concerns. There is admittedly much to be done in the realm of collaborative care among different health care providers, and the coalition supports such collaborative initiatives. However, we do not support attempts to fill gaps in physician numbers by turning to providers who may not be qualified for the job. This can only compromise patient safety and outcomes and increase the costs, thus compromising the very sustainability of our medical system. We urge the government of Ontario to slow down and study the issues carefully

before launching measures which may actually make matters worse, just as adopting the Barer-Stoddart report on physician numbers was in the 1990s.

Finally, we urge the government to consult with physicians, rather than acting unilaterally, even to the point of giving itself the power to take over any regulated health care college that does not abide by government policy. This is presently set out in Bill 179. The concept of collaboration cannot be limited to among various health care professions but must also extend to government if it is to have any real meaning. Doing so simply invites further errors and virtually assures compromising our health care system further.

The Chair (Mr. Shafiq Qaadri): Thank you, gentlemen. We have about 20 seconds per side. Mr. Balkissoon.

Mr. Bas Balkissoon: Thank you very much for coming forward and making your presentation.

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

Mrs. Christine Elliott: You've raised an important point with respect to the expanded scopes of practice. I completely agree with you that until we get our electronic health records up and going, we're not going to be achieving any savings.

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

M^{me} France Gélinas: Thank you for your presentation, and I would have a question about your view of the supervisor, but I know I won't have time. Try, if you speak really fast.

Dr. Felix Klajner: The supervisor?

M^{me} France Gélinas: Yes. You said "to consult with physicians rather than acting unilaterally"—

Le Président (M. Shafiq Qaadri): C'est tout, Madame Gélinas. Ce n'est pas possible.

M^{me} France Gélinas: Why do I bother?

The Chair (Mr. Shafiq Qaadri): Thank you, Dr. Klajner and Dr. Mark, for your deputation on behalf of the Coalition of Family Physicians of Ontario.

GRASSROOTS OPTOMETRISTS

The Chair (Mr. Shafiq Qaadri): I would now invite our next presenter, Mr. Miller of the Grassroots Optometrists, to please come forward. Welcome, and please be seated. Please begin.

Dr. Gregory Miller: I'm Dr. Miller. I'm an optometrist in private practice in Toronto, a member of this organization and also the Ontario independent optometrists.

I have one basic concern with a change that has happened since our profession actually saw the original legislation, of which we were not given any opportunity to respond.

The first draft of the designated drugs regulation that was submitted identified categories of drugs that were to be prescribed by optometrists. The college of optometrists has now notified us that lists of drugs are to be identified rather than categories of drugs to be prescribed by optometrists. An expert committee is then to be

established in order that new drugs be added to the list of drugs that are already okayed by Health Canada as being safe and effective.

As I said, the profession was not given an opportunity to respond to this change, which was, we felt, unusual. One can only assume that somebody was convinced that the change would in some way add some kind of protection to the public. The new drugs that would fall in the original categories will have already been scrutinized by Health Canada and offered to the public as both safe and effective.

The college of optometrists has been mandated by statute to regulate the self-regulating profession in order to protect the public interest. The college has done so for many years in an exemplary fashion. There is no reason to change the self-regulation of the profession now. In fact, the creation of the suggested expert committee would be costly in terms of man-hours and, of course, public dollars. The committee would be redundant, costly and will not add any further protection to the public that the profession of optometry serves.

There would, however, be negative consequences if this change were to remain in Bill 179. The list of designated drugs provided is already outdated and incomplete as I speak to you now. This would be compounded as new drugs become available, due to the long time frame involved with getting committee approval, a committee that has not been established yet. I have already spoken to the added costs of a redundant process of approval by committee.

The delay would force a compromise in patient care. The optometrist would be forced to use older drugs for treatment that would be less effective and possibly have more side effects and not as good a safety profile. Also, newer drugs have better dosage schedules, which improve patient compliance, and therefore the treatment is more effective.

I'll digress for a second from what I gave you, just to give you two quick examples.

There's a drug available right now called AzaSite, and it's azithromycin. It has a dosing schedule for conjunctivitis, a bacterial infection, of one drop twice a day for two days, one drop for the next five days and that's it. On the other hand, if you had to use one of the drops on the list, and a mother or father had to give a six-year-old drops—say, ofloxacin—for that same condition, it would be four times a day for seven to 10 days, struggling with a six-year-old. I would much rather, as a parent, give one drop twice a day for two days, and then one drop a day for five days. It doesn't make sense to put patients through that.

