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## **Official Report of Debates (Hansard)**

**Monday 23 April 2007**

## **Journal des débats (Hansard)**

**Lundi 23 avril 2007**

**Standing committee on  
social policy**

Health System  
Improvements Act, 2007

**Comité permanent de  
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## LEGISLATIVE ASSEMBLY OF ONTARIO

## ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

STANDING COMMITTEE ON  
SOCIAL POLICYCOMITÉ PERMANENT DE  
LA POLITIQUE SOCIALE

Monday 23 April 2007

Lundi 23 avril 2007

*The committee met at 1545 in committee room 1.*

## SUBCOMMITTEE REPORT

**The Chair (Mr. Ernie Parsons):** Petitions have ended, orders of the day have started, and I will call the meeting of the standing committee on social policy to order. We are meeting to receive input on Bill 171.

The first order of business is the report of the subcommittee on committee business. Mr. Mauro.

**Mr. Bill Mauro (Thunder Bay–Atikokan):** Your subcommittee met on Tuesday, April 10, 2007, to consider the method of proceeding on Bill 171, An Act to improve health systems by amending or repealing various enactments and enacting certain Acts, and recommends the following:

(1) That the committee meet in Toronto on April 23 and 24, 2007, for the purpose of holding public hearings.

(2) That the committee clerk, with the authorization of the Chair, post information regarding public hearings on the Ont.Parl channel, the Legislative Assembly website and in the Ontario edition of Canada NewsWire.

(3) That interested parties who wish to be considered to make an oral presentation contact the committee clerk by 5 p.m. on Friday, April 13, 2007.

(4) That, in the event all witnesses cannot be scheduled, the committee clerk provide the members of the subcommittee with a list of requests to appear by 6 p.m. on Friday, April 13, 2007.

(5) That the members of the subcommittee prioritize and return the list of requests to appear by 5 p.m. on Monday, April 16, 2007.

(6) That groups and individuals be offered 10 minutes for their presentation. This time is to include questions from the committee.

(7) That the requested background material be prepared by the research officer by Monday, April 23, 2007.

(8) That the deadline for written submissions be 5 p.m. on Tuesday, April 24, 2007.

(9) That a summary of presentations be prepared by the research officer by Monday, April 30, 2007.

(10) That for administrative purposes, proposed amendments be filed with the committee clerk by 12 noon on Friday, May 4, 2007.

(11) That the committee meet for the purpose of clause-by-clause consideration on Monday, May 7, 2007.

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

I move that the report be adopted.

**The Chair:** Thank you. Discussion?

**Mrs. Elizabeth Witmer (Kitchener–Waterloo):** I have a question. Number 11 says, "That the committee meet for the purpose of clause-by-clause consideration on Monday, May 7, 2007." I'd just to know, in the event of a lot of amendments, which is quite possible, given the feedback we're receiving, are we sitting beyond 6 o'clock that evening?

**The Chair:** If I could respond to that, it is required that the committee stop at 6 o'clock. However, the committee is authorized to meet Mondays and Tuesdays, so the committee could meet the following day, May 8, if necessary, which is a Tuesday.

**Mrs. Witmer:** Right. Thank you very much.

**Ms. Shelley Martel (Nickel Belt):** Very briefly with respect to the motion before us, I want to say that I am opposed to it, and I was opposed to it at the meeting of the subcommittee, for this reason: At the time that the subcommittee met, we already knew that there were 55 applications that had come into the clerk's office for people who wanted to appear, either people or organizations or a combination of both. That was before the committee had even advertised that we were going to meet and the days that we were going to meet. We have received some 118 applications, all told, and we are only able to hear from 30 presenters over the course of the next two days, so 88 groups and individuals are not going to be able to be heard. I expressed concern at the subcommittee meeting that we should hear from more people, and we certainly had the days to do it. It's clear that it is a very complex bill, with some 17 schedules—lots of interest. There are people in an overflow room right now. I think we made a serious mistake in not agreeing to hold two more days of public hearings so more people could be heard. So I'll be voting against this report.

**The Chair:** If there's no additional discussion, those in favour of the motion?

**Ms. Martel:** Recorded vote.

**Ayes**

Fonseca, Kular, Mauro, Ramal.

**Nays**

Martel, O'Toole, Witmer.

**The Chair:** The motion is carried.

HEALTH SYSTEM  
IMPROVEMENTS ACT, 2007  
LOI DE 2007 SUR L'AMÉLIORATION  
DU SYSTÈME DE SANTÉ

Consideration of Bill 171, An Act to improve health systems by amending or repealing various enactments and enacting certain Acts / Projet de loi 171, Loi visant à améliorer les systèmes de santé en modifiant ou en abrogeant divers textes de loi et en édictant certaines lois.

**The Chair:** That moves us now to the first presentation. I would ask whoever is making the presentation if, prior to speaking, you would identify yourselves for Hansard. It's necessary that you state your name. There are 10 minutes allocated for presentation. Any of the time you do not use will be divided equally among the parties for questions.

1550

ONTARIO NURSES' ASSOCIATION

**The Chair:** I would call first for the Ontario Nurses' Association.

**Ms. Vicki McKenna:** Good afternoon. My name is Vicki McKenna. I'm a registered nurse, and I'm the first vice-president of the Ontario Nurses' Association, ONA. Joining me today, on my far left, is Joan Boudreau. Joan is from our legal expense assistance team plan. Next to her is Lawrence Walter, our government relations officer. On my right is Kate Hughes, our legal counsel.

I'm speaking on behalf of over 53,000 front-line registered nurses and allied health professionals who deliver care in hospitals, long-term-care facilities, public health, community agencies, and other settings right across Ontario.

ONA is pleased to have this opportunity to provide the standing committee our concerns with Bill 171 from the perspective of front-line nursing. While we don't have time to review all of our concerns, we have provided the standing committee with our full submission.

I want to begin with our concerns regarding some of the proposed changes to the Regulated Health Professions Act and the Health Professions Procedural Code contained in schedule M. Specifically, ONA has grave concerns with respect to personal health information of our members to be placed on the public register and the college website, including a synopsis of the decision in every incapacity proceeding and the terms and conditions imposed on a member's certificate.

The grounds for a finding in an incapacity proceeding is typically a statement of the health condition that has caused this incapacity. The terms and conditions imposed in an incapacity case contain extensive references to a member's medical condition, diagnosis, treatment and other private personal health information. We have included two cases with our submission to assist the standing committee. Provisions that require publication of such information will have a disproportionate and discriminatory impact on members with disabilities, which in our view contravenes the fundamental rights to equality under both the Human Rights Code and the Canadian Charter of Rights and Freedoms. We understand that the government is trying to achieve greater transparency regarding college decision-making in order to enhance public protection. However, personal health information is highly sensitive and private and should not be placed on a public register or posted for all to see on a website.

ONA also has serious concerns with respect to mandatory reporting in all situations where a facility operator has reasonable grounds to believe that a member who practises at the facility may be incompetent or incapacitated. We believe the mandatory reporting obligation should be amended to apply only to situations where the public is at risk.

Often members deal with incompetence and incapacity concerns with their employers in a responsible fashion by acknowledging an underlying disability, withdrawing from practice and undergoing appropriate treatment. A member returns to work upon obtaining appropriate medical clearance. Many of these cases are not reported to the college because there is no risk to the public. If employers are mandated to report these cases to the college in the future, it will likely result in an unnecessary delay in members returning to work, since some employers will likely wait until the outcome of a college case before allowing a member to return. It may also negatively impact attempts to have members disclose their health condition and seek appropriate treatment. A report to the college will also place an unnecessary stressor on disabled members who are acting responsibly, when the focus should be on treatment and health.

ONA also has serious concerns with respect to the proposed legislative changes that will, in the future, allow the ICR committee, if it decides to refer a matter, to make an interim order to suspend or impose terms on a member's certificate of registration without notice to the member. This authority is unprecedented and a serious breach of the fundamental principles of natural justice and procedural fairness. There is no demonstrated need for such a radical departure from due process, as we are unaware of any cases where a member has harmed a patient while making a submission regarding a potential interim order.

In addition, ONA has serious concerns with respect to the requirement that the ICR committee, in deliberating about a complaint or report, consider all available prior decisions regarding a member. Again, it's a serious breach of the fundamental principles of natural justice

and procedural fairness. It's also extremely prejudicial to members, since it may lead to the disposition of a current matter, not on its own merits, but because of a previous matter.

Turning now to schedules F and K, we want to remind the standing committee that these proposed changes flow from Justice Archie Campbell's thorough and insightful report into the SARS outbreak. We find that schedule F ignores Justice Campbell's key recommendation that the precautionary principles are to be expressly adopted in the Health Protection and Promotion Act and all relevant health statutes. Accordingly, we also recommend codifying the precautionary principle in the Public Hospitals Act through schedule I.

In addition, Justice Campbell strongly recommended that the Ontario Health Protection and Promotion Agency have a well-resourced, integrated section that focuses on worker safety research and investigation and on integrating worker safety and infection control. Schedule K clearly fails to do so.

The functions of the corporation listed in section 6 make no mention of worker safety research.

The definition of "minister" in section 2 makes no mention of the Minister of Labour, the crown minister who is responsible for occupational health and safety.

Section 14 provides that the Chief Medical Officer of Health has automatic membership on the strategic planning standing committee, but no counterpart in the Ministry of Labour has similar standing.

Sections 22 and 23 provide that the board must issue reports to the Minister of Health and Long-Term Care and the Chief Medical Officer of Health, but is not required to issue reports to the Minister of Labour or other counterpart in the Ministry of Labour.

No occupational health and safety experts, Ministry of Labour specialists or labour representatives were given an opportunity to provide input as to the purpose, structure and functioning of the proposed new agency.

As a result, ONA is recommending that implementation of schedule K be delayed until a committee, comprised of the foregoing experts, is consulted and schedule K is redrafted accordingly.

Finally, ONA recommends that section 9 in the legislation be amended to expressly require labour representation on the agency board.

The nurses of Ontario insist that the lessons of SARS not be forgotten. The precautionary principle must be adopted, as Justice Archie Campbell recommended, and worker health and safety included as a fundamental component of this new agency.

We sincerely request that our submission be given serious consideration by the standing committee, and we thank you very much for your time.

**The Chair:** Thank you. We have one minute for questions.

**Mrs. Witmer:** Thank you very much, Vicki, and all of the nurses who are here.

One question I have for you: Obviously, you've been in preliminary discussions with the Ministry of Health on

some of these concerns. As a result of that, is there any indication that amendments are going to be made to certain sections that you've expressed concern about?

**Ms. McKenna:** Not that I am aware of, no.

**Mrs. Witmer:** Is there anything in here that would be different from the recommendations of the initial report, where directions were not followed per the report?

**Ms. McKenna:** Which report? I'm sorry.

**Mrs. Witmer:** That was put out by the RHPA. Is there anything contradictory here, or is this all that has come from the ministry?

**Ms. McKenna:** No.

**Mrs. Witmer:** There's nothing here? Barbara Sullivan had a report.

**Ms. McKenna:** No.

**The Chair:** Ms. Martel, there is about 20 seconds if you have a question.

**Ms. Martel:** Thank you for being here. Very quickly, in terms of putting the precautionary principle into schedule K, do you want it in the preamble, and are there other places where it could be included?

**Mr. Lawrence Walter:** Yes, it could be included in the preamble or it could be included in a separate clause. In the Campbell report there wasn't any specific language on where that precautionary principle should be. It should be included in any health statute, though, so we want it included also in the Public Hospitals Act, in the Health Protection and Promotion Act and in any other health statutes that are relevant. There are no changes—

**The Chair:** We're out of time; I'm sorry.

I will credit you one question for some later date.

1600

#### ONTARIO SOCIAL WORK DOCTORS' COLLOQUIUM, USE OF TITLE TASK FORCE

**The Chair:** I would ask next—I'm an engineer by training, so some of these words I may mispronounce, and I apologize—the Ontario Social Work Doctors' Colloquium, Use of Title Task Force. If you would state your name for Hansard, you have 10 minutes.

**Dr. Frank Turner:** My name is Dr. Frank Turner. My two colleagues with me are Dr. Nancy Riedel Bowers from Kitchener and Dr. Alex Polgar from Hamilton.

Mr. Parsons, members of the committee, I'd like to begin by thanking you on behalf of the Ontario Social Work Doctors' Colloquium for this opportunity to present in person our position concerning the use of the title "doctor."

Some time ago, we prepared and widely disseminated an extensively researched position paper that outlines a number of factually supported reasons why the Ontario government should amend a specific clause in the RHPA, a clause that prohibits social workers with university-granted doctorates from using their title when providing or offering to provide health services. I will leave copies of this document with you today and therefore will not summarize its content. Instead, I want to use this time to

convey some additional information; specifically what we have concluded based on our experience.

