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Mardi 24 avril 2007

**Standing committee on
social policy**

Health System
Improvements Act, 2007

**Comité permanent de
la politique sociale**

Loi de 2007 sur l'amélioration
du système de santé

Chair: Ernie Parsons
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LEGISLATIVE ASSEMBLY OF ONTARIO

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

STANDING COMMITTEE ON SOCIAL POLICY

COMITÉ PERMANENT DE LA POLITIQUE SOCIALE

Tuesday 24 April 2007

Mardi 24 avril 2007

The committee met at 1559 in committee room 151.

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 (Mr. Ernie Parsons): I would call the committee to order. I apologize for the late start. Question period went late today, and we are required to wait until the completion of petitions, which is another 15 minutes, so we are now at orders of the day. There is an overflow in committee room 2 for those unable to sit here, and I'm actually speaking to the wrong crowd when I say that.

Each presentation is 10 minutes. You're free to use up to 10. If you finish before the end of 10 minutes, the time will be divided equally between the three parties for questions.

ONTARIO ASSOCIATION OF SOCIAL WORKERS

The Chair: The first presentation is the Ontario Association of Social Workers. I would ask, once you are seated, if you would state your name for the purposes of Hansard.

Ms. Joan MacKenzie Davies: Good afternoon. My name is Joan MacKenzie Davies, and I'm the executive director of the Ontario Association of Social Workers.

OASW welcomes the opportunity to respond to a number of issues related to Bill 171. While our written submission addresses three significant issues—the exclusion of social workers from the Psychotherapy Act and use of the title “psychotherapist,” the amendment to the harm clause and restrictions on the use of the title “doctor” by health care professionals with earned doctorates—my oral presentation will focus solely on the Psychotherapy Act, which as currently drafted excludes social workers. This exclusion, as well as the actual wording of any amendment to the act, is of major concern to our organization.

I want to begin by noting that OASW has been working with the Ministry of Health to find an acceptable solution to address the social work profession's concerns. We also want to thank Minister Smitherman for publicly stating that he intends to present a legislative amendment that will recognize the profession and ensure that social workers can continue to provide important psychotherapy services.

Psychotherapy is a treatment intervention that is provided by practitioners from a diverse array of backgrounds. Among the existing regulated professions, social workers are in fact the largest professional group providing psychotherapy services in Ontario. Moreover, social workers provide psychotherapy services through a wide variety of funded settings and private practices, and in many small rural and remote communities, social workers are often the only profession providing these services.

HPRAC's New Directions report in April 2006 fully recognized social workers as one of the four regulated professions qualified to provide psychotherapy. OASW is very concerned that failure to recognize social workers as equal partners to the other professions authorized to provide psychotherapy will cause members of the public, employers and insurance companies to erroneously perceive our profession to be less qualified to provide these services than members of the existing regulated professions listed in the Psychotherapy Act along with members of the new College of Psychotherapists.

OASW has received legal opinions that confirm the fact that there is no impediment to government making an amendment to the Psychotherapy Act that acknowledges members of the Ontario College of Social Workers and Social Service Workers as qualified to perform psychotherapy. Based on our concern, OASW has proposed an amendment to the Psychotherapy Act that authorizes social workers to perform the controlled act of psychotherapy and recognizes social workers as equal partners to the other professions that are currently authorized to perform this controlled act. Wording for this amendment is provided in our written submission.

I will close by thanking you for this opportunity to comment on Bill 71.

The Chair: Good. We've got about a minute and a half for each caucus for questions. I forget where we finished yesterday, so I'm starting fresh. Mrs. Witmer.

Mrs. Elizabeth Witmer (Kitchener–Waterloo): Thank you so much for your presentation. Certainly we

value very much the work of social workers and also their work in the delivery of psychotherapy services in the province of Ontario.

I've had a chance to hear from many of your members—in fact, I would have to say that your members have probably lobbied harder and more than almost anybody else on this bill in order to ensure that there was no exclusion of social workers. Are you, then, totally comfortable that any amendment that would be forthcoming from the government would be worded as you have indicated it should be here?

Ms. MacKenzie Davies: No, we have not seen wording at this point that would capture the full recognition of social workers as equal partners, and that's really what we're pressing for.

Mrs. Witmer: Right, but you feel that this particular amendment would do that?

Ms. MacKenzie Davies: Yes. We're seeking wording that would authorize us and would ensure that the public and employers—that it would be clear to everyone that it's equal and we're on equal footing.