There's a new drug just being released by the FDA in the States and given approval called besifloxacin, a sister drug to the other ones on the list. The only difference is it has a couple of chlorine atoms added to it. It has a better safety profile because it has never been used for other conditions, whereas all these other drugs have been used for respiratory infections, ear infections and what have you. This is a drug specifically designed for use in the

eye; therefore it has a better safety profile. It hasn't got the resistance that is showing up more and more in our populations and therefore would be much more effective. It also will replace some drugs that have already gained resistance, and those would not be available to our patients.

So in an urban centre like Toronto, I could refer the patient. It would be a lengthy thing; it would be costly for the government and would delay treatment for that patient. What about a rural setting, where the optometrist is the only vision care provider in that setting? This patient does not get the drug they need, period, and that's the end of it.

There is growing bacterial resistance to some of the drugs on the present list, and this has been stated over and over. And if this situation is encountered, the optometrist in the optometrist's office—there would be no other way to delay or not to provide the care. The delay or denial of the best drug available in the optometrist's office would create a two-tier vision system. You want the best drugs, you go to ophthalmology. You want the older drugs, you go to optometry. I don't think that's what the government had in mind when they decided to have us practise in this area and expand our area.

Then there is the question of who will sit on the expert committee. If representatives from medicine sit on that committee, their political agenda will be injected into what should be a professional, educated, science-based decision made in the optometrist's office.

Of note: In their reasons for going forward with the treatment of glaucoma by optometrists, the HPRAC committee told of their disappointment in seeing the despair of optometric representatives due to the fact that two years after being asked by the committee, there was still no co-operation from ophthalmology with optometry on the treatment of glaucoma. This situation must not be repeated over and over with each new drug that Health Canada makes available in the designated categories.

The stated goals of the ministry—universal access in a timely manner—will not be served by this change to lists rather than categories of drugs.

I leave time for your questions.

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The Chair (Mr. Shafiq Qadri): Thank you. There's about a minute per side, Dr. Miller, beginning with Ms. Elliott.

Mrs. Christine Elliott: No questions. Thank you very much.

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

M^{me} France Gélinas: Your ask is simple: You want it to be categories of drugs rather than a drug list.

Dr. Gregory Miller: Exactly, as the original recommendation was. We don't know what happened in the meantime. We weren't given a chance to know why.

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

The Chair (Mr. Shafiq Qadri): To the government side: Monsieur Lalonde.

Mr. Jean-Marc Lalonde: Thank you very much for your presentation. You refer to the new drugs available

for patients. I'm sure that you know the procedure before they are approved to be distributed or recommended by OHIP procedures.

Dr. Gregory Miller: I'm sorry? I couldn't—

Mr. Jean-Marc Lalonde: You referred to new drugs available and that we still have the old drugs.

Dr. Gregory Miller: Yes. New drugs become available mostly.

Mr. Jean-Marc Lalonde: I'm sure you know the procedure to follow before doctors or optometrists—

Dr. Gregory Miller: Oh, of course. This is part of our education. First of all, Health Canada rules that they are safe and effective in those categories—the same categories, and we wouldn't get them outside the categories. Our college makes sure that our education is up to date, and that's mandated by statute.

Mr. Jean-Marc Lalonde: Because Ontario will only approve them whenever they're approved by Health Canada—

Dr. Gregory Miller: Yes, that's right. Exactly. Health Canada will have approved them.

The Chair (Mr. Shafiq Qadri): Merci, Monsieur Lalonde, and thanks to you, Dr. Miller, for your deputiation on behalf of Grassroots Optometrists.

PEDIATRICIANS ALLIANCE OF ONTARIO AND ONTARIO MEDICINE ASSOCIATION—PEDIATRICS SECTION

The Chair (Mr. Shafiq Qadri): I would now invite Dr. Yamashiro of the Pediatricians Alliance of Ontario and the Ontario Medicine Association—Pediatrics section to please come forward. Welcome and please begin.

Dr. Hirotaka Yamashiro: My name is Dr. Hirotaka Yamashiro. I'm representing the pediatricians of this province. First of all, hopefully to the relief of the committee, I don't plan to take all 10 minutes with my presentation. At the end of a long day, it might be a bit of a relief to you. We do come to you with some comments and concerns about this bill.

First of all, a little bit about who we are: We represent the pediatricians of Ontario. The Pediatricians Alliance of Ontario is a partner organization of the Section on Pediatrics with the Ontario Medical Association. We work together to represent all pediatricians in this province. We now number 1,200 strong in this province, of whom about 400 are based in the community. As most of you know—and if you didn't know—pediatricians are medical specialists with four to seven years of training after medical school, looking after the health and welfare of children, infants and youth in all aspects as necessary.