We are of the firm belief that the Ontario government's position regarding the use of the title "doctor" simply represents an absence of political will to rectify something that should never have happened in the first place. When the act was written and passed, there were no credible empirical bases for including in it the restriction clause pertaining to the use of the title "doctor." In spite of our concerted, indeed exhaustive, efforts, we have not been able to discover to date any credible evidence that would justify the restriction and thereby justify not amending the act now.

Therefore, in our view, the Ontario government's position on this matter appears prejudicial and discriminatory, violating the charter-guaranteed rights of social workers with university-granted doctorates. Our position, among other reasons, is based on the following:

The Health Professions Regulatory Advisory Council, after extensive analysis, which included broad consultations, in its New Directions report has recommended that the restriction on the use of the title "doctor" be amended, albeit without singling out any one discipline. In section 34, points 1, 2, 3, and 4, it is clearly spelled out how the amendment should be made. This recommendation has been ignored in the omnibus Bill 171 for, to us, no apparent reason. The Ontario government has not provided to us, or anyone else who has advocated on our behalf, any credible evidence for not making the recommended amendment.

Since we wrote and disseminated our position paper, we have also met with and discussed our issue with individuals, groups and a number of elected representatives. Without exception, all have been completely supportive. Many have conveyed their support in writing to the Minister of Health and Long-Term Care.

Anticipating a possible 11th-hour reason for not striking down the RHPA restriction concerning the use of the title, we have obtained a legal opinion. Our counsel, a recognized expert on regulatory laws, tells us that there are no legal impediments to modifying the RHPA as we have requested and as it has been recommended in the New Directions report. However, inadvertently, the intent of our request and the intent of the Health Professions Regulatory Advisory Council could be subverted. He has advised us therefore that, as in the Personal Health Information Protection Act—statutes that are intended also to apply to our profession—separate provisions be crafted referring specifically to social workers. This recommendation is consistent with the submissions made by both our college and association in response to the New Directions report.

Alternatively, the simplest solution would be to strike down and remove completely the prohibition in its entirety, leaving the issue of the use of the title "doctor" to be dealt with by existing general provisions dealing with false representations or misleading of clients.

No one we have spoken to opposes our request for the amendment, nor that which is recommended by the New

Directions report. Our colleagues in other disciplines acknowledged that the doctorate is the highest academic degree one can earn, that the degree represents a significant contribution to the discipline in which it was granted, and that the process for earning a doctoral degree conforms to a tradition that is 1,000 or more years old entrusted to the universities.

Now more than ever, much of the research conducted for a doctoral degree is directly applicable to practice. Currently, a researcher who does research can legitimately use the title, but if he turns clinician, he cannot use the earned title of doctor in his practice, although it was duly conferred by an accredited university.

While not explicitly addressed in our position document, the sacrifice, effort and commitment required to earn a doctorate requires reflection. Everyone who embarks on this arduous journey does so in good faith, seeking to advance their competence and to make a contribution to their field of study. On average, it takes approximately seven years after having earned a master's degree to complete a doctoral program. When the degree is conferred, it is done without conditions, restrictions or disclaimers.

It is therefore an absolute travesty that Ontario is the only place on earth where there is a restriction imposed on the use of the title "doctor." Nowhere else does this exist. It is an even greater travesty that the only rationale—public protection—has never had, and continues not to have, any empirical basis; none whatsoever.

On the contrary, instead of protecting the public, the RHPA-imposed restriction accomplishes the opposite. Specifically, the restriction is paternalistically derogatory to the public, which can and does seek information and uses it appropriately. Most importantly, in a climate of exponentially growing needs, the RHPA restriction limits the public's ability to make informed decisions about whose assistance they should seek and what quality of resources are available in Ontario.

I would like to conclude by reiterating that we believe the Ontario government's refusal, as reflected in the draft bill, to make the amendment that we requested and that was recommended in the New Directions report by the Health Professions Regulatory Advisory Council, is based on an unknown reason but clearly one that is simply conjecture. It is therefore markedly prejudicial to our group and the profession of social work. While perhaps well intentioned, this restriction is also inadvertently an impediment to those who are served by our profession.

We thank you again for the opportunity to speak to this issue.

**The Chair:** Twenty seconds per party, starting with the Liberals.

**Mr. Peter Fonseca (Mississauga East):** I'd like to thank the Social Work Doctors' Colloquium for its fine presentation, and all the social workers of Ontario for the fine work they do in providing social services as well as the delivery of psychotherapy. When it comes to schedule M—

**The Chair:** Thank you. Mrs. Witmer.

**Mrs. Witmer:** Thank you very much, Dr. Turner, for your presentation. I hope that when we come to the time for amendments, the government will recognize the need to lift this restriction on the use of the title “doctor” and that we are at the same place as everybody else—

**The Chair:** Thank you. Ms. Martel.

1610

**Ms. Martel:** Thank you for being here. Since social workers aren’t regulated under the RHPA, what’s the amendment you have to make under the RHPA to do what you want to do?

**Dr. Alex Polgar:** Strike it down completely, as was recommended to us, or provide a clause in the RHPA that specifically outlines that social work would be exempt from that.

**The Chair:** Thank you. We’re out of time.

#### ONTARIO HOMEOPATHIC ASSOCIATION

**The Chair:** The next group is the Ontario Homeopathic Association. While they’re coming forward, I’m going to suggest to the committee that where we have just a few minutes left, perhaps we’ll have just one party take the time.

**Mrs. Witmer:** That’s a good idea.

**The Chair:** I apologize for that. I started down a road I couldn’t get off of once I started.

I would also remind those who have cellphones—if you would turn them off. Perhaps you can put them on vibrate rather than ring. Heck, you might even enjoy a phone call.

Okay. The time is yours.

**Ms. Maya de Szegheo-Lang:** I’m Maya de Szegheo-Lang. As president, I represent members of the Ontario Homeopathic Association, referred to as OHA. With me is Mirsada Vins, head of the homeopathic department of the Ontario College of Homeopathic Medicine, referred to as OCHM. We would also like to acknowledge Ranvir Sharda, president, and members of the Homeopathic Medical Council of Canada, HMCC, who are in support of this submission.

We wish to thank the Chair and committee members for the opportunity to comment today on the regulation of homeopathy in schedule P of Bill 171.

The Ontario Homeopathic Association is a non-profit, voluntary association of highly qualified homeopaths who must adhere to a code of ethics and must meet educational and practice criteria which include specified hours of general arts and science courses, medical science courses, homeopathic instruction and clinical internship in homeopathy.

**Ms. Mirsada Vins:** Through review and consultation, the OHA proposes the following: With respect to the establishment of the College of Naturopaths and Homeopaths of Ontario, the OHA submits that homeopaths and naturopaths ought to be regulated under separate colleges. We acknowledge that naturopaths receive some education in homeopathic principles. It is common

amongst regulated health professions for there to be some aspects of shared knowledge or practice. However, homeopathy is a distinct system of medicine with a core body of knowledge that is unique to the practice of homeopathy. A separate college would provide homeopaths with the opportunity to develop the appropriate regulatory scheme for homeopathy in Ontario.

We note that when the College of Midwives of Ontario was created, it had 67 members. In the ensuing 14 years, its membership has grown to approximately 400 members. The OHA estimates that there are currently approximately just over 500 highly qualified homeopaths in Ontario who would be eligible for membership as regulated health professionals. As well, both the OHA and the OCHM have seen an steady increase in the past 10 years in the number of persons wishing to obtain homeopathic education. This increase in interest in homeopathy has been mirrored by an increase in members of the public who wish to have access to alternative medicine. There are sufficient number of homeopaths in Ontario to warrant and support a college of homeopaths of Ontario.

We acknowledge that experience and regulation is of great assistance when developing policies, procedures and programs. We expect to consult with and draw on the expertise of the many established regulatory bodies in Ontario and include representatives from other colleges on our transitional council. In our view, such collaboration and consultation is a more beneficial approach than relying on a composite college system.

Therefore, we recommend that schedule P to Bill 171 be amended to provide for separate regulatory bodies for homeopaths and naturopaths by creating a college of homeopaths of Ontario and a college of naturopaths of Ontario.

With respect to the use of the title “doctor,” the OHA and OCHM, amongst other homeopathic groups, such as the HMCC, have worked to establish the minimum standards for theoretical and practical knowledge required to undertake the diagnosis of conditions, treat within the scope of practice and make inter-professional referrals in the best interests of patient care.

The OHA recognizes that some homeopaths in Ontario have advanced theoretical and clinical training above those minimum standards. For example, homeopaths in many jurisdictions are required to have a medical or osteopathic medicine degree in addition to post-graduate training in homeopathy. The qualifications of such homeopaths match or exceed the academic and clinical requirements for regulated health professionals in Ontario, such as chiropractors, dentists, optometrists or psychologists, who are currently entitled to use the protected title “doctor.”

The government of Ontario has already acknowledged that within a regulated health profession there are practitioners with a range of experience and training and that it is appropriate in the public interest to recognize advanced academic and clinical training with the use of the title “doctor.” For example, in the Traditional

Chinese Medicine Act, 2006, all members of the College of Traditional Chinese Medicine Practitioners and Acupuncturists of Ontario are provided with the restricted title “traditional Chinese medicine practitioner” or “acupuncturist.” However, the council can make regulations regulating or prohibiting the use of the title “doctor” and can prescribe a class of certificates of registration for members who use the title “doctor.”

This scheme gives the minister the ability to ensure there is consistency across the regulated health professions with respect to the prerequisite education and clinical experience that would entitle a practitioner to use the title “doctor.” It also provides the public with an assurance that regulated health practitioners who are authorized to use the title “doctor” have extensive academic and clinical expertise.

Therefore, we recommend and propose that schedule P to Bill 171 be amended to provide the Council of the College of Homeopaths with the authority to make regulations similar to the authority provided in the Traditional Chinese Medicine Act, 2006, regulating the use of the title “doctor” and prescribing a class of certificate of registration for homeopathic members who use the title “doctor.”

**Ms. de Szegheo-Lang:** We also feel that some controlled acts belong within the scope of homeopathic practice.

Communicating a diagnosis: Diagnosis is a vital and fundamental aspect of the homeopathic system of medicine. A homeopathic diagnosis is based on a patient’s physical, mental and emotional condition, objective and subjective symptomology, history, diagnostic test results and physical exam findings. A homeopathic diagnosis is necessary to prescribe the correct homeopathic remedy and to identify and discuss treatment and conditions, including those that require urgent emergency medical attention.

Administering, by injection or inhalation, a prescribed substance: Traditionally, homeopathic medicines were administered orally or, if indicated, by inhalation. However, scientific research being conducted in a number of medical centres in Europe has established that some homeopathic medicines are more effectively administered by injection, so it is standard homeopathic practice in some jurisdictions to administer some homeopathic medicines by injection. Permitting a homeopath to perform the controlled act of administering a prescribed homeopathic substance by injection in accordance with the appropriate regulations is in the public interest. This will allow the most effective homeopathic treatment under prescribed conditions that protect the public.

Prescribing, dispensing, selling or compounding a drug as defined in subsection 117(1) of the Drug and Pharmacies Regulation Act: Most homeopathic medicines used in the practice of homeopathy in Ontario are defined as “natural health products” pursuant to the natural health products regulations made under the Food and Drugs Act. This means that they are not considered to be drugs as defined in the Drug and Pharmacies

Regulation Act and homeopaths can prescribe, dispense, sell or compound them. However, there are some homeopathic medicines contained in the accepted homeopathic pharmacopoeias which are not defined as natural health products. Homeopaths in Ontario cannot legally use them in the practice of homeopathy because, absent being defined as “natural health products,” they are defined as drugs. It is a controlled act to prescribe, sell or dispense a drug.

In order to ensure that homeopaths and their patients in Ontario can benefit from the full range of homeopathic medicines in the homeopathic pharmacopoeia, homeopaths require the authority to perform the controlled act of prescribing, dispensing, selling and compounding homeopathic medicines.

Therefore, we recommend that schedule P to Bill 171 be amended to include the following: In the course of engaging in the practice of homeopathy, a member is authorized, subject to terms, conditions and limitations imposed on his or her certificate of registration, to perform the following:

(1) administering, by injection or inhalation, a prescribed homeopathic substance;

(2) communicating a homeopathic diagnosis that may be identified through an assessment that uses homeopathic techniques and includes assessing the individual’s physical, mental and emotional conditions and symptoms, and is used to prescribe the appropriate homeopathic medicine or therapy;

(3) prescribing, dispensing, selling or compounding a homeopathic medicine which is defined as a drug in subsection 117(1) of the Drug and Pharmacies Regulation Act.

We note that the council would also require the authority to make regulations concerning the three controlled acts.

Thank you for your time.

**The Chair:** Thank you. There’s enough time for one question. I’m making an arbitrary decision that it go to the government because they did not get in on the first rotation. Mr. Fonseca.

**Mr. Fonseca:** Thank you, Chair. You’re so kind.

I’d like to thank the Ontario Homeopathic Association. I’d just like to tell you that the commitment from this government is to make sure that right now there is an equal representation on the college between naturopaths and homeopaths. We are also seriously looking at separating the college.