Mrs. Witmer: And we wholeheartedly would support that. Certainly we would be putting forth that amendment ourselves to make sure that it was discussed and debated.

What about the doctor title? You didn't say anything about that. I've also received quite a bit of communication. I do have social work schools in my riding, and I'm very proud of the education they deliver to our students. Could you just expand on that, please?

Ms. MacKenzie Davies: We believe that use of the title "doctor" should be available to all health professionals who have earned doctorates and who are members of the regulatory college. Our research has indicated, and it was supported in the HPRAC New Directions report, that it really is an anomaly in Ontario, that it does not serve public protection, that in fact the public relies on information about credentials, whether it's a plumber, an accountant or someone who's providing important health care services, to know what their qualifications are. That informs choice.

Mrs. Witmer: So—

The Chair: I'm sorry. Ms. Martel.

Ms. Shelley Martel (Nickel Belt): Thank you for being here today. I was actually very surprised that social workers weren't included in the original bill, and I thank some of your members who sent good letters that I ended up using in the debate to show why this should be the case now.

I want to ask about what kinds of conversations you've had with the ministry since the minister announced the day the bill started that you were going to be included, and whether there is an amendment they have proposed to you that you feel comfortable is going to fix the problem.

Ms. MacKenzie Davies: We don't think that they're a long way off, but we would want to ensure that an amendment is worded in the positive so it authorizes us to perform the activity. We do not wish to be exempted in an amendment or have wording that would suggest

that there was anything less than full authorization, assuming of course that the individual was a member of the Ontario College of Social Work and Social Service Workers.

Ms. Martel: At present, you've seen an amendment. It is, I gather, more in a negative sense, as around an exemption, rather than positive. Have you gone back to the government to say, "This is not acceptable to us. Can we see some other language?"

Ms. MacKenzie Davies: Yes, and we've provided them with a copy of this amendment.

Ms. Martel: So the language you have given to them is the language that we have in the brief, and that's the one you'd like to see in the bill.

Ms. MacKenzie Davies: Yes.

Ms. Martel: Very good.

Ms. MacKenzie Davies: And from the onset, that has been our position, that it needs to be a positive authorization.

The Chair: Mr. Fonseca.

Mr. Peter Fonseca (Mississauga East): Thank you very much, Chair, and the Ontario Association of Social Workers. Firstly, it was always our intent to include social workers, but because it was outside the RHPA, we were going to do it in regulation. But we thank you very much for having so many of your members contact our offices and let us know your concerns.

I'll just read a couple of excerpts very quickly here from the letter that was forwarded to you by Minister Smitherman. He is very well "aware of the valuable contribution made by social workers to the delivery of psychotherapy services in Ontario." And then, just in his conclusion: We "will recognize the profession and ensure that those social workers who provide psychotherapy services associated with the new controlled act will continue to be able to provide these very important services" in the province.

We thank you and your 3,400 members for the great work that you do for all Ontarians.

Ms. MacKenzie Davies: Thank you.

The Chair: Thank you.

ASSOCIATION OF ONTARIO MIDWIVES

The Chair: I would ask next for the Association of Ontario Midwives. If you would state your name for Hansard, please.

Ms. Juana Berinstein: Juana Berinstein, director of policy for the Association of Ontario Midwives.

The Chair: You have 10 minutes.

Ms. Berinstein: Thank you. The Association of Ontario Midwives, or the AOM, is pleased to have an opportunity to address the standing committee on social policy regarding Bill 171 today.

The AOM is the professional body representing midwives and the practice of midwifery in the province of Ontario. There are approximately 366 registered midwives in the province working in over 60 practice groups.

Midwives are autonomous primary care providers regulated and authorized to provide comprehensive care for low-risk pregnant women and newborns and to deliver in both home and hospital settings. Midwives consult with and refer to specialists if clinically indicated during the course of care.

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Our presentation today will focus on our support of changes in Bill 171 that allow for categories of drugs. These changes will have a positive effect on health care by allowing midwives to work fully within their scope, ensuring optimal client safety and best use of system resources.

The AOM strongly supports the addition of drug categories to regulations as outlined in schedule B, section 13, and again in the Midwifery Act, section 11. Currently, regulation limits midwives to a specified list of drugs. As I will explore in this presentation, limiting midwives to a specified list of drugs leads to numerous problems and inefficiencies. Enabling midwives to prescribe and administer drugs from categories, and not lists, is needed in order to enable midwives to provide safe and up-to-date care and in order to ensure an effective and efficient health system.