We would like to thank you for this opportunity. You've probably heard many presentations from many different medical groups. We realize and we've been privy to the main submission by the Ontario Medical Association, and as part of the discussion for that, we certainly would like to highlight that we agree with many of the points made. Interestingly enough, my colleagues from family medicine, who went before me, have made

some very important points as well. But the pediatricians would like the committee to really be aware of one key concern, and again, it revolves around the wording of what is proposed for independent prescribing by pharmacists.

Altering and renewing existing prescriptions certainly sounds like a very simple and straightforward item. However, as the committee is likely aware, infants and children are very unique in many ways, one of which is that they're growing on a daily, weekly and monthly basis. If they were having any chronic illnesses or were on any medications on a long-term basis, the extension of needed prescriptions of course is important, but on top of the changing per-kilogram body weight dosages or, at times, our calculation called for body surface area doses that are needed on an ongoing basis—at certain times, certainly; maybe not at every prescription change—the committee should be aware that, depending on the medical condition, a review is usually needed by a physician in what would be termed a medical history and/or physical examination.

What we would be looking for is, obviously, somebody who has an awareness of why the medication has been prescribed, what the purpose is, what side effects could be possible, what physiological changes may have occurred and many other factors that not only need to be reviewed, but probably documented before any prescription is renewed.

Now, it could be argued that many prescriptions, at the end of the day, even after such a review, would not change substantially. But as an example, smaller infants with chronic medical issues such as vesicoureteral reflux—in layman's terms, that's where urine is refluxing from the bladder back to the kidney, which is a common problem that some babies are born with—congenital cardiac disease and many other chronic illnesses, if the legislation were not to specify the oversight that is critical and oftentimes needed, it would put patients unnecessarily at risk for significant morbidity and/or mortality. So certainly, we think, just from that standpoint, we want the committee to be aware that having physician oversight is quite important.

By contrast, we understand that the concept of inter-professional care, having been on committees with the OMA looking at the issue of interprofessional care, is certainly maximizing the scope of practice so that patient care is better served by everybody in the health care system. It is a noble concept that definitely should be pursued. However, it should always be in a collaborative manner. In context, we'd like to point to the hospital setting, where pharmacists function in a team model with physician oversight. It's a team decision, and responsibilities for everything are shared. Independent altering of prescriptions in a community setting, as this bill may allow in the current or in future forms, would certainly fly against this team model. Again, I come back to the fact that it would be detrimental to patient care, especially for children, infants and youth in this province.

So we do have a suggestion at the end of our submission that, because of the uniqueness of the pediatric

population, which is often overlooked—a lot of people tend to lump children and infants in with everybody else in the health care system—that the committee strongly considers something to reflect that in the final legislation. The pediatricians of this province would certainly appreciate it if you were able to do that.

The Chair (Mr. Shafiq Qadri): Thank you, Dr. Yamashiro. About 90 seconds per side; Ms. Gélinas.

M^{me} France Gélinas: You've talked about collaborative care between pediatricians and pharmacists in hospitals. In the community, are you aware of any collaboration happening between the two professions?

Dr. Hirotaka Yamashiro: That's an excellent question, because unfortunately there isn't any formal mechanism. I believe that in a smaller community everybody gets to know everybody else within the medical and ancillary health care models, but unlike family medicine, where you have specified team models with a specified structure, pediatricians do not have a formal mechanism of communicating with pharmacists. When you think about the potential repercussions of medication errors and the importance of two-way communication, we would like to see something along that line. It's probably a discussion for a separate forum, but that's an excellent question, absolutely.

The Chair (Mr. Shafiq Qadri): Ms. Mitchell?

Mrs. Carol Mitchell: Thank you very much for your presentation. I wanted to give you the opportunity to talk about where your model works well in a hospital setting, with the understanding that it's expansion of their roles within health care—be it a pharmacist, be it a nurse practitioner, whatever. I wanted you to give me an example, in a hospital setting, where a pharmacist and a pediatrician work well as a collaborative team.

Dr. Hirotaka Yamashiro: Absolutely. Well, I think doctors and pharmacists—after my pediatric residency, I did a pediatric respirology fellowship at the Hospital for Sick Children. When you are looking after the in-patients or even in an outpatient setting for different patients with a whole variety of conditions—cystic fibrosis and what-not—it's a multi-disciplinary team. So the pharmacists in that setting—for instance, the cystic fibrosis clinic I was in—would be very involved altering dosages, but they would have the information right there—what the physiotherapist found, what the pulmonary function testing showed, what the medical reviews showed—so that when they leave that setting, whether it's an in-patient or a clinic setting, they've had the benefit, really, of that kind of collaborative care.