I want to ask you a question in regard to standards in terms of education standards for a doctor. What standards are there? Is there a standard exam that all homeopaths take? Can you tell me a little bit about that?

1620

**Ms. de Szegheo-Lang:** No. As far as the Ontario Homeopathic Association, most members will have a BA coming into homeopathic study and then do what is equivalent to about a five-year university tenure in homeopathy.

**Ms. Vins:** We’re also working toward increasing the standards to match those that exist in other jurisdictions

in the world that require medical degrees, training in the health sciences and an extensive training in homeopathy and in the clinic as well.

**The Chair:** We're out of time. Thank you.

CANADIAN UNION OF  
PUBLIC EMPLOYEES,  
AMBULANCE COMMITTEE OF ONTARIO

**The Chair:** I would call forward now the Canadian Union of Public Employees, Ambulance Committee of Ontario. Again, if you would state your name for Hansard.

**Mr. Michael Dick:** Good afternoon. I'm Michael Dick. I'm the chair of CUPE Ambulance Committee of Ontario. Joining me is Mr. Joe Matasic, CUPE national rep, CUPE Canada ambulance coordinator. I want to thank you for giving us this opportunity to appear to voice our concerns and give a presentation on Bill 171.

Emergency medical services have undergone almost constant restructuring since the downloading of EMS to upper-tier municipalities at the turn of the century. Many changes ensued, starting with changes in employment, for most paramedics. On the positive side, though, CUPE, along with some concerned members of the community, campaigned for public delivery of emergency medical services, and we have been largely successful in achieving this goal. CUPE has become the largest union of EMS employees, representing approximately 3,600 paramedics in different locations around Ontario.

Even after the downloading, restructuring continued, with municipalities gradually taking over the direct operation of EMS, where it had been delivered by hospitals or the odd for-profit corporation. With the municipalities now operating most services directly, the pace for restructuring has slowed of late, with only one major change in employment relationship in the past year, so some stability has now been achieved. One positive outcome of these changes is that paramedicine as a career has matured. While in the past many would only pass through the profession, more now see work in paramedicine as a full working-life career. With these changes, employers now also expect more commitment and more stability. This has real benefits for EMS. A less positive outcome of these changes has been the desire of some municipalities to narrow the scope of their responsibilities.

There has been an almost constant campaign to move transfers between health care facilities away from land ambulances. The result has been the establishment of a whole new industry: private, for-profit companies, often presenting themselves as ambulances or as paramedic services. These for-profit businesses are transporting patients. In the last few years, these vehicles have become a common sight on our roads. They are completely unregulated and have further fragmented our health care system, despite the government's stated aim of integrating health care. To date, however, they have been restricted to the transportation of the less ill patients. As

far as we can see, the main outcome is to replace unionized workers earning a reasonable income by workers who earn less. Currently, most of these transfer services are unorganized.

Now we see the second step in the campaign by the municipalities to escape some other EMS responsibilities: the creation of a new body to transfer seriously ill patients between facilities. This is the stated purpose of the legislated amendment. We understand that 20,000 such transfers occur now, which is a significant amount of work. We believe, however, that such transfers have the potential to become a much more important area of work for paramedics.

Aided by the establishment of LHINs, there is significant interest in regionalizing health care. So, for example, there is a lot of interest in creating trauma centres which would handle the bulk of the trauma cases. EMS, as first responders, may take the trauma patients to a local hospital, but after being stabilized, these patients may be transferred to trauma centres that are some distance away.

Currently, physicians and RNs attend the patients transferring between these facilities, but this is expensive, and in any case, physicians and RNs are not trained to provide these sorts of services. Highly trained critical care paramedics are supposed to take over, and such services are already provided in the city of Toronto by CUPE members who work for the city's EMS. Turning such work over to a new organization will, again, fragment the health care delivery and limit the career path for some paramedics working in land ambulance services.

Currently, there are two levels of work for paramedics: primary care, and advanced care. The advanced care has an additional skill set and training. There is a third, even more highly skilled level, known as critical care paramedics. Critical care paramedics are authorized to perform very specialized controlled medical acts, including the administration of specialized drugs and other intensive medical treatments that are often required during the transportation of critically ill patients. Examples of these acts include lab blood interpretation, monitoring arterial and central venous catheters, gastric intubation and suction, chest X-ray interpretation, management of chest tubes and chest drainage, and mechanical ventilation.

We are not convinced that putting all, or virtually all, of the critical care paramedics with one employer is a good practice in terms of human resources development. Extensive travel may be associated with the work, so we are uncertain this new organization will be a long-term career choice.

As well, the separation of critical care paramedic work from land ambulance services prevents land ambulance paramedics from aspiring to be critical care paramedics. Again, we are not certain this is best for the industry in the long run. The government characterizes this initiative as "integrating" critical care transport, but the initiative will separate critical care transport from the great bulk of ambulance services and ambulance workers.

Secondly, we do not know the exact division of labour between land ambulance and critical care inter-facility transfers. What exactly are the limits to the new role for Ornge? We presume the regulation will provide some clarity on this. We hope the government is open to discussing this important point before finalizing the regulation.

Finally, we understand that the legislation may be necessary to establish a new role for Ornge, the air ambulance organization of today, so that it can deal with the critical care, inter-facility transport. We do not understand, however, why the legislation has to be written in such an open-ended way; for example, it appears to envisage the creation of any number of new ambulance providers, including first-response providers.

Paramedics have been through extensive restructuring already. After all this change and struggle, we believe that more change in employment relationships at this point would be counterproductive. Moving in this direction or creating multiple ambulance employers in certain areas would, or could, create chaos in an industry that has already seen its share of change.

I'd like to thank you for the opportunity of presenting today.

**The Chair:** We have about 30 seconds, so I believe the next rotation—

**Mrs. Witmer:** I'll give it to Ms. Martel.

**The Chair:** Okay. Ms. Martel.

**Ms. Martel:** Thank you for being here today. You have some obvious concerns. What kinds of discussions have you had with the government about your input around what's currently in the bill, or the development of any regulations that flow under schedule A?

**Mr. Dick:** Very little, if any.

**Ms. Martel:** You've written to them, asked for meetings? What have you done?

**Mr. Dick:** We have just actually—we weren't really aware of this bill coming through, because it was put in with some other changes, so it just came to our attention in the last few weeks. We did contact emergency health services and had some discussion with them, but that's not the level where this needs to be discussed.

**Ms. Martel:** Were they reluctant to take it further?

**Mr. Dick:** We didn't really ask them to take it any further; it was just not something that was in their scope.

**The Chair:** We're out of time. Thank you.

**Mr. Dick:** Thanks.

1630

#### JOHN McEACHERN

**The Chair:** The next presenter is John McEachern.

Assuming that you're not both John McEachern, I would ask that you state your name for Hansard when you start to speak. You have 10 minutes.

**Mr. John McEachern:** If your son, your daughter or your loved one suffered a sudden cardiac arrest, would you want to do everything in your power to make sure that whoever saw them collapse had a defibrillator near-

by and did not hesitate even for one second to use it to save their life? Mr. Chairman, members of the Ontario Legislature, thank you for giving me this opportunity to speak to you about Bill 171. I am joined here by Rocco Rossi, CEO of the Heart and Stroke Foundation of Ontario.

I am speaking on behalf of my wife, Dorothy, and my son, Cole. I am John McEachern, the father of 11-year-old Chase McEachern, who passed away February 15, 2006, due to cardiac arrest. It is with my deepest sadness and great hope for the future that I stand before you today. It is on a deep personal note that I am here to support Bill 171 and especially the Chase McEachern Act (Heart Defibrillator Civil Liability), 2006.

Our son Chase was diagnosed with a heart condition known as atrial flutter. This condition caused his heart to beat very fast, sometimes for unknown reasons. Chase was diagnosed in October 2005. In November 2005, Chase witnessed a frightening scene during an NHL game. It was the sight of a Detroit Red Wings player, Jiri Fischer, collapsing from a similar condition that spurred Chase to write a letter to Don Cherry. Chase's letter to Don Cherry requested help to bring awareness to this heart condition and the need for more defibrillators, especially in arenas, because Chase loved to play the game of hockey.

Sadly for us all, Chase went into cardiac arrest February 9, 2006, during a gym class at school. A defibrillator did not arrive in time. Chase passed away on February 15, 2006, after six days on life support.

Soon after Chase's passing, Rocco Rossi, the CEO of the Heart and Stroke Foundation, called us, and together we created the Chase McEachern tribute fund. Donations to the Chase McEachern tribute fund are earmarked exclusively for the purchase of defibrillators, training in their use, and their placement in communities throughout Ontario.

Subsequently, with the ever-growing number of defibrillators being installed, it is easy to see the need for a civil liability act to promote their use. The Chase McEachern Act would ensure that users of defibrillators and the owners and occupiers of premises on which they are installed are protected from civil liability.

Chase had a dream to make defibrillators mandatory in arenas and schools everywhere. CPR and defibrillators can improve cardiac arrest survival up to 50% if delivered in the first few minutes. Let's make sure, by passing the Chase McEachern Act, that that help will be there and that no one else will hesitate to use a defibrillator. Because of Chase's dream, more lives can and will be saved by the use of defibrillators. The Chase McEachern Act will forever be a living legacy and a tribute to a special boy, our son, a boy who loved life and who shall help others live.

Just this past weekend, we got a letter from North Bay. Over the last week, there were two people in North Bay arenas who were saved by people stepping up and using defibrillators. It's just the start of what's going on.

**Mr. Rocco Rossi:** Thank you, John.

As John has mentioned, my name is Rocco Rossi. I'm the CEO of the Heart and Stroke Foundation of Ontario.

Sadly, Chase's case is not unique. Each and every year, some 7,000 Ontarians suffer cardiac arrest outside of hospital settings, and the current survival rate is less than 5%. With defibrillators and early CPR in the first few minutes we can increase that survival rate to 50% or above, so potentially 3,500 Ontarians a year could be saved instead of the current 300.

Sadly, each and every minute after you go into cardiac arrest, your chances of survival without treatment decrease by 7% to 10%, so there are 10 to 12 minutes to act. Literally, hesitation leads to death: hesitation on the part of donors to commit money to put more defibrillators into arenas, hesitation on the part of property managers to put these life-saving machines into their facilities, hesitation on the part of potential bystanders to do something in the case of cardiac arrest. So we applaud the government for including the provisions entitled the Chase McEachern Act within Bill 171. We strongly encourage the committee to support the bill, and particularly this element within the bill. We have many donors and expressions of interest from people who are simply holding back because of the lack of clarity on the liability issue. The current good-Samaritan legislation that's in place in Ontario, while good, is silent on the issue of defibrillators. This change would literally save lives, and I encourage you not to hesitate, because hesitation leads to unnecessary death.

Thank you again for allowing us to speak.

**The Chair:** We have about 50 seconds per party. I've lost track of where we were, so I'm going to go to the government caucus first.

**Mr. Fonseca:** Thank you, Mr. McEachern and Mr. Rossi, for your comments and your presentation. I know Chase's legacy will live on.

I would like to make a comment: One of our colleagues, Bruce Crozier, the MPP for Essex, brought forward a private member's bill. He wishes he could be here with us right now. He's actually in the Speaker's chair.

Allowing for the private sector and all to be able to have these defibrillators without the scare of being liable for their usage will, as you said, save many, many lives, and we can't act fast enough to get them out there. Thank you very much for presenting in front of us today.

**Mrs. Witmer:** Thank you very much for your presentation. Certainly we support this part of Bill 171 very strongly, and I appreciate your coming here today. I know that our colleague Joe Tascona, the member for Simcoe, is very supportive and certainly urged all of us to support it. At this point in time, as far as Bill 171 is concerned, obviously if the government wishes to pass that bill, that bill will pass, and we're hopeful that this section can become law.

**Ms. Martel:** Thank you, both of you, for being here. To Mr. McEachern in particular, thank you for coming and telling a personal story which was very difficult for you to do. I admire your courage in having made the decision to do that and to come to Toronto today. It was a

pleasure of mine, as NDP health critic, to speak on Bruce Crozier's bill, so it's a pleasure to meet you in person as well. We were supportive of the private member's bill and are certainly supportive of the schedule that has this change in it.

**The Chair:** Thank you for coming. Mr. McEachern, I want to particularly thank you for trying to make something good out of a tragedy. Chase's life was not without purpose. Thank you.

#### ONTARIO PSYCHOLOGICAL ASSOCIATION

**The Chair:** Our next presentation is the Ontario Psychological Association.

**Dr. Jack Ferrari:** Mr. Chairman and committee members, thank you for giving us this opportunity to—

**The Chair:** I need you to state your name first for Hansard.

**Dr. Ferrari:** Okay. I was going to come to that. I'm Jack Ferrari, the president of the organization. With me on my left is Dr. Ruth Berman, the executive director, and on my right is Dr. Ian Nicholson, the chair of our RHPA task force.