For the AOM, the addition of drug categories in Bill 171 is a very welcome initiative. In a discussion paper dated May 2004, the College of Midwives of Ontario outlines both potential categories for drugs as well as an approach for working with drug categories. The approach includes providing specific guidance to members on the use of drugs. We strongly feel that the specificity of drug use is best entrusted to the college. It is the college that is best situated to provide standards in which midwives may use drugs of a specific category, as well as recommendations for choice of drug.

Drug categories, for example, are regulated in midwifery legislation in Manitoba, which names categories of drugs in its regulation within the scope of providing maternity and newborn care. There has been no evidence of abuse of this authority. In fact, the scope of practice for midwives naturally limits the usage and prescription of proposed categories of drugs.

Legislating drug categories will more easily enable midwives to practise fully within the midwifery scope. Since legislation of midwifery and the initial development of regulations, there have been changes in the standard of care regarding medications used in the provision of maternity care. Drug categories would enable midwives to respond to such changes quickly and appropriately.

Further, within the context of a shortage of providers, it makes sense to support midwives in the provision of routine maternity care. Allowing for categories of drugs enables midwives to provide care within their scope without the unnecessary involvement of physicians. It allows for the right provider at the right time by freeing up physicians to consult on cases where they are truly needed and enabling midwives to work to their full scope as primary care providers.

Legislating drug categories ensures timely treatment and client safety. It permits midwives to avoid being placed in a situation where they cannot provide the appropriate standard of care to clients simply because government has not been able to amend regulated drug lists in a timely way. By allowing midwives access to drug categories, midwives are better able to provide safe and effective care when research evidence indicates new medications may be required.

As the example of ergonovine maleate demonstrates, listing drugs is simply too restrictive. Ergonovine was one of two medications to control postpartum hemorrhage listed in midwifery regulation and that the second-line drug midwives had available to address situations of postpartum hemorrhage. However, in 2004, due to a raw ingredient shortage, ergonovine was unavailable for a period of time. Again, a drug category of anti-hemorrhagics, versus the specific drug list, in this case ergonovine, would have meant that midwives could have easily switched to another anti-hemorrhage drug in the case of a shortage or unavailability.

Legislating drug categories enables access to timely care. Significant delays to treatment, and costs to the health care system, can occur when a physician consult is required due to restrictions created by regulation but not clinically necessary.

For example, upon routine urine culture to screen for asymptomatic urinary tract infection, UTI, a midwife may find a positive culture. The medical literature indicates that asymptomatic UTI in pregnancy should be treated. Currently, in order to access treatment in this situation for her client, a midwife must call the client and ask her to book an appointment to see her family doctor or to go to a walk-in clinic if she doesn't have a family doctor. The midwife will fax the lab report and a consult letter outlining the need for treatment of asymptomatic UTI in pregnancy to the family doctor or clinic. The client sees her doctor for treatment, and three weeks later she returns to the midwife for a routine prenatal visit. The midwife, who has reasonably assumed that the doctor has prescribed the appropriate treatment for the UTI, discovers that the family doctor, who likely doesn't practise obstetrics, has indicated to the client that they do not treat asymptomatic UTI. The midwife must then consult again with the doctor or walk-in clinic to ensure adequate treatment of UTI. Considering that the risk in pregnancy of asymptomatic UTI left untreated is ascending infection, this lack of timely access is a client safety issue.

Legislating drug categories will support interprofessional relationships. A common intrapartum issue is the prophylactic treatment for women in labour who have a positive group B streptococcus or GBS screen. The standard of care in most communities is to offer every woman who has screened positive for GBS antibiotics in active labour. While midwives can administer this treatment, they are unable to order the necessary drug to ensure prophylaxis under their own authority. As is the way with birth, active labour so often occurs outside of daytime hours.

Currently, this means that midwives must wake their obstetric colleagues from much-needed sleep every time they have a client requiring GBS prophylaxis, in order to be able to access the medication required. This is disruptive to the obstetrician on call, an unnecessary added cost to the system and an unnecessary delay in treatment. Such restrictions have the potential to undermine inter-professional collaboration.