In a hospital setting obviously it's easier to do, because you have rounds, you have structures where you can bring in different people to talk very easily. In a community setting that's much more of a challenge because of the physical separation. You have to put a mechanism in place to encourage that same sort of—

The Chair (Mr. Shafiq Qadri): Thank you, Ms. Mitchell. Ms. Witmer?

Mrs. Elizabeth Witmer: Thank you very much for your presentation. You indicate here that we should

consider that any power to independently alter or renew prescriptions would contain this exception. Would there be any exception where pharmacists could be able to renew a prescription or are you saying, *carte blanche*, that should never, ever, ever happen?

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Dr. Hirotaka Yamashiro: I can see the concern about where you start being dogmatic, “You can’t do this,” or “You can’t do that.” But the other side of the coin is, if you start specifying, “This condition’s okay,” “That condition’s okay,” “This type of medicine’s okay,” you’re going to end up with a pretty long menu left. Then you’re getting the word out to pharmacists, “Okay, here’s the big list, and you can do anything on this list.” I wonder if that would be actually more confusing. I don’t know if it’s much easier to make sure that you just encourage—it’s almost like a last resort where the physician is just not available, or you just don’t know. Sometimes it happens, right? There are children who are on anti-epileptic, anti-seizure medications, and they have to renew things on an emergency basis.

But if anybody’s on chronic medication, it usually means they have a chronic illness. With a chronic illness, we really think that, whether it’s two words or a full conversation, oversight really cannot be removed.

Mrs. Elizabeth Witmer: So basically you’re saying no?

Dr. Hirotaka Yamashiro: From a patient safety standpoint, if you look at all the issues that have gone on in the hospital setting with *C. difficile*, everything comes down to communication and information and then the sharing of that.

The Chair (Mr. Shafiq Qadri): Thanks to you, Dr. Yamashiro, on behalf of the Pediatricians Alliance of Ontario.

ONTARIO COALITION OF MENTAL HEALTH PROFESSIONALS

The Chair (Mr. Shafiq Qadri): I’d now invite our next presenter, Mr. Cohen of the Ontario Coalition of Mental Health Professionals, to please come forward. Welcome, Mr. Cohen. Please begin.

Mr. Rod Cohen: Hello. I have already spoken with some of you quite recently at the legislative select committee. My name is Rod Cohen; I am the chair of the Ontario Coalition of Mental Health Professionals and also the past president of the Ontario Society of Psychotherapists.

The Ontario Coalition of Mental Health Professionals is an umbrella organization whose members are professional associations in the field of mental health. Founded in 2002 and officially convened in 2004, the coalition is an organization of non-statutory, self-regulated, like-minded partners dedicated to the recognition of psychotherapy and counselling in the province. There are 13 member associations in the coalition, representing psychotherapists; counsellors; marriage and family therapists; and art, drama, music, play and child therapists.

The coalition was specifically formed to address the issue of the incoming regulation of psychotherapy and counselling in Ontario. It strives to understand the needs of the diverse community of its members in Ontario and aspires to being inclusive in its membership and a strong voice for the promotion of psychotherapy and counselling. Our goals include promoting the development of policies and practices for the provision of accessible, competent and accountable psychotherapy and counselling services throughout the human life span, in a manner sensitive to the pluralistic nature of Ontario’s society; to seek government regulation of non-statutory, self-regulating mental health professionals as indispensable members of the health care system in Ontario; and to research awareness of the issues and their implications among professionals, government and other stakeholders.

Since its inception, the coalition has worked vigorously to promote the statutory regulation of those who currently provide mental health services under a system of voluntary non-statutory self-regulation. Over the past number of years, we have worked extensively with HPRAC and the government of Ontario to change the legislative and regulatory framework governing psychotherapy services so as to promote and enhance public protection and greater clarity regarding the skills, training and regulation of mental health professionals.

These efforts culminated in the Psychotherapy Act, 2007, which created the new college of psychotherapists and registered mental health therapists and the designation of two new protected titles for members of the college, namely “psychotherapist” and “registered mental health therapist.”

The coalition was very supportive of the Psychotherapy Act and would like to see government move expeditiously to implement the key tenets of the legislation. Bill 179, currently under review here by yourselves, proposes changes to important provisions of the Psychotherapy Act, 2007, before the legislation has even come into force.

While the coalition understands the rationale for such amendments, we argue that further modifications are necessary to protect the spirit and intent of the act. The sections below outline our analysis of the impact of the proposed amendments and provide a recommendation for further strengthening the bill.