Let me start by saying that we wholeheartedly endorse the current move to regulation of, and hence improvement in, the standards of provision of health services in the mental and emotional health area. RHPA was an important step forward in health regulatory legislation and has been very helpful in providing the parameters needed for the development of a full range of high-quality professional responses to the health needs of Ontarians.

The early emphasis of the RHPA, as it needed to be, was on physical health. We are very pleased with the current initiative, indicated by the creation of a new controlled act and by the broadening of the definition in the harm clause, to give mental and emotional health their proper place in the regulatory framework.

**1640**

We understand how difficult and contentious this legislation has been, and we would take the opportunity to offer all those involved our congratulations for their efforts and responsiveness in ensuring that the full range of professionally trained individuals, including our colleagues outside of the RHPA in the College of Social Work and Social Service Workers, have been included.

We do, however, have some significant concerns and would like to suggest what we hope are minor and acceptable modifications in the proposed legislation, in a spirit of collaboration and in the hopes of helping to ensure applicability and sustainability as the new regulations are implemented.

There are three interrelated matters we would like to draw the committee's attention to. We note that the part of the omnibus legislation to which we are responding, schedule Q, has as its aim the regulation of certain mental health activities which, if performed without requisite skill, could endanger the public—the group of activities

called psychotherapy. It also has the aim of regulating previously unregulated practitioners in a broad spectrum of mental health services. We believe that the distinction between these two legislative aims, the activity and the practitioner, may lead to a need for some amendments to the proposed legislation.

The legislation defines a new title of practitioner, the psychotherapist, and stipulates that only members of the new college will have access to this title. The reason cited is that the public will be able to identify the new practitioner and the regulatory body to which this practitioner belongs by this title. However, the term “psychotherapist” is in common public use, has a long history and belongs to many practitioners other than the newly regulated. In particular, we feel the title rightly applies to our members in one of their most important activities, and we feel the public would be deceived if there were a restriction of the title to a single group at the expense of the senior professions—psychology, psychiatry and social work, to which we would include some members of nursing and occupational therapy—all of whom can easily argue for the rightful use of the title.

There has been concern cited about the use of two titles, psychotherapist and psychologist, within the same college. We’re unaware of any jurisdiction in which this has in fact caused a problem, and we would note that our members have learned in the years of being well regulated to be sure to present themselves and their services to the public in an accurate and complete manner.

Related to the difficulty in restriction of title is the proposed name of the college itself. The new college will do more than regulate a specific activity; it will regulate, for the first time, a heterogeneous group of professionals who work with mental health issues in a variety of ways and at a variety of levels, some practising with total autonomy, some within various supervisory and consultative structures. Yet the proposed name of the college is the College of Psychotherapists, with no indication in that title of the diversity of practitioners who will seek and gain entry. Moreover, this title may create a false impression among the public that the psychotherapeutic services of the other regulated professionals that have historically been identified as providing psychotherapy and who are also authorized to do so under this bill, such as our own, may not be at an equivalent standard or level of care.

Our own regulatory body, the College of Psychologists of Ontario, has proposed that the public will be better served, with less occasion for confusion, if the name is changed, to more reflect the proposed reality, to the College of Mental Health Therapists.

Finally, again following from the heterogeneity of the proposed college, we wish to state our concerns that the legislation, as currently proposed, seems to leave too many decisions regarding levels of membership and entry criteria to be determined by the transitional council of the new college without giving it the tools it may need.

Our own experience has taught us that, legally, a differentiation can be made between a title and a class,

and unless classes are defined in the enabling legislation, they cannot later be assumed simply because titles differ. Without a definition of classes of membership, class limitations, terms or conditions cannot be imposed. We would argue, however, that the new college is going to have to come to grips very early on with the need to impose class limitations because of the wide variety of backgrounds in individuals seeking entry to the college.

We would ask, then, that a clause be entered into the enabling legislation defining, at the very least, two classes, one of psychotherapists and the other of mental health therapists, who would not be expected to have access to the controlled act and, in some cases, would have a requirement for supervision in at least some of their professional activities.

We trust, as well, that our profession with its historical expertise will be invited to participate in the transitional council of the new college, and we would welcome the opportunity to do so.

**The Chair:** Thank you. There are about 35 seconds per caucus, starting with the official opposition.

**Mrs. Witmer:** Well, thank you very much. Have you had any discussions with the ministry regarding the change in name of the college to Mental Health Therapists?

**Dr. Ferrari:** Yes, we have.

**Mrs. Witmer:** And what was the response?

**Dr. Ruth Berman:** We did meet with members of the bureaucracy and with the people in the minister’s office as well. There was an indication that they understood why we were concerned, but there has been no indication of whether the government intends to put forward any change.

As Dr. Ferrari indicated, one of the arguments in favour of the current name was that it would be clearer to the public which college a practitioner would belong to. But as you are aware, psychologists are psychotherapists, and the public has been aware that we’re psychologists. We don’t feel that that argument is warranted.

**The Chair:** We need to move on. Ms. Martel?

**Ms. Martel:** Thank you for being here today. I’m going to go to the last concern, where you say that a clause should be entered into the enabling legislation so that psychotherapists and other mental health therapists don’t have access to the controlled act. Who would, then?

**Dr. Ferrari:** No, psychotherapists would always have access to the controlled act. What we are talking about is a clause similar to a clause in the Nursing Act that defines two classes. That enables the college to place terms, conditions or limitations on the class. There would be a class of mental health therapists who would not and should not have access to the controlled act.

**Ms. Martel:** Because of their level of education, etc.

**Dr. Ferrari:** Yes.

**The Chair:** We’ll move next to the government caucus, then.

**Mr. Fonseca:** I’d like to thank you for your presentation. As we look to improve our health care system, we ask that it always be patient-centred and that various

groups work together, so that the colleges work together and always look to implement best practices. That's what we're asking for in this case. I thank you for your presentation.

**The Chair:** Thank you.

#### ONTARIO ASSOCIATION OF OPTOMETRISTS

**The Chair:** The next presenter is the Ontario Association of Optometrists. If you would state your names for Hansard.

**Dr. Joe Chan:** Good afternoon. My name is Joe Chan. These are my colleagues Dr. Christopher Nicol and Dr. Derek MacDonald, currently the president of the Ontario Association of Optometrists.

The Ontario Association of Optometrists, OAO, is pleased to have this opportunity to appear before the standing committee on social policy during the public hearings on Bill 171, the Health System Improvements Act, 2006. Founded in 1909, the OAO is the voluntary professional organization that represents almost 1,200 optometrists in Ontario. The association proudly serves the profession by performing a variety of government advocacy, membership education and public awareness initiatives.

Optometrists are professionally educated and clinically trained to provide community-based primary eye health and vision care services regulated under the Optometry Act, 1991, and the Regulated Health Professions Act, 1991. Optometrists provide comprehensive eye care for patients of all ages to optimize vision and prevent vision loss.

Comprehensive eye examinations contribute to the early detection and diagnosis of sight and potentially life-threatening diseases. Optometrists play a vital role in the assessment, diagnosis, treatment and continuing management of eye conditions for nearly three million residents in Ontario annually.

Optometrists are involved in preventive care, health maintenance, remediation and rehabilitation, and community health programs. Preventing blindness and preserving vision are priorities for Ontario's optometrists.

Our submission today is restricted to comments on schedule B, "Amendments Concerning Health Professions," section 17 on the Optometry Act, 1991, on pages 10 and 11. The proposed amendments to section 4 of the Optometry Act, 1991, will add the controlled act of prescribing drugs designated in regulations to the practice of optometry. The specified drugs will be subject to review by the minister and will be limited to those that can be used in the practice of optometry. The association would strongly recommend that this be accomplished through the specification of drug classes, with supporting practice guidelines to optimize care as new innovations in therapy rapidly evolve. Over 30 years of North American experience with the optometric use of therapeutic pharmaceuticals provides a ready reference for the specification of appropriate classes of topical and oral

medications by the council of the College of Optometrists of Ontario.

#### 1650

Indeed, fully 96% of North Americans reside in state, provincial and territorial jurisdictions that presently permit optometrists to prescribe certain therapeutic pharmaceutical agents for ocular conditions. Optometrists in six Canadian provinces—Alberta, New Brunswick, Nova Scotia, Quebec, Saskatchewan and Newfoundland—and one territory, the Yukon, are permitted to prescribe pharmaceuticals for therapeutic purposes. Further, all 50 US states also extend therapeutic drug privileges to optometrists.

Ontario is one of the last jurisdictions in North America to authorize the prescribing of drugs by optometrists. The changes to the Optometry Act proposed in schedule B will provide the public with better access to a high level of eye care from qualified practitioners and will reduce health care costs by eliminating unnecessary referrals.

Graduates from Canadian optometric programs meet the qualifications for licensure in all jurisdictions in Canada and the United States. Optometrists are educated and clinically trained at the university level and have the necessary skills and knowledge to safely prescribe topical and oral medications for the treatment of eye disease. In fact, "Graduates come away with the skills to therapeutically manage eye conditions, including ocular surface diseases, eye and eyelid infections, ocular inflammation and pain, ocular allergies and glaucoma." To qualify for registration, graduates of optometric education programs, including the optometry program at the School of Optometry at the University of Waterloo, typically complete a minimum of seven years of university education.

We understand that this legislation is premised on the advice that Minister Smitherman requested and received from the Health Professions Regulatory Advisory Council, HPRAC, on the question of expanding the scope of practice of optometrists to include prescribing drugs. HPRAC undertook an independent, comprehensive and evidence-based review of that question. The process of review included literature and jurisdictional reviews, stakeholder consultations and an examination of the proposed pharmaceutical categories by an independent pharmacological expert.

The review determined the following:

—"The vast majority (75%) of optometrists in Ontario have the requisite knowledge, training and education to appropriately prescribe therapeutic pharmaceutical agents."

—"The public safety experience has been impressive in jurisdictions that have enacted legislation allowing optometrists to prescribe TPAs."

—"HPRAC's jurisdictional review of provinces and territories where optometrists are authorized to prescribe TPAs failed to find any evidence of patient complaints or safety issues."

—"Enhanced access for patients to a qualified health care provider of their choice generally improves the system's accountability to the public."

—“Broadening the scope of practice for optometrists by permitting limited use of TPAs will provide more access to care for Ontarians, make Ontario a more attractive location for optometrists to practice, and help address some of the physician-supply problems in the province.”

HPRAC recognized that some practitioners might not currently possess the required training to prescribe therapeutic pharmaceutical agents. Further educational opportunities will be provided to the profession, and the College of Optometrists of Ontario will continue to establish and enforce practice standards and guidelines to ensure practitioner accountability. The association also believes it is critical that the College of Optometrists develop guidelines on after-hours and collaborative patient care, as we look forward to continuing to work with our colleagues in pharmacy and medicine. OAO is confident that the College of Optometrists can fulfill these mandates.

In Ontario there is one optometrist for every 9,139 residents, compared to one ophthalmologist for every 30,000 residents. Optometrists are readily available to provide the essential eye care services required by the residents of Ontario. More than 1,400 optometrists are widely distributed across the province, serving over 220 communities.

Optometrists are located in the majority of communities that were designated by the Ontario Medical Association and the Ontario government as being underserved. Further, in many of these underserved communities, optometrists are the only source of specialized eye care.

Optometric care is timely, easily accessible, safe and cost-effective. Moreover, adding the controlled act of prescribing topical and oral drugs to the practice of optometry will allow optometrists a broader range of treatment options to better meet the eye care needs of the public throughout Ontario.

An increased scope of practice for optometrists will permit more efficient treatment, since patients will receive more complete care from a single qualified practitioner. There will be fewer referrals of optometric patients with eye disease to either a hospital or a physician for treatment.

Clearly, the addition of the controlled act of prescribing drugs to the scope of practice for optometrists will have significant benefits for the residents of Ontario. Accordingly, OAO respectfully requests that this committee approve the proposed amendments to section 4 of the Optometry Act.

Thank you for your time today and for the opportunity to present the views of OAO on Bill 171 to the committee. If you have any questions, I would be pleased to provide answers.

**The Chair:** I’m sorry; you’ve timed it to fit 10 minutes.

**Dr. Chan:** Oh, okay.

**The Chair:** I’m sorry. There is no time for questions, but thank you for being with us.

ROYAL COLLEGE  
OF DENTAL SURGEONS  
OF ONTARIO

**The Chair:** The next presentation is the Royal College of Dental Surgeons of Ontario. Welcome. If you would state your name for Hansard.

**Mr. Irwin Fefergrad:** My name is Irwin Fefergrad. I’m the registrar of the Royal College of Dental Surgeons of Ontario. The royal college is the regulator for some 8,000 dentists and has been around since 1869. I myself am a lawyer and I’m certified as a specialist in civil litigation and health law. I tell you that not to impress you but perhaps to suggest I might come with a touch of a different perspective.

Our college supports the amendments to the RHPA and commends Barbara Sullivan and HPRAC for their thoroughness in consultation not only with the colleges but, as well, with the public members who have been appointed by government to sit on our council.