Legislating drug categories enables the college, and by extension, practitioners, to respond to ongoing changes in the standard of care in obstetrics in a timely way. For example, in August 2006, research published by Dr. Gideon Koren in the *Journal of Obstetrics and Gynaecology Canada* demonstrated that maternal consumption of folic acid containing prenatal multivitamins was associated with a decreased risk for several congenital anomalies, including neural tube defects. Since then, *Motherisk*, a program at the Hospital for Sick Children and a leading national authority on pregnancy information, recommends a dosage of five milligrams of folic acid per day for all pregnant women. However, midwives in Ontario are limited to prescribing no more than one milligram of folic acid. Women under midwifery care will now need to go to their family doctor or a walk-in clinic to get a folic acid prescription. Last year, midwives cared for approximately 10,000 women.

It can cost approximately \$30 for a physician to see a woman, repeat the assessment made by the midwife and write a prescription, and that's likely a conservative number. That's a cost of \$300,000 for the health system that is spent on appointments that are not clinically necessary. This is an unnecessary cost to the system and exacerbates the shortage of family physicians. Drug lists create these kinds of health system redundancies. They make what should be a simple and straightforward process into an unnecessarily complex process.

The Chair: I'm sorry, but I have to be ruthless on this.

Ms. Berinstein: That's fine. I have distributed the submission.

The Chair: We have the written copies and they certainly will be read. We appreciate your being here.

AGENCY IMPLEMENTATION TASK FORCE

The Chair: The next presentation is Cancer Care Ontario. I would remind you that there is an overflow in committee room 2, with seating and television broadcasting this, if you wish.

Dr. Terry Sullivan: My name is Terry Sullivan. I'm the president and chief executive officer of Cancer Care Ontario. Thank you for allowing me to appear this afternoon. I should say that I am appearing here in my capacity as co-chair of the agency implementation task force, and my remarks will focus exclusively on schedule K of this bill, dealing with the Ontario Agency for Health Protection and Promotion Act.

My co-chair, Dr. Geoff Dunkley, is unable to join me here today because he's practising in Mali, Africa, at the

moment. But I'm speaking here with the support of all members of our agency implementation task force.

This task force was struck in 2004, in direct response to recommendations arising from the expert panel on SARS and infectious disease control, to provide advice to the Ministry of Health and Long-Term Care on the design, development and implementation of a public health protection and promotion agency.

I should say to you that in addition to my day role, I'm a behavioural scientist, and I have a faculty appointment in public health sciences and in health policy management evaluation at the University of Toronto.

The task force reported to the chief medical officer of health and, through her, to the Minister of Health. The minister and the chief medical officer of health appointed the members of the task force, and the membership included national experts in public health, a representative from the Public Health Agency of Canada and individuals with expertise in a range of functional areas of the agency, including research, infectious disease control, health protection, zoonotic diseases etc.

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The task force delivered an interim report to the ministry in October 2005 and its final report in March 2006. The chief medical officer of health endorsed and accepted the report on behalf of the ministry, and the task force recommendations regarding the governance model, as reflected in these remarks, have also been endorsed by Dean Walker, who chaired the expert panel on SARS and infectious disease control.

In assembling its recommendations, the task force used a range of approaches, including reviews of the scientific literature, analyses of jurisdictions elsewhere and an examination of best practices in a range of areas related to public health agencies. We developed a governance structure, we consulted with experts in governance, we looked at governance models in place for a range of public health agencies in other jurisdictions, and we held discussions with key leads in research and health sector agencies in Ontario and across Canada.

Let me say a little, then, about the governance model for the agency. Consistent with the task force recommendations and the Walker report, the act proposes that the agency be established with an arm's-length relationship to government. The arm's-length model is consistent with the structure in place at the BC Centre for Disease Control and the Institut national de santé publique du Québec. It is noted that these agencies were cited by the late Justice Campbell as models for an Ontario agency and in the first interim report of the independent SARS commission, SARS and Public Health in Ontario.

As a crown agency, the organization would operate independently from direct government control, yet remain accountable to the Minister of Health and Long-Term Care for its activities, and ultimately to the Legislature, through adherence to Management Board directives for crown agencies and a memorandum of understanding to be entered into between the agency and the ministry.

The task force suggested that the proposed crown agency status for the organization set out in the act reflects the appropriate balance between independence and accountability.

The task force also supports a very active role for the chief medical officer of health in the agency's governance structure as set out in the act.

The act provides that the CMOH or designate be entitled to attend any meeting of the agency's board of directors and participate in such meeting to the extent that the board may allow. The CMOH is to be provided with reasonable notice of all board meetings and copied with the meeting materials. The act further provides that the board shall not unreasonably limit the participation of the chief medical officer of health at all board meetings.