Bill 179 proposes two material changes to the Psychotherapy Act. In section 23 of the bill, it is proposed that the protected title “psychotherapist” be amended to “registered psychotherapist” for those regulated under the new college. Subsection 24(6) and section 26 suggest further changes to allow the use of the “psychotherapist” title by those currently regulated by the College of Nurses of Ontario, College of Occupational Therapists of Ontario, College of Physicians and Surgeons of Ontario, College of Psychologists of Ontario and College of Social Workers and Social Service Workers of Ontario, subject to certain conditions.

These changes would allow designated members of all of the regulatory colleges whose members have access to

the controlled act of psychotherapy to publicly identify themselves as psychotherapists as long as any written or oral use of the title was combined with reference to their profession or regulatory college. For example, a nurse who practises the controlled act of psychotherapy would, under the proposed bill, be allowed to refer to himself or herself as a nurse/psychotherapist or as a member of the College of Nurses of Ontario psychotherapist. However, only members of the College of Psychotherapists and Registered Mental Health Therapists of Ontario would be able to refer to themselves as a registered psychotherapist.

The amendments identified above provide a credible response by government to address the fact that some professionals regulated under existing colleges, such as physicians and surgeons, have been referring to themselves as psychotherapists for several years. The provisions of the act, if enacted unchanged, would have required these professionals, who already have access to the controlled act of psychotherapy, to cease referring to themselves as psychotherapists unless they sought membership in the new College of Psychotherapists and Registered Mental Health Therapists. This situation could be unacceptable to long-serving professionals who have been providing psychotherapy services for many years and have sometimes referred to themselves as psychotherapists.

The coalition supports the amendments proposed in subsection 24(6) and section 26 because they expand the eligibility to use the title “psychotherapist,” subject to sensible qualifications that ensure that public protection and clarity is not undermined. One of the driving concepts behind title protection is to facilitate clarity regarding regulation, training and skills. Members of the public who encounter problems in dealing with regulated health professionals should know where to turn for help. For example, problems with individual nurses would be addressed by the colleges of nurses, occupational therapists and so on.

The risk in expanding the title “psychotherapist” to members of five additional colleges is that the public may be left in the dark about with whom they’re actually dealing, what qualifications the professional has and where they can turn for assistance if things go wrong. For this reason, the government’s proposal that extension in the availability of the title be combined with strict qualifications about also identifying one’s home profession makes sense. The public is much better served by being able to choose between a nurse psychotherapist, a physician psychotherapist or a social worker psychotherapist, rather than just three more generic psychotherapists who actually may all have quite different education, training and regulatory regimes.

It’s imperative that these sections of the bill remain in the legislation as the bill progresses through the standing committee. Any changes could have the potential to undermine public protection, clarity and choice. The extension in the title “psychotherapist” to other disciplines has the potential to undermine the clarity and

rationale for the act unless other amendments are passed to ensure that a distinct title remains available for members of the new College of Psychotherapists and Registered Mental Health Therapists. For this reason, the coalition strongly supports the government’s proposal in section 23 that the protected title available to members of the college be amended to “registered psychotherapist.” The amended title helps to ensure that members of the college are able to cultivate a distinct identity with the public.

Despite our general support for the legislation, the coalition believes strongly that the current package of amendments proposed through Bill 179 is incomplete and, as it stands, inconsistent. As mentioned previously, the government has sought to prevent potential confusion regarding the expansion of psychotherapists to the additional five regulatory colleges by changing the name of the protected title to “registered psychotherapist.” Only those regulated by the College of Psychotherapists and Registered Mental Health Therapists of Ontario will have access to this new title, and with this modification in the protected title, it would now make sense to also amend the name of the college to reflect and be consistent with this change. It is suggested then that the name of the new college be amended to the College of Registered Psychotherapists and Mental Health Therapists of Ontario. Such a name would promote greater public clarity and be more consistent with the titles of the members regulated by the college.

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The Chair (Mr. Shafiq Qaadri): Just under a minute, Mr. Cohen.

Mr. Rod Cohen: The college strongly recommends that the Standing Committee on Social Policy support an amendment to the name of the College of Psychotherapists and Registered Mental Health Therapists to reflect the changes made elsewhere in the bill. It is possible that such an omission is merely an oversight by government, but the committee has an opportunity to rectify this situation.

The coalition thanks the members of the Standing Committee on Social Policy for the opportunity to comment here. We are confident the committee will take the necessary measures through the legislative review to ensure that critical mental health services are provided to the public in a way that promotes transparency, high quality and public choice.