I thought what I would do is spend a few minutes and do some nuts and bolts for you on three or four areas that might be problematic. As you know, we deal with this legislation every day under the RHPA, and we do have concerns about some of the drafting or perhaps some of the intentions in the sections.

The first one I’d like to approach is section 38, which speaks to pre-hearings. Most colleges have pre-hearings. We do; we’ve had them for about 10 years. The act proposes that the chair appoint a panel from the discipline committee to sit as pre-hearing conference people. I can tell you that this will create havoc with quorums for a discipline hearing. I can tell you that it would create conflicts, and it’s not necessary. I think it ought to be left to the chair to appoint perhaps a public member, in our case a dentist, who would be best qualified. It doesn’t have to be a member of the discipline committee. It could be somebody who has already been on council. It could be somebody perhaps who has taken courses in this kind of activity.

So my first submission to you is to rely on the Statutory Powers Procedure Act. It sets out fairness. Don’t handcuff the colleges by requiring a panel to come from where the quorum has got to be drafted and taken anyway for discipline.

Second, under the section 75 provisions, which are the investigative provisions, usually a registrar’s investigation confirmed by the new ICR committee, the statute, as amended or as proposed, suggests that the investigation ought to take place at the place of practice. In today’s environment, that’s very limiting. For example, we have now health professional corporations, and the books and records may not be in the practice. They may be in an accountant’s office. They may be in another office which might be the head office of the corporation, which may not be in the practice. It seems to me that in order to protect the public and allow the colleges to do their work, you might wish to consider allowing the investigation to take place wherever the records are held. Our bread and

butter in these investigations, of course, is access to books and records, especially when dealing with fraud or billing for unnecessary services, that kind of activity. If we don't have access to the place where the books and records are actually kept, we will be handicapped in doing the job that you entrust us with.

**1700**

My third nuts-and-bolts point for you is the ADR provisions: lots of good things in it. It speaks to confidentiality, which is important in any ADR proceeding; it speaks to consent of the parties—of course, absent consent, you're not likely going to get a very good resolution; and it speaks to some independent facilitator, all of which are very commendable. Frankly, for those of us who have had ADR experience, that's the hallmark of our own internal process.

The problem in the proposed legislation, however, is that it proposes that the investigation continue parallel to an ADR process. I can tell you, that won't work. What will happen is that it won't stop the adversarial mechanism that's in place, necessarily. When you have a complainant, in our case a dentist, it won't encourage facilitation. In fact, some wily folks may use the ADR process to try to gear up the college's machinery to gain some ends through the new ICR process. I would urge you therefore to provide for an interruption of the investigation process to allow for a fulsome exchange, for the mediation process to take place in a meaningful way with the parties through the proceedings, namely the complainant and the member, to try to resolve it themselves without having another time clock or another agenda.

My final nuts-and-bolts—I can't tell if this is really drafting or intention. In our college's submissions to HPRAC, we recommended that the complaints committee and the executive committee, now the ICR committee, have the ability to order courses. So if a member has a problem, say it comes out of complaints, the ICR committee identifies legitimately that there are some problems with the member's standards of practice, it would be very helpful for the committee to order that the member take a course. Today we get around it by encouraging the member to sign an agreement, and most of the time the member does. But under the proposed legislation, it appears that it says you need to look at the quality assurance provision. So if you look at subsection 26(2), it says that the ICR committee has similar powers to the quality assurance committee in section 80.2. Section 80.2 says that in order to determine those powers, you need to look at section 82. Section 82 provides for an assessment before there can be some sort of resolution on courses.

It's far too cumbersome. I don't think that was the intention of HPRAC. I think HPRAC really intended to say, "Look, if your ICR committee determines that a member needs to get to a course quickly so that the public is protected, let's not waste time by going to another committee and have another assessment." I don't think that's really what is meant, although I think there is

some clumsiness in the drafting. I would say that if it's drafting clumsiness, let's fix it. If it's intention, then the intention is not going to protect the public. You're going to have the same bad practice or the same standard of practice that's not meeting standards continuing for far too long a period when the primary committee, the ICR committee, will have its finger on the pulse of the member's practice and be able to deal the appropriate courses.

Two very quick items, more philosophical, I suppose: One is the regulatory provisions. Generally speaking, it's very difficult for colleges to get regulations through. There is competing time, I suspect, at cabinet. It's not so easy, and as a result many of our regs don't get the attention as quickly as we'd perhaps like. It might be useful. I'm just a dumb lawyer, so I don't know how this works, but it might be useful if you would give consideration to the minister himself or herself perhaps being able to sign off on regs and give effect to it—just a suggestion.

Second, the public members are wonderful appointments. Part of the problem is that they come with very little education as to the college's processes. They do not understand how much time is committed until they actually get to work. They do not understand their responsibilities until they're given a lengthy orientation.

For us, we're handicapped when a public member's term expires if we're at the brink of our quorum. We've had a situation where we've been below our minimum number of public members, and consequently, it means that the complaints committee, the discipline committee and all the statutory committees of the college can't function. So I would suggest that you might consider, if somebody's term expires, simply having it extended until there's a replacement; or if the government of the day doesn't wish to do that, then to say that by virtue of falling below the minimum, the work of the rest of the statutory committees doesn't fall by the wayside, and there's an implied quorum.

I think that's all I really wished to say.

**The Chair:** We're out of time. Thank you very much.

#### ONTARIO ASSOCIATION OF NATUROPATHIC DOCTORS

**The Chair:** The next presentation is Sheryl Sasseville. I believe I'm pronouncing it—pardon me, I'm out one; the Ontario Association of Naturopathic Doctors. I'm just checking whether you folks are keeping track or not. I make mistakes intentionally once in a while—more as I get older.

**Ms. Ruth Anne Baron:** Good afternoon. I'm Ruth Anne Baron, naturopathic doctor and past chair of the Ontario Association of Naturopathic Doctors. Joining me is Alison Dantas, CEO of the Ontario Association of Naturopathic Doctors, which is the professional association representing Ontario's registered naturopathic doctors. Our purpose for appearing here today is to offer the committee our recommendations for improvements to Bill 171, most importantly to ensure that the Naturopathy

and Homeopathy Act will not reduce the scope of practice that naturopathic doctors currently provide to patients.

Let me start by stating that we welcome this legislation. By improving the regulation of Ontario's naturopathic doctors, this legislation shows a commitment to supporting Ontarians who choose complementary health care by making sure that they have better access to high-quality care.

Ontario now has over 800 naturopathic doctors, more than anywhere else in North America. We are currently regulated under the Drugless Practitioners Act and are highly trained primary care providers with an educational structure similar to that of medical doctors.

Naturopathic doctors practise a unique and comprehensive form of medicine which helps our patients to live healthier lives and has resulted in a growing demand for naturopathic medicine. Naturopathic doctors support and stimulate the body's ability to heal itself, focusing on prevention and the integration of standard medical diagnostics with a broad range of natural therapies. The primary goal of naturopathic treatment is to understand and address the cause of illness, rather than simply treating or suppressing symptoms.

The government committed to us at the outset of the legislative process that their goal was to ensure that we moved into the RHPA with our scope of practice intact, and we've been working closely with them to accomplish this. We would appreciate your support in making these needed changes which will preserve the current scope of practice and treatment options available to our patients.

Certainly we understand the challenges the government has faced in preserving our scope of practice and providing the necessary controlled acts in the move from the Drugless Practitioners Act into the Regulated Health Professions Act. For the most part, Bill 171 has been successful at implementing HPRAC's recommendations on how to accomplish this. I will focus on three critical issues that still need to be addressed.

The first is our scope of practice statement. The proposed statement is simply not an accurate description of our profession and does not fully describe the scope of practice that we currently have under the Drugless Practitioners Act. We are asking for the scope statement to specifically recognize that we perform diagnosis and treat diseases as well as disorders and dysfunctions. The scope statement also needs to specifically recognize the essential approach of naturopathic medicine to treat the whole person, and we have proposed wording in our written submission to accomplish this.

The second issue is the description of the controlled act of diagnosis. Bill 171 creates the concept of a naturopathic diagnosis, and we are concerned about the consequences of establishing this as a concept that appears to be different than a diagnosis made by a chiropractor, dentist or medical doctor. The change of removing the word "naturopathic" is important to us and to our patients, because the ability to have a shared understanding of diagnosis will make it easier to collaborate with other

primary care practitioners. Otherwise, we're just creating silos in the health care system, rather than the kinds of relationships that will benefit our patients.

#### 1710

We're also seeking wording changes to more closely model our controlled act on the current description of communicating a diagnosis under the RHPA, such as specific reference to disease and symptoms. These changes are outlined in our written submission.

The last issue with regard to preserving our full scope of practice is ensuring that we can continue to access the natural substances that are integral to naturopathic medicine. This is essential for the treatments we provide to our patients. The problem is that more and more natural substances are being reclassified as prescription drugs by the federal government and thereby removed from the treatment options available to NDs for their patients. This reclassification is simply because it has been determined that these natural substances are not suitable for over-the-counter sale to the public. The issue then for naturopathic doctors is that unless the province provides us with access to a specific formulary of drugs, these natural substances will also no longer be available for use in naturopathic medicine.

This is why HPRAC recommended we should have the controlled act of prescribing. I can assure the committee that we have no interest in seeking access to pharmaceuticals. However, we need the controlled act to have a mechanism that will preserve our access when natural substances become reclassified by the federal government, as is continuing to happen.

Next, I want to bring your attention to our concerns about how Bill 171 proposes to change our title to "doctor of naturopathy," and the confusion this could create for the public. In short, "doctor of naturopathy" is not the title we use in Ontario. Across North America, this title is understood to be used only by poorly trained, unregulated practitioners. Changing the legislation to permit the continued use of our current title, "naturopathic doctor," will maintain the public's confidence that they are seeing a regulated health care provider.

Likewise, we'd appreciate the college to be named the College of Naturopathic Doctors, and where the legislation refers to "naturopathy," this should be changed to "naturopathic medicine." Getting the descriptions of our profession right is important to the profession, to our patients and to the general public.

The last topic I want to raise today is our concern about a joint college. Naturopathic medicine is a distinct system of primary care that addresses the root cause of illness and disease and promotes health and healing using natural therapies. Preserving and maintaining the tenets of naturopathic medicine is better done by having our own regulator made up of professional and public members.

I think it's clear that the two professions are at very different starting points. The transition for naturopathic doctors to be regulated under the RHPA is going to be quick, efficient and relatively straightforward. We have

been regulated under the Drugless Practitioners Act for over 80 years and we already have standards of practice, eligibility requirements and a united profession.

We are concerned also about who is going to pay for transition, given that homeopaths are not currently regulated. Naturopathic doctors are not willing or able to bear the financial burden of regulating another profession. Also, creating this joint college simply adds to the challenge the public has in differentiating between the two professions. I would urge you to let each of our professions maintain our distinct identities and approaches to medicine and move at our own pace by awarding us our own self-regulating college. If a joint college is still the preferred option of the government, naturopathic doctors will work with homeopaths as long as the concerns we've raised regarding financial burden and differing pace of evolving through transition are addressed.

We also have some specific comments on the transition council itself. Naturopathic doctors are committed to modernizing our standards of practice and incorporating the best practices of other regulated health professions as we move under the RHPA. That's why it's important to have a transition council that has broad professional member representation that is selected through a clear and transparent process. We strongly urge you not to make amendments which would limit this fresh start by adding provisions related to the transition council, unless it's limited to the transfer of assets from our current regulator.

We believe that our amendments will strengthen Bill 171 and allow Ontario's naturopathic doctors to be able to maintain the care that they're already able to provide under the Drugless Practitioners Act. As well, separate colleges will ensure that there's a clear and more effective transition for both of our professions. Our written submission includes more details on the need for these changes and the proposed wording necessary to implement them in Bill 171.

I want to thank all members of all parties for the support you've shown for naturopathic medicine over the years. Thank you.

**The Chair:** I'm afraid we're out of time. Thank you very much.

#### SHERYL SASSEVILLE

**The Chair:** The next presentation is Sheryl Sasseville. Welcome.

**Ms. Sheryl Sasseville:** Thank you.

Good afternoon. I'm Sheryl Sasseville. I'm owner of Onsite Dental Services in Sudbury.

Mr. Chair and members of the committee, thank you very much for the opportunity to speak to you today. I'm a registered dental hygienist who has been struggling to work in long-term and residential care homes for the last four years. I'm here today to represent myself and this population in Greater Sudbury of about 5,500 seniors.

The following have been my experiences that I have been struggling and celebrating for the last four years. It will serve to create an abstract of current situations at hand and hopefully answer any questions brought forth. The year 2007 is a happy year for me because the Legislature's decision on the passage of the amendments on the Dental Hygiene Act in schedule B of Bill 171 either reinforces or clearly states to me that the long road I have travelled will have been worthwhile and that the struggles I have been dealing with can finally stop.

Please allow me to state my business's mission statement, which I wholeheartedly believe in and follow with accuracy: "Onsite Dental Services strives to provide services to individuals who have difficulty obtaining dental treatments through conventional dental practice settings. We endeavour to help maintain optimal oral health with all citizens and our clients and encourage the highest quality with respect to current standards."

Many months of applying to conventional dental practices with seven years' experience proved to me that there are very few job openings in Sudbury for dental hygienists. Unable to find a job in a dental practice, in January 2002 I started a two-year study complete with surveys, statistical review and pro forma financial projections to see if an independent dental hygiene service would be beneficial and successful in long-term-care homes. There was no service of this kind and no previous attempts to start this type of service, at least of which I was aware. Not only did I find the service would be used but it was also very much appreciated, due primarily to residents' mobility barriers.

Knowing that I needed an order from a dentist, I brought forward my idea to a local dentist whom I worked for years ago. Not only was he excited, but he told me that my timing with this idea was impeccable because this was an issue the dentists were addressing at their last society meeting one week prior. They were not able to solve the issue of long-term-care homes, and he thought this was a wonderful solution.

Anxious to bring the idea forward to his peers, he told me he would contact me as soon as the meeting took place. He told me after that even though my idea would solve their dilemma, it was not only turned down but it turned into a very heated discussion with dentists upset about a dental hygienist working in this capacity. I offered to go to their next meeting to explain the findings in my survey and how much this service is needed. The dentist told me honestly that he thought it would be like throwing me to the wolves.

He believed along with me that this service was required, and started coming in with me to long-term care, examining patients and signing orders for the much-needed cleanings. Unfortunately, he moved away after about a year of working with me, leaving me to seek help from other local dentists.

After he moved away, I made many attempts to have some of the over 70 local dentists participate with me. Yearly mass mail-outs explaining my services and asking for help have gone out to every local dentist, with not one

response, either positive or negative. Several times, I have formally requested to meet with the local dental society to make a formal presentation on how necessary it is to provide onsite services to this population of Sudbury who cannot get out, and each time I was verbally denied the opportunity.

Acquiring participation from the local dentists has been a struggle from day one and continues to be a struggle, including being denied orders from residents' current dentists, to driving all over the city with charts to obtain an order. I have been verbally abused by dentists, had dentists demanding commission from my work and had one dentist who told one of my clients' power of attorney that what I am doing is illegal. I received one order from a dentist to proceed with the cleaning for one of his patients, but he then refused to sign the client's insurance claim form and subsequently sent me a letter citing that he would not participate in my "back door" efforts.

**1720**

For approximately one and a half years, two local dentists have been signing orders for me to provide services based on my completed charted assessment findings after I physically take each client's chart to their dental clinic. Before agreeing to this process, the dentists contacted their college to ask them if it is permitted. The RCDSO told them that due to the clients' circumstances, it would be allowed without concern of my level of education above and beyond what I have acquired through post-secondary education and ongoing courses. This went on for about a year.

In June 2006, the two dentists called me to a meeting, telling me that they would no longer sign orders for the clients unless they examined them first. Seeing that there were no dentists accompanying me to the long-term-care homes, they requested that all of my current and new patients visit their offices. I explained that residents in long-term care signed up for my service because they cannot or will not attend a traditional dental practice for a variety of reasons. Reasons varied from being too stressful on the resident, medication timing issues, wheelchair access, transportation issues, incontinence, family support attendance, money, forgetfulness and many more. "That's what the Handy Transit is for," was the dentists' response. "Book the Handy Transit, fill it with 15 or so seniors and bring them to our office for exams." I inquired, "What is Mrs. X with Alzheimer's and incontinence issues supposed to do for hours while the other 14 clients are being assessed, not to mention the confusion, missing meals and medications?" I contacted many patients to notify them to visit a dentist's office for an exam and was told in many cases that it was impossible to do so. They are upset because they are going to no longer have this service due to new barriers put in place by dentists.

With dentists no longer providing support, long-term-care residents will lose the service that I am offering and revert to emergency care only, with which this model would require transport every time to a dental clinic: no more preventive care, oral hygiene instruction or advo-

cating proper oral health, and therefore little, if any, improvement to overall health; no more proper screening for potential oral cancerous lesions and prompt early care; no opportunity to truly study dental issues in the aged and no furthering of the science; and a sudden and unnecessary ceasing of the excellent oral hygiene they maintained prior to entering long-term care.

I was assured in June 2006 that ongoing efforts from dentists were being made to try to get more dentists to accompany me for dental exams in long-term care. It is now April, 11 months later, and not one dentist has entered a long-term-care home. I have advised these homes and the clients' family members that at present I am not giving up, and have asked for their assistance in calling the dentists, politicians and other large organizations.

I read in an Ontario Dental Association magazine that provincially there are over 900 dentists working in long-term-care homes. Where are they? Precisely, the article states that over 900 dentists are on a list of having provided a service in a long-term-care facility. The article does not state how often service was provided. Therefore, in theory, a dentist visiting a sick relative and rendering some dental care four years ago is now on the list of practising within a long-term-care home. I can attest that in my city, dentists do not visit long-term-care homes due to the facilities' not having proper equipment such as a dental chair. Forget that, all the while, Mrs. M has an abscess that she has tolerated for some months. Because there is no dental chair and she cannot get out, the abscess will eventually cause a systemic infection that will cause her complications due to her already compromised health status and, further, the routine medications that she takes because of her advanced age now complicate her recovery. I have all of the equipment required to meet the standard of care, including a dental chair and a registered portable X-ray unit. I have been using this equipment without issues or errors for four years.

**The Chair:** You have one minute.

**Ms. Sasseville:** Two dentists have used my equipment for fillings.

I would like to finish now on my latest struggle. A month ago I was told by a dentist that there are now 25 local dentists who are signing up to help me in long-term-care homes. They also want to use Sudbury as a pilot project for long-term-care homes for the rest of the province. I have to ask myself why, in the last four years, I have struggled so hard for support, and now suddenly there are 25 dentists who want to help me. The only conclusion I can come to is this bill. The dentists want to take all of the systems I have developed and put into place to implement in other long-term-care homes throughout Ontario. If the dentists' concern is truly to care for the residents in these homes, they would have started helping me four years ago, when I began, not starting at full tilt when there is the possibility of this bill being passed.

At their last meeting, I was told by a dentist that one of these 25 dentists expressed concern that if this bill passes, I will open up a private dental hygiene—

**The Chair:** I'm sorry. We certainly will finish reading it prior to deliberations. We appreciate your being with us.

**Ms. Sasseville:** Okay. Thank you.

ESTHER ALLEN-FOGARTY

**The Chair:** The next presentation is Esther Allen-Fogarty.

**Ms. Esther Allen-Fogarty:** Good afternoon. My name is Esther Allen-Fogarty. I'm a nurse practitioner, RN(EC), BSCN, master's in nursing. I hold certificates in diabetes and an aeromedical certificate as well. I'm 14 years an RN and five years an RN(EC)/NP. The majority of my nursing career has been in northern Ontario rural areas. I'm presently a proud member of the Espanola star family health team. Yes: Espanola, on the map.

*Interjection.*

**Ms. Allen-Fogarty:** That's right. That's why I wear my Liberal red today.

**The Chair:** If they're bothering you, I'll take care of them.

**Ms. Allen-Fogarty:** I get extra time heckling with you guys.

I want to speak to you today re: the amendments to the Nursing Act, 1991 made in Bill 171. Specifically, section 14 of the Nursing Act is amended by adding the following subsection: "Individual drugs or categories." In subsection 1.1, "A regulation made under clause (1)(d) may designate individual drugs or categories of drugs." The addition is "categories of drugs."

As stated by the Honourable Mr. Smitherman on January 30, 2004, the goal of the Health System Improvement Act is to increase Ontario's access to services and regulated health care professionals. Amending the act to include categories is a step in the right direction to increase access to care, but I argue that the amendment is grossly insufficient in enhancing the services the NP can provide to patients. Why is the amendment insufficient? Because it doesn't remove the barrier of the list of drugs, now to be a category list. It doesn't allow flexibility to address the clinical nuances of individual cases. It doesn't eliminate the barrier of the lab and diagnostic imaging list.

Firstly, speaking to the barrier of the drug, now to be a category list, this list of drugs and categories does not keep pace with the most recent scientific research. For example, the vaccine Gardasil, which prevents cervical cancer, is now on the market and MDs can prescribe it. Yet the NP cannot prescribe Gardasil because it is not yet on the list.

Not having expedient access to new vaccines undermines my ability to meet the mandate of the scope of my practice, which is to prevent disease—College of Nurses of Ontario, 2004. It takes years to have the list amended through an act of Parliament. Proof in point: the 2005 proposed amendments to the drug list were just approved in March 2007—see the CNO website.

Secondly, it doesn't allow flexibility for the NP to address the clinical nuances of each case. NPs deliver essential primary health care services in multiple settings. It is not logical that a specific drug list or categories will ever be comprehensive enough to cover all the clinical nuances of each case.

In summary, the NP is quite competent and capable of ordering and adjusting medications. This is supported by a Carryer, Gardner, Dunn and Gardner article in 2007 that says that NPs are capable of synthesizing the appropriate multiple disciplinary guidelines and, combined with clinical judgment and experience, are capable of prescribing the appropriate pharmaceutical intervention based on the individual needs of the patient. Presently, we're limited by the drug and lab list barrier.

It doesn't get rid of the lab diagnostic imaging list; it's a specific list of what NPs can actually order. For example, we can order arm X-rays, leg X-rays and abdominal ultrasounds. But if the patient needs a shoulder X-ray or to be screened for prostate cancer or osteoporosis, they unnecessarily need to see another health care professional or they go to the ER or they go to a walk-in to have the test ordered as the NP is not able to order them the specific lab test. The barrier of the lab list prevents me from meeting my mandate of screening patients.

So what's the solution? The solution is to adopt the college of nurses' recommendation. In 2006, the College of Nurses of Ontario proposed the following amendments to the Nursing Act: The RN(EC)/NP has the authority to prescribe, dispense, sell or compound a drug, removing any reference to drug category, scheduling or a list in regulation. This amendment "would allow the RN(EC) the authority to openly prescribe, which enables the nurse practitioner to meet the needs of their client and keep pace with current practices"—College of Nurses of Ontario, 2006, page 3.

The College of Nurses also requests that the requirements for the performance and ordering of controlled acts be detailed in standards of practice of the RN(EC) and not in the regulations. This will remove the laborious process of amending the act when a revision to a drug category and lab lists is required for improved patient care.

**1730**

Now I'd like to speak to the myths or the fears around a nurse practitioner being able to openly prescribe. One is that open prescribing for NPs is new, that patient safety would be jeopardized, and that it also changes the focus of nursing.

Nurse practitioners prescribing can be traced back to the early 1990s when it was becoming increasingly acknowledged that nurse practitioners were being held back by their lack of prescription authorities; this is from Culley, cited in Wilson and Bunnell. In over half of the states in the United States, NPs have open prescribing authority to prescribe all medications; this is Running, Kipp and Mercer, 2006.

Since May 2006, British nurse practitioners have had the majority of their prescribing restrictions removed and

are able to prescribe all medications, except for some controlled medications—cited in Wilson and Bunnell.

Unlike Ontario, which has a list of medications and conditions in which the NP can prescribe, the College of Registered Nurses of British Columbia has developed a very short list of drug restrictions that the NP cannot prescribe. This gives the BC NP the flexibility to prescribe broadly in order to meet the needs of the patients. The Northwest Territories, Newfoundland and Labrador, and Nova Scotia can also prescribe very broadly.

Patient safety is a paramount goal of the NP. According to Carryer et al., 2007, such fears of patient safety are unsubstantiated in any scientific literature.

Why is it safe for NPs to prescribe? It's because we are highly trained in advanced practice and prescribing, according to Wilson and Bunnell, 2007.

In Ontario, the nurse practitioner is trained in therapeutics—prescribing medications and counselling—and must successfully complete the COUPN exam, the provincial exam, and then another 1,800-hour review proving their competency to practise as a nurse practitioner, including diagnosing and prescribing medications. This is from the College of Nurses, 2007.

An increasing number of NPs, like myself, are master's-prepared. We're also mandated by our college to be continuous learners.

It has been found that NPs have similar prescribing habits and outcomes as physicians. This speaks to places that have nurse practitioners who are openly prescribing. According to Moody, Smith and Glen, cited in Running, 2006, who have researched nurse practitioners' prescribing habits, physicians' and nurse practitioners' choices of medications, diagnostic screening and diagnoses were very similar. The differences they found: The NPs were more likely to provide teaching and counselling as their most common therapeutic service.

In summary, the studies show that NPs are cautious, competent and safe prescribers. They have similar prescribing patterns to physicians and achieve comparable outcomes; this is Wilson and Bunnell, 2007.

Nurse practitioners openly prescribing does not change the focus of nursing. Carryer, Gardner, Dunn and Gardner, in 2007, found that the additional function of ordering diagnostic tests and prescribing does not change the focus of nursing but actually improves access to services by allowing the NP to provide the full exposure of care. This is our goal with this bill.