The Chair (Mr. Shafiq Qaadri): Thank you, Mr. Cohen. I think I’ll just thank you on behalf of all committee members for coming today and for your deputiation on behalf of the Ontario Coalition of Mental Health Professionals.

ONTARIO SOCIETY OF CHIROPODISTS

The Chair (Mr. Shafiq Qaadri): I’d now invite our next presenter, Mr. Springer of the Ontario Society of Chiropractors. Welcome. Please begin, Mr. Springer.

Mr. Andrew Springer: Thank you very much. I have to begin almost every presentation by explaining to people what a chiroprapist is. A chiroprapist is regulated by the College of Chiroprapists of Ontario, and we provide foot care to people of all ages, from all backgrounds. We treat diseases, disorders and dysfunctions of the foot and the foot as it relates to the lower extremities and to the rest of the body.

Ontario chiroprapists are actually the largest group of foot care providers in Canada, and there is a broad distribution of practitioners across the province, right through to underserved areas and First Nation communities.

Chiroprapists have been regulated in Ontario for a long time, since 1944, and have always been considered primary care practitioners. They work independently, though they do and can function as part of a health care team. They do not require referral to access their services.

Unfortunately, this is the only jurisdiction in Canada that still uses the antiquated term “chiroprapist.” The more modern term is “podiatrist.” We have a separation here to identify those people trained in the United States and registered before 1993. Those are the only folks in Ontario who are called podiatrists, and anyone trained anywhere else in the world or in Ontario is still called a chiroprapist. This actually causes a bit of a problem in terms of access to service for our patients because a lot of people are unfamiliar with the term, though there are 445 chiroprapists registered in Ontario and only 75 podiatrists, not all of whom actually are practising here; many are out of province and just retain an Ontario licence.

Chiroprapists in Ontario provide in excess of one million patient visits per year and deal with people living with diabetes and its complications, those with poor circulation and ulceration, as well as the very mundane—those who have difficulty with corns and calluses and problems with their toenails. However, I think the salient point here in terms of the services provided is that chiroprapists provide care that ensures that people retain mobility and independence; there are clear health benefits and clear savings in terms of health care costs for those people who do not have to have amputation because they’ve received preventive care and education from a practitioner; from those whose ulcerations are healed; from those who continue to be ambulatory and stimulate their circulation simply because they are moving around.

You do have a submission from us in hand and I won’t go into all the details of that. I think the most important detail from our standpoint is that we see Bill 179 as somewhat of a missed opportunity in terms of dealing with some of the things that have been legislated for chiroprapists. The focal point for that is the communication of a diagnosis. Legislation—for example, the Consent to Treatment Act—requires that we communicate the reason for treatment that we’re providing to patients, the alternatives, the benefits and the risks, and to be able to do that effectively we need to be able to tell people what’s wrong with them. It only makes sense.

Chiroprapists hold an undergraduate degree before being admitted to a postgraduate diploma program, three years of intensive study, and they do authorize acts such as the injection of substances into the foot, prescription of medications and cutting into the subcutaneous tissues of the foot. These are acts that do carry great risk for our patients, especially those who are considered high-risk because of their health status. As a result of that, we feel that it only makes sense, after all of these years of providing this kind of care and of providing this kind of primary care independently, that legislatively we’d be permitted to communicate the diagnosis to our patients.

The Chair (Mr. Shafiq Qadri): Thank you very much, Mr. Springer. We have generous time, beginning with Ms. Elliott, about 90 seconds a side.

Mrs. Christine Elliott: Could you just explain what you are able to communicate at this point and what you would not be able to?

Mr. Andrew Springer: Well, it’s very interesting. The whole debate around communication of a diagnosis is a little bit about smoke and mirrors anyway. I gave you a document that was generated from a working group of which I was a part back in 1994, where we sat around at the College of Physicians and Surgeons of Ontario to determine what goes into this authorized act. It’s very specific in terms of the number of things that call it a diagnosis. The fact of the matter is, most of the time, including physicians, very often what we call, as lay people, a “diagnosis” is the result of an assessment, and that’s what’s communicated to patients. It has become somewhat of a matter of boasting amongst different colleges that, “We have this act and you don’t.” We’re just trying to clear that up. But we can and have to communicate our findings—what’s wrong with you, what’s caused your problem—and very often that is a disease, a disorder or a dysfunction. So in essence, that’s how it works.

The Chair (Mr. Shafiq Qadri): I’d now like to offer the floor to Madame Gélinas.