The NP continues to focus on illness prevention, health promotion, education and follow-up compliance—Running et al., 2006.

What are the benefits of adopting the College of Nurses' proposal? You're going to have increased access to care. Having nurse practitioners prescribe and order diagnostic tests builds capacity—that's what we're trying to do—into the service, therefore increasing access to care. The NP who can openly prescribe according to her skills, experience and knowledge will instantly increase access to care by speeding up the treatment process and patient comfort.

In conclusion, NPs who openly prescribe do so safely, appropriately and cautiously while still maintaining a nursing focus of health promotion and disease prevention. It's time to adopt the recommendations of the College of Nurses of Ontario, which is to amend the Nursing Act to allow the nurse practitioner to openly prescribe and order diagnostic testing that is appropriate; also, that the requirements for the performance and ordering of controlled acts be detailed in standard practice and not in regulation. This change will allow for greater flexibility and independence in meeting the needs of the evolving health care system—

**The Chair:** I'm sorry. You're a fast talker, but I'm sorry.

**Ms. Allen-Fogarty:** Thank you for the opportunity to speak to the committee.

**The Chair:** We have your written submission too. Thank you.

#### ONTARIO TRIAL LAWYERS ASSOCIATION

**The Chair:** The next presentation is the Ontario Trial Lawyers Association.

**Mr. Duncan Embury:** Good afternoon, members of the committee. My name is Duncan Embury. I'm on the board of directors of the Ontario Trial Lawyers Association. You may note that you don't have any written materials from us. They will be coming tomorrow, and I apologize for that.

The Ontario Trial Lawyers Association is an organization of plaintiff trial lawyers from across this province with 1,250 members. Our mission is to represent the interests of people who have been injured through the wrongs of another and to ensure access to justice in all facets.

A few weeks ago, our Minister of Health said that transparency is the dance partner of accountability. That, in our view, is what is required when one looks at amendments to the Regulated Health Professions Act—accountability and the transparency that's necessary to get us there. I want to make three points before you today in terms of where that transparency is lacking or where it could be improved.

HPRAC in 2001 encouraged public access to information about doctors from the college. Bill 171 goes partway there with the changes to section 23 of schedule 2 of that act, but in our submission it should go further. That provides that a public register, accessible to the public, contain certain information at the college. You will see when you get our written materials that we recommend that that register be broader than what is contained in the legislation. It should contain a reference to the status of all complaints against a physician or other health care practitioner upon final disposition. It should contain all oral or written cautions issued against a health care practitioner, the terms and conditions or limitations imposed against that practitioner, the results of negotiated resolutions that result in any sanction, relevant

findings from other regulatory agencies and, in our view, it should contain the disposition of all lawsuits.

We say this for this reason: The public is entitled to information. They can act on it, and they can act responsibly. There is no suggestion, nor is there any evidence, that they can't. A few recent examples that have made the headlines across this province are enough to show that the public, without that information, is placed at harm. The public should not be placed at harm; that's what accountability is all about.

As well, in section 26 of that same schedule there is reference to the fact that the panel may have reference to prior decisions, unless the decision was to take no further action. We say only this: That exception should be removed because if there is a history of complaints being made, that should inform the panel hearing it to act otherwise than they might if it was the first complaint. That's a good thing for Ontarians because it ensures that where there's a pattern of mismanagement or incompetence by a physician, it is picked up as quickly as practicable by the college and dealt with, rather than a situation where, as in some recent cases, over 10 serious complaints were made before any action was ever taken because the prior complaints were never looked at. People were injured, and they were injured very badly, as a result of that failure.

The last issue in terms of transparency that I point this committee to is subsection 36(3) of the Regulated Health Professions Act. It's a section that's in force now and it is one where, by way of this bill, no suggestion is being made to change it. It is a section that provides that no document, report or written communication prepared for the purpose of a college complaint, including the decision of the complaints committee of the college, is admissible in a civil proceeding. There is no other profession that has that immunity. There is no other province in which regulated health practitioners have that immunity other than this one. It has resulted, at least in one recent situation in the college, having found that a doctor was far below the standards of his practice.

**1740**

When the child who was injured as a result of that substandard practice went to trial to get compensation to which he was justly entitled, the court—having no reference, of course, nor being advised of what the doctor's own college, the people in the best position to assess the care, had found—found that the doctor met the standard of care. That child has no compensation and will never have compensation.

That is not an accountable system. There is every reason to suggest that the college has the expertise to properly investigate and regulate its own, and it has done so quite well. But to not allow that access to information, either to the public through the means of the register, to the courts or others, in order to allow a consistent system, is folly, in our view.

The last point I simply make is this: There is, in the proposed amendments, a suggestion to increase the timing through which complaints are dealt with from

what is currently 120 days to 150, plus 60 in the event that it's not decided within 150—so, to 210 days. There is, in our submission, no purpose to be gained by that; rather, it appears to be a result of the fact that certain complaints have not been dealt with historically within 120 days. We say only this: If there is undue delay in the system, then the system should be addressed rather than moving the goalposts, because that doesn't do Ontarians a service. They're entitled to a prompt response, and the college has the means to do it, and it should be left the way it is, with encouragement that they do so within those parameters.

There are further points raised in our written submissions. I hope you will find them useful, and I certainly thank you on behalf of the Ontario Trial Lawyers Association for the opportunity to address this committee.

**The Chair:** Thank you. There's time for one quick question per caucus. Ms. Martel.

**Ms. Martel:** What has been your experience with respect to decision-making in a timely and prompt way; i.e., in accordance with the law?

**Mr. Embury:** It very much depends. I can speak only anecdotally and personally to that. In a large number of complaints, the complaints committee has the expertise within the committee to address them. There are other situations where they require or request an independent assessor to review, and it is typically those situations that cause the delay, because of course there's someone else's schedule to be considered, and obviously those are situations of complexity. Perhaps the way to address that is to suggest that if there is an independent assessor, add 30 days or 60 days for that rather than change the entire process by what is now a 90-day change, in effect.

**The Chair:** Mr. Fonseca.

**Mr. Fonseca:** Thank you very much for your presentation. In this legislation we're looking to provide greater access to information to the public. Through the colleges, they would now be required to make sure the public has access to them for information in a timely manner; so, as soon as they ask for it of the college during regular work hours. They also have to put this information on their website.

Do you feel there are other measures that could be taken further, and what do you think of these ones?

**Mr. Embury:** I think those are probably very sufficient. I think, at this point, people use the website more than almost anything else. To us, it's a question of what information we are dictating to the college needs to be brought forward to the public. The public, as I say, in our view, has a right to know, and they are responsible people who can make competent decisions if given proper information.

**The Chair:** Ms. Witmer.

**Mrs. Witmer:** Thank you very much for your presentation. This right to know—which is really important, I think, particularly in light of some of the media coverage where obviously individuals didn't have information:

How far do you think that right to know should go? There's always that fine balance.

**Mr. Embury:** It seems, in our submission, that it should include all complaints that have been made; the outcome of those complaints, whether positive, negative or otherwise; the results of negotiated deals; and lawsuits, because, at the end of the day, in our submission it will be the minority of physicians or other health care practitioners who say, "No, that's not okay. We can't have that." Most are absolutely okay, in our submission, with the public knowing what their track record is. They're entitled to know that information to make a competent decision.

**Mrs. Witmer:** Thank you very much.

#### ASSOCIATION FOR REGISTERED HOMEOPATHS OF ONTARIO

**The Chair:** The next presentation is the Association for Registered Homeopaths of Ontario. If you would state your name for Hansard, you have 10 minutes.

**Ms. Ghislaine Atkins:** Good afternoon, ladies and gentlemen. My name is Ghislaine Atkins. I am the president of the Association for Registered Homeopaths of Ontario. This association has been recently created by a group of homeopathic practitioners who had at the time also recently graduated. As we were entering a new career in a profession about to become regulated, we felt it was our duty to become involved in the regulation process in order to better ensure the protection of public health.

There are four topics that I would like to address today. The first is why homeopathy should be regulated. ARHO believes that there are direct and indirect risks of harm arising with homeopathic treatment when prescribed by a non-qualified practitioner, as a result of an incorrect assessment, failure to refer or fraud. Some examples of direct risks are adverse reaction and interference of remedies with non-compatible conventional drugs. Examples of indirect risks are wrong diagnoses; failure to identify a critical state of disease, which could lead to delay of effective therapy; disregarding contraindications; discontinuation; potentially hazardous diagnostic procedures; and interference of remedies with conventional treatments.

The second reason we believe homeopathy should be regulated is the increased demand of the public. Patients wish to take the lead in their own health care decisions, including treatment outside of traditional medicine. Therefore, there is an increased need for public accountability. Patients should have the confidence that those who provide their care are adequately trained; operate within an appropriate scope of practice, professional and ethical standards; and provide safe care.

To conclude on this topic, ARHO agrees with the HPRAC recommendation that statutory regulation under the RHPA represents the best approach to providing public protection, quality care and public accountability for the homeopathic profession.

The next topic is related to the detailed scope of practice. ARHO approves the HPRAC recommendation not to grant homeopaths access to the following controlled acts under RHPA: communicating a diagnosis; performing a procedure on tissue below the dermis; administering a substance via injection or inhalation; applying or ordering the application of a form of energy prescribed by the regulations under this act; and prescribing, selling and compounding drugs.

Similarly, ARHO believes that homeopathic doctors should not be engaged in a disease diagnosis approach. Homeopathy is a complementary and alternative system of medicine to conventional and other alternative medicines. Those conventional and other alternative medicines already have access to these acts, and those acts are out of the scope of homeopathic practice principles. Instead, ARHO suggests that an increased reliance on homeopathic medicine will encourage collaborative practice between homeopathy and conventional medicine.

The next topic is educational requirements. We believe there are two important principles associated with homeopathic medicine that need to be transmitted to future homeopaths. The first is understanding a disease, but most importantly, the various stages of a disease, in order to be able to identify the need for appropriate treatment and to understand the function and impact of modification in order to recognize what symptoms are drug-related.

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The second objective is to ensure that future homeopaths differentiate between common symptoms of a disease and those unique to these individuals. In other words, it is important that homeopath practitioners practise according to homeopathic medicine principles. To support those homeopathic medicine principles, specific educational requirements exist. I would recommend the following education standards as per the homeopathic standards issued by the Homeopathic Medical Council of Canada in 1999. Those standards require minimum hours of education in medical science courses provided by accredited teachers of medical science and according to the HMCC accreditation of teachers. Those are listed below.

Similarly, a minimum of hours of education in homeopathic courses, clinical externship and other related courses by accredited teachers of homeopathic science according to the HMCC accreditation of teachers are required. Those are also listed below for your information.

The last, but not least, concern touches on the remedies that homeopath practitioners should have access to and other alternative medicine and conventional medicine. The first one is that the prescription of remedies of a 200 CH potency and up and certain low dilutions as stated in the Homeopathic Pharmacopoeia of the US be the exclusive jurisdiction of homeopathic doctors and other health care professionals properly trained in homeopathy.

The second item is that remedies made from narcotics, biological poisons, venoms and diseased human tissue be granted as the exclusive domain of homeopathic doctors and other health care professionals properly trained in homeopathy.

I will end this presentation with a couple of words on the future. The Association of Registered Homeopaths of Ontario would be pleased to assist and volunteer in the further development and implementation process of the regulation of homeopathy or in any other associated activities. Thank you for your attention.

**The Chair:** Thank you. There is time for 40 seconds per caucus, starting with the government.

**Mr. Kuldip Kular (Bramalea–Gore–Malton–Springdale):** First of all, thank you very much for coming out and taking time to present before the committee. I'm a medical doctor turned politician, so I have two questions for you. The first question is: What's your opinion of having a common college of naturopaths and homeopaths? You said you recently formed this association. How long has this association been in existence; how many months, how many days?

**Ms. Atkins:** To answer the first question, I believe it is a good thing that naturopathy and homeopathy are regulated under the same college as long as, as the previous speaker mentioned, they are still separated into individual colleges.

Secondly, the association was created in December 2006.

**The Chair:** Thank you. Ms. Witmer.

**Mrs. Witmer:** Thank you very much for your presentation. I see that there is some difference of opinion amongst some of the homeopaths. You've indicated here that you agree with the recommendation not to grant access to the following five controlled acts. Do you want to explain exactly why you feel that way?

**Ms. Atkins:** We believe that this is out of the scope of the homeopathic principles. There are conventional medicine professionals and other alternative professionals who have access to those acts, and the opinion of the association is that we should work together and not try to go on to the practice of something that we haven't been properly trained for.

**Mrs. Witmer:** So the key is "not properly trained for"?

**Ms. Atkins:** Right. So we do have a certain education, but not enough to give us this ability.

**The Chair:** Ms. Martel.

**Ms. Martel:** We do note the differences, but that's why it's good to have public hearings. That's what it's all about. I just want some clarification around the college, because the current proposal is a dual college.