M^{me} France Gélinas: I forgot for one minute—do you need a referral to see somebody or can somebody walk in?

Mr. Andrew Springer: Somebody can walk in independently.

M^{me} France Gélinas: Okay, so you don’t need a referral?

Mr. Andrew Springer: No—

M^{me} France Gélinas: So you could get somebody, do your assessment and then you cannot tell them what’s wrong with them, but you can treat them?

Mr. Andrew Springer: Theoretically, yes.

M^{me} France Gélinas: Oh, lovely. Your point is clear, and well taken. Thank you.

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

Mr. Bas Balkissoon: Thank you very much. You’ve clarified my confusion too.

The Chair (Mr. Shafiq Qadri): Thanks to you, Mr. Springer, for your deputation on behalf of the Ontario Society of Chiroprapists.

ONTARIO DENTAL HYGIENISTS'
ASSOCIATION

The Chair (Mr. Shafiq Qaadri): I now invite our next presenters, Ms. Newton and Ms. Carter of the Ontario Dental Hygienists' Association. Please begin.

Ms. Shelley Newton: Good afternoon. My name is Shelley Newton and it is my privilege to lead the Ontario Dental Hygienists' Association and my honour to address you on behalf of our members. We have provided the standing committee with a written submission that provides more detail about the issues we will talk about today, as well as some comments on sections of Bill 179 that we will not have time to address today.

The Ontario Dental Hygienists' Association, or ODHA, is a non-profit organization representing the interests of registered dental hygienists and promoting the profession of dental hygiene in Ontario. At present, ODHA has close to 6,000 professional members providing care to an estimated eight million Ontarians. Recognized in Canada for more than 60 years, dental hygienists are health professionals contributing to overall health through the prevention of oral disease and the promotion of oral health. We are regulated by the College of Dental Hygienists of Ontario under the Regulated Health Professions Act and the Dental Hygiene Act.

Most often employed by dentists in private dental offices, a growing number of dental hygienists are choosing careers in public health, education, hospitals or independent practices, including mobile services for long-term-care homes and those confined to their home. More than 2,200 dental hygienists have received authorization to self-initiate their controlled act of scaling teeth and root planing, a choice made possible through the amendment of the Dental Hygiene Act in 2007.

Self-initiation has increased the public's access to affordable, preventive oral care services by the practitioner of their choice. At present, there are 110 independent, direct care dental hygiene practices, both storefront and mobile, and this number is continually increasing.

Dental hygienists are highly skilled in assisting clients to attain and maintain optimal oral health. We provide professional treatment that helps to prevent periodontal or gum disease and caries or cavities. We use a process that includes assessing the oral condition, planning treatment according to individual needs, implementing the treatment plan, and evaluating the success of the treatment and planning for the future.

Our comments and suggestions on Bill 179 are related to three sections of the bill, those specifically related to the Dental Hygiene Act, the Healing Arts Radiation Protection Act, or the HARP Act, and the changes proposed for the RHPA itself.

First and foremost, ODHA is pleased that the government has moved forward to implement the recommendations related to prescribing, dispensing, compounding and selling drugs in the practice of dental hygiene. It is indeed an important step. However, it is a very small step

in comparison to the potential this bill could have afforded to the profession in its service to Ontarians.

In the HPRAC review of drugs used by dental hygienists, we sought the ability to perform local anaesthesia, which would mean the additional authorized act of administration of a substance by injection. Local anaesthesia is necessary for the management of pain and anxiety that may occur when scaling and root planing procedures are being performed.

At this time, a client who requires local anaesthesia must be seen at a dental office, scheduled on a day when a dentist is available and wait for a dentist to administer the local anaesthetic. The dental hygienist can then proceed with scaling and root planing. The alternative is to either treat the client without pain control or not treat them at all.

We strongly believe this denies the client's right to access care from a provider or location of their choice; nor is it consistent with the HealthForceOntario position of utilizing health care practitioners to the fullest extent of their skills, competencies and scope of practice. It also continues to make dental hygienists dependent on dentistry.

Close to 300 dental hygienists in Ontario are currently qualified to administer local anaesthetic. Their qualification comes from completing an entry program of study in one of the western provinces or travelling out of province post-diploma to take a course. Those few dental hygienists who are able to administer local anaesthetic in Ontario have had to receive delegation from a physician who is qualified to administer oral anaesthetic. The Royal College of Dental Surgeons of Ontario does not permit its members to delegate controlled acts. The process of obtaining delegation from a physician is a complicated and convoluted process in order to utilize our skills to benefit our clients.

Independent dental hygienists contribute significantly to their communities. Dental hygiene is an accessible, convenient, cost-effective and flexible service for remote communities, the uninsured and the poor. By adding the ability to administer local anaesthesia, we will be even more effective in providing care to clients in all settings.

We know that there is a need for education and skill training. We will work with the CDHO and the schools to revise the current program and to develop a process for current practitioners.

All professions evolve and advance with time. This is a natural process which helps meet the growing demands on the health care system. In the spirit of inter-professional collaboration, the next logical evolution for our profession is the ability to prescribe and self-initiate radiographs. Radiography is a valuable diagnostic tool for us. X-rays are vital to the assessment of the tissues below the gum line, bone levels, deep calculus or tartar or misplaced crown and bridge cement.

We need the ability to perform a comprehensive assessment. We are well educated and able to discern when an X-ray is needed. Clients who are being seen by an independent dental hygienist can only receive full and

comprehensive dental hygiene care with the use of radiographs. With portable X-ray equipment, we could provide a service without transporting the client to a dental office. Dental hygienists in Alberta, Manitoba and Saskatchewan expose, process and interpret dental radiographs on their own authority. A dental hygienist from Ontario who relocates to one of those provinces is expected to do the same, based on the education received in Ontario.

It is interesting to note that dental hygienists can own radiography equipment but we cannot prescribe radiographs or be radiation protection officers under the current HARP Act. This seems counterintuitive, and ODHA seeks to change this anachronistic situation. Dental hygienists should be named as radiation protection officers under section 9 of the HARP Act. CDHO will ensure that only those dental hygienists who meet their requirements will be able to self-initiate radiographs and be radiation protection officers.

I am going to ask Margaret Carter, ODHA's executive director, to very briefly address some of our concerns about some proposed changes to the RHPA.

Ms. Margaret Carter: Good afternoon. While some of the changes proposed for the RHPA are reasonable and forward-thinking, ODHA is concerned about some of the amendments proposed for the RHPA. We do understand that you may have heard similar concerns from others.

Enshrined in the RHPA is the privilege of self-regulation or self-governance. Except for the cost of public councillors, the members of our profession fully fund the operations of their regulatory college. Our members truly recognize and appreciate this privilege, as this is a profession which, prior to the RHPA, was regulated by another profession; that is, dentistry. Dental hygienists have truly seen the other side.

It is with this backdrop that some of the proposed amendments in Bill 179 are of great concern to the profession, as they seem to significantly and harmfully erode our hard-fought-for self-governance. In our view, there is no greater threat to the self-governance than the proposal to appoint a college supervisor. The minister already has significant authority in section 5 of the RHPA to require a college to take action. To our knowledge, the minister has never exercised this authority, so ODHA cannot understand why the ministry seeks to expand upon the authority in section 5.

ODHA is also very concerned about the breadth of the authority to establish an expert committee to advise the

minister. ODHA understands that this is the role of HPRAC.

That said, we do understand that the current process for approving drug regulations is cumbersome, untimely, resource-consuming, and often so delayed that the regulations are outdated by the time they are approved. For this reason we can foresee an expert committee to advise the minister specifically about drugs. However, we are very concerned about the potential for membership of that committee to perpetuate traditional roles of subservience and turf protection under the guise of public protection.

ODHA is a strong proponent of collaborative care, and supports interprofessional collaboration—

The Chair (Mr. Shafiq Qadri): About a minute left.

Ms. Margaret Carter: Thank you very much—and the removal of barriers that challenge such collaboration. However, we are very concerned that the current wording of subsection 11 implies that there must be one common standard amongst all of the practitioners that share the same, or parts of the same, controlled act. Professions sharing a controlled act must work together to achieve standards of practice that are as consistent as possible, but that must be within the overall framework and scope of practice of individual health care professions.

There are other components of Bill 179 about which we have concerns, and ODHA has addressed these in our written submission.

In conclusion, a dental hygienist who is able to administer local anaesthesia and prescribe and self-initiate X-rays will benefit the public by being more effective and efficient.

This will also help meet the demand on the health care system and increase interprofessional collaboration.

Thank you for your time and consideration. If there is time, we're happy to take questions.

The Chair (Mr. Shafiq Qadri): Thank you, Ms. Newton and Ms. Carter, for your deputation on behalf of the Ontario Dental Hygienists' Association.

Just for the information of committee members and Legislative Assembly officers here, the deadline for amendments remains Wednesday, October 14, at 5 p.m., and we'll be having clause-by-clause hearings on Monday, October 19, in this room.

If there is no further business before the committee, committee adjourned.

The committee adjourned at 1754.

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