**Ms. Atkins:** That's right.

**Ms. Martel:** So is your association in favour of that, or do you want a separate college? I didn't clearly understand the previous response.

**Ms. Atkins:** The same college is fine as long as, again, the rules that will govern education for both practitioners, naturopathy and homeopathy, are different.

**Ms. Martel:** So your concern is around the educational qualifications of the practitioners.

**Ms. Atkins:** Absolutely.

**The Chair:** We're out of time.

#### NORTH AMERICAN SOCIETY OF HOMEOPATHS

**The Chair:** I would call now for the North American Society of Homeopaths. You have 10 minutes. Please state your name first for Hansard.

**Mr. Basil Ziv:** My name is Basil Ziv, and I'm here with my colleague Jim Roy. We very much appreciate the opportunity of meeting with you today. We are here to convey the significant concerns of many in the homeopathic community concerning the proposed Naturopathy and Homeopathy Act in schedule P of Bill 171, the Health System Improvements Act.

Jim Roy and I are members of NASH, the North American Society of Homeopaths. I practise homeopathy here in Toronto and am board-certified. Jim has extensive experience as a management consultant and is a student of homeopathy.

Since 1990, NASH has pioneered the concept of voluntary self-regulation. Accordingly, NASH-registered homeopaths adhere to a strict code of ethics. NASH has advised a number of jurisdictions across North America on how best to foster self-regulation.

Jim and I have been involved in facilitating discussions among different groups in the Ontario homeopathic community regarding this regulation project and have met with officials of HPRAC. As well, I assisted NASH in conducting a survey of 10 homeopathic associations and schools operating in Ontario and a number of individual homeopaths to get their feedback on the Ministry of Health's decision to regulate homeopathy and compel us to enter into an arranged marriage with the naturopaths.

Before we provide you with NASH's feedback on the Ministry of Education's decision, I would like to take a few moments to share with you our understanding of what homeopathy is, its uniqueness and its place in the overall health system. Mahatma Gandhi, who saw the impact of homeopathy on a large percentage of the population of India, said, "Homeopathy cures a larger percentage of cases than any other method of treatment and is beyond all doubt safer, more economical, and the most complete medical science."

If you're not already familiar with homeopathy, this may appear to be an audacious statement, but bear with me. I will explain it, and you will see how this vision of homeopathy guides our perspective on the regulation project and our recommendations.

What Dr. Samuel Hahnemann, the founder of homeopathy, revealed some 200 years ago in the *Organon of Medicine* was a revolutionary method of treatment which focused on the core complaint of the patient and found a remedy that would bring the patient safely to a complete state of cure. This is radically different from other

healing modalities, which are focused on the management or elimination of certain symptoms without curing the whole patient. Homeopaths bring their patients to a complete state of health using safe and inexpensive remedies taken from the animal, plant and mineral kingdoms. This is certainly the most economic way of dealing with the serious and chronic health challenges faced by so many in the population, which place an enormous burden on our publicly funded health system.

I would now like to call on Jim to share with you our feedback and recommendations.

**1800**

**Mr. Jim Roy:** As mentioned by Basil, we've been very much involved. We have a homeopathic community which, you all realize, is quite split. We worked in a coalition, trying to bring some understanding and to work with HPRAC. Unfortunately, we have to say that we feel that the HPRAC process, in regard to homeopathy, was flawed really due to, I think, a lack of adequate resources and time and the complexity of the issue that they've had to face. They haven't been able to keep to their published principles and processes. This would be, I would say, one situation where public consultations would have been essential. Why? Because they're coming up with a proposal which is not what came from either the consensus of the community or even one group in the community. They had solicited the Ontario Homeopathic Association to put in a proposal, and yet what we've seen coming out of this is actually HPRAC picking up another proposal and adjusting it from the naturopaths, in which they've indicated that, frankly, another health care profession distinctly different from our own is going to be given a role of stewardship over our own profession.

Ontario homeopaths, under common law, have the right to practise their profession even in the absence of statutory regulation, as long as their occupation does not present a substantial risk of harm. Like all healing professions, the homeopathic practice is an occupation of common right. We contend that HPRAC has failed to prove scientifically that the homeopathic profession meets the first criterion under the Regulated Health Professions Act, namely, that it's a modality which would pose a substantial risk to a patient if exercised by an unqualified practitioner.

We do not, though, oppose in principle statutory regulation for a new model of primary care practitioner which includes homeopathy. Therefore, we would also add on some of the controlled acts, and you can see that there's an argument as to which of the controlled acts. I think that speaks to the real point we're all trying to get to: What is the definition of a profession? Because we're not regulated—and these are critical, that they'll make us regulated—and we have significant differences, it's really pick and choose as to which ones they want to put in. Frankly, we feel that the critical reason is simply to trigger regulation, as opposed to improving homeopathy and the care we offer to people and, certainly, the protection to the patients.

What we strongly object to, though, is the redefinition of the existing model of homeopathy in order to require all homeopaths to become primary care practitioners and therefore to be brought under statutory regulation. We really see ourselves in partnership with medical doctors and naturopathic doctors. In our own code of ethics and that of other associations, we have to advise the patient, "Make sure you've got a doctor. Make sure you get a diagnosis. Make sure that your case is being properly managed." We have a wonderful health care system in this province which provides for that and even provides it free of charge. So we want to work together; we do work together with these other practitioners.

We feel, therefore, that HPRAC has failed to prove that criterion number 7 of the RHPA has been met, namely, that such a redefinition and decision to regulate has the support of the majority of our profession. I think today it has been proven to you. We estimate that there's a minority of approximately 200 homeopaths—the OHA was here; we have the most recent, newly-brought-in group. They're part of that camp, so to speak, that seeks to become primary care practitioners with the controlled acts. There is a majority of approximately 700 homeopaths who are happily performing homeopathy and curing patients without access to the controlled acts.

**The Chair:** One minute.

**Mr. Roy:** Basically, then, we would ask that there be amendments made to the act. We certainly would want to see the naturopaths and the homeopaths separated, because there are clearly different distinctions, and there are Competition Act issues that you'd have to watch for. But most importantly, we would like the homeopaths to be able to continue in our path of self-regulation, where we certify our people according to international standards.

Thank you.

**The Chair:** Thank you. There about 30 seconds for the three parties, so is there one question out of—

**Mrs. Witmer:** No; I'd just like to make a comment. You've identified an issue which is of big concern to myself and our party, and that is the lack of consultation on such a huge piece of legislation. As we listen to you today and all the submissions come into our offices—we are trying to do so much in this huge omnibus bill. My major concern is that we will not get it right, and the people who are going to suffer are the people in the province of Ontario. To be quite truthful, I don't feel I'm in a position to make some of these decisions, and I believe that there are experts who need to make some of these decisions. So I think we're going to end up with a bill that obviously doesn't meet the public safety needs.

**Mr. Roy:** We would—

**The Chair:** I'm sorry. We're out of time.

**Mr. Roy:** Thank you very much.

#### PERTH DISTRICT HEALTH UNIT

**The Chair:** The last presentation is Perth District Health Unit. I always confuse the town of Perth with the county of Perth. Are you the county of Perth?

**Dr. Rosana Pellizzari:** We're the county of Perth; that's correct.

**The Chair:** Okay. Thank you. I'm more familiar with eastern Ontario.

**Dr. Pellizzari:** You must come and visit us some time.

**The Chair:** Thank you. You have 10 minutes.

**Dr. Pellizzari:** Good afternoon. My name is Dr. Rosana Pellizzari. I am the medical officer of health for the Perth District Health Unit, based in Stratford, Ontario. I'm here today on behalf of the Perth district board of health, which in March 2007 passed a resolution calling for an amendment to the Immunization of School Pupils Act. Efforts by Ontario's public health units to ensure that all children receive publicly funded and mandated immunizations in a timely fashion are hampered by legislation that is out of date. Since Bill 171, in schedule E, proposes changes to the Immunization of School Pupils Act that would allow nurse practitioners to immunize, my board of health is advocating for one additional change that would significantly improve the public health sector's ability to protect the public.

The Immunization of School Pupils Act was enacted to increase the protection of children against certain designated and vaccine-preventable diseases. Under this legislation, parents, with certain exemptions, are required to cause pupils to complete a prescribed program of immunization related to these six designated diseases. Contravention of this requirement is an offence and could lead to a fine of up to \$1,000.

As part of the Immunization of School Pupils Act, medical officers of health are required to maintain records of immunization of pupils and to keep under review a record of pupils who have not completed the prescribed program of immunization. Such pupils are subject to temporary suspension from school if parents have not complied with the legislation or even exclusion in the event of a potential or actual outbreak of one of the designated diseases. You may recall that when Oxford county had its rubella outbreak, in fact there were students who were excluded from school because they were susceptible.

Ontario children begin their immunizations at two months of age, with the bulk of publicly funded vaccines being administered before 18 months.

Physicians who provide immunization to children are required to provide parents with a signed statement of the vaccines given, and although not specifically referenced in legislation, parents are expected to provide this to the medical officer of health at the time of school entry.

Although the majority of vaccines are required to be administered prior to the second birthday, school entry occurs at about the age of four to five, some two to three years after the time of the immunization or when it should have been provided. Such a delay in the transfer of immunization information can and does sometimes result in a complete loss of the required documentation, incomplete transfer of information and delay in receipt of protection by immunization. Parental attempts to obtain

copies of immunization records can be thwarted by loss of physician records, retirement and relocation of physicians, and this may require parents to pay additional fees. Failure to obtain copies of lost records can subject schoolchildren to school suspensions, exclusions, repeat immunization and otherwise unnecessary blood testing or unwarranted exemptions. Just last week, I had to write a letter to one of our retired community physicians threatening to make a complaint to the college in order to expedite release of records to parents who had exhausted their efforts to obtain immunization histories for their children.

Vaccines are provided to physicians by the health unit at no direct cost to the physicians, and physicians are paid through OHIP for the giving of immunizations. It certainly seems fitting that a bill to improve the health system not overlook an opportunity to improve the existing system of preventing vaccine-preventable illness in our children, schools and communities.

Under section 38 of the Health Protection and Promotion Act, physicians who provide immunization are required to advise the person providing consent that they should report any adverse reaction to the vaccine to the physician, and they, in turn, are required to report this to the medical officer of health. Section 10 of the Immunization of School Pupils Act currently states that every physician who administers a vaccine to a child shall provide the parent with a signed record.

Ironically, however, physicians are not required to report the fact of the administration of any vaccine to a child to the medical officer of health, nor to seek the consent of the parent to provide information regarding immunization to the local medical officer of health. Your proposed amendments in schedule E fail to address this fundamental flaw in the original legislation. Left as is, if your bill becomes law, the non-reporting of my primary care physician colleagues will only be compounded by the non-reporting of another regulated health profession.

The current method of data collection relating to the immunization of children in Ontario, as I have explained, is inefficient, ineffective and results in added public health costs. While the province has been considering better data collection for almost 20 years through the introduction of vaccine-specific billing codes, this has not occurred and is likely becoming less possible with the continuing increase in the number of vaccines and their many combinations. There's been considerable discussion regarding the value of electronic medical records for all Ontario residents and the sharing of information amongst all health professionals. Such an ideal is unlikely to be available across the province for a considerable time and, even when available, will still require some level of consent for the sharing of information.

The province has an opportunity, by amending section 10 of the Immunization of School Pupils Act through Bill 171, to improve the protection of children from vaccine-preventable diseases, reduce the potential for suspension or exclusion of children from school and improve the effectiveness and efficiency of data collection for im-

munization by medical officers of health. This could be easily accomplished by the amendment of section 10 of the Immunization of School Pupils Act so that any professional administering a vaccine for protection against a designated disease would be required to seek consent for the reporting of the immunization, and with such consent be required to report the immunization to the medical officer of health.

This past January in Perth county, our health unit sent a letter to 343 students and their families, warning them of impending suspension due to deficiencies in immunization. That represents almost 4% of our total student body in the county. First letters are followed by second letters; second letters are accompanied by faxes to physicians with a request for assistance. All this work eventually identified that almost 75% of these children had already had their immunizations and were in fact up to date.

The real problem was that immunization records were missing or out of date, and until physicians and nurses

are required to report, we in this province will continue to spin our wheels, waste time and energy and potentially disrupt the learning of our children, unless we fix the fundamental problem once and for all through a very simple amendment to the Immunization of School Pupils Act. That is what my board is requesting, in addition to your proposed amendments in schedule E. Although simple to do, this change would be by no means trivial. It would in fact unfetter significant public health resources that are currently consumed in chasing missing records so that we in public health could reallocate these very scarce resources to emerging public health issues such as environmental protection and emergency response. Thank you.

**The Chair:** Thank you. There is no time for questions.

It now being precisely 6 o'clock, this committee stands adjourned until 3:30. Just a reminder to committee members that we will be in room 151 tomorrow.

*The committee adjourned at 1814.*

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