In deliberating the governance model for the agency, the task force concluded that the chief medical officer of health should not be a formal voting member, as this would represent a serious conflict of interest. The CMOH also serves as the ADM for public health within the ministry and would have controllership in relation to the funding for the agency. As ADM, the CMOH would also be privy to confidential decisions with respect to the ministry determinations that might directly affect the agency beyond issues of funding. The task force concluded that it is contrary to good governance principles for the chief medical officer of health to be both accountable to the ministry for the operations of the agency and a member of the agency's board, with its consequent fiduciary obligations.

The act further provides that the chief medical officer of health, by virtue of office, is a member of the agency's strategic planning committee responsible for setting priorities for the agency, and ultimately that the chief medical officer of health play a key role in aligning these priorities from a funding point of view with the ministry. The chief medical officer of health is responsible for leading interministerial committees and would have a process for ensuring that government-wide priorities are brought forward to the agency's planning standing committee and aligned with the agency's activities with respect to its annual budget negotiations. By virtue of the status of the CMOH at the board and membership on the planning committee, there are clear channels to provide input into the ongoing work and provide overall direction of the agency.

Finally, let me say something about emergency readiness and response. Consistent with the task force recommendations, the act provides that the CMOH has the power to mobilize the resources of the agency to provide scientific and technical advice and operational support in any emergency or outbreak situation with health implications. This is an important power, because it ensures that the CMOH has ready access to a pool of highly skilled scientific and technical areas of specialization during times of a public health emergency. The explicit directive-making authority of the CMOH over the agency's resources is a far stronger lever of control than any seat on the board.

The power of the chief medical officer of health to issue directives in times of emergency ensures that the agency is working within the chain of command established within the province and the ministry during such events. This will help to ensure that there are clear lines of communication, clarity of roles and responsibility, and coordination among the various players during an outbreak.

As the objects of the agency make clear, the supporting role to be played by the agency in times of emergency or outbreak is just one aspect of the broad mandate in public health. The agency has a role in surveillance, epidemiology, research, knowledge exchange, laboratory medicine, professional development and communication. One of the key components of the agency's work will be reforming and strengthening of the Ontario public health laboratory system. This is a broad scope of work that must be led by a full-time, experienced CEO with an international reputation and a mandate autonomous from government. The autonomy of the agency and its CEO, real and perceived, is critical to the ability to carry out its objects and recruit, frankly, first-class researchers and scientists, and build relationships with the best and brightest public health scientists in Ontario institutions and beyond.

Thank you very much for the opportunity to present these remarks. Just to summarize, we fully support the establishment of the dedicated agency as laid out in the statute, and the establishment of this agency is critical and very welcome to advance the state of public health knowledge and practice for Ontario and for Canada. We fully support the governance model set out in the act for this agency. We submit that it strikes the right balance between autonomy and accountability, ensuring the alignment of the agency's work with the ministry and ensuring that the CMOH can mobilize the agency during times of a public health emergency.

Thank you very much, Mr. Chair.

The Chair: Thank you very much. We appreciate you being with us. There is no time for questions. I'm sorry. I'm thinking of trying this technique at home with our nine- and 10-year-olds.

Dr. Sullivan: Okay. Thank you.

REGROUPEMENT DES INTERVENANTES
ET INTERVENANTS
FRANCOPHONES EN SANTÉ
ET EN SERVICES SOCIAUX DE
L'ONTARIO

The Chair: The next presentation is en français. I'm an engineer by training. I can butcher the English language quite easily, and the French language is far too beautiful for me to attempt it and mispronounce it. So I would ask the next group to come forward. For committee members who require translation, these are not iPods but—

M^{me} Christiane Fontaine: Monsieur le Président, membres du comité, mon nom est Christiane Fontaine et

je suis la directrice générale au Regroupement des intervenants francophones en santé et en services sociaux de l'Ontario, le RIFSSSO. Premièrement, j'aimerais vous remercier de m'avoir accordé quelques minutes afin de vous demander des modifications à l'article 69 de l'annexe M du projet de loi 171.

Le RIFSSSO est un organisme provincial qui regroupe plus de 4 000 professionnels francophones provenant des quatre coins de la province. Il est actif dans le dossier de l'identification des professionnels de la santé aptes à offrir des services et des soins de santé en français principalement depuis les cinq dernières années. Il a fait plusieurs interventions auprès des ordres réglementés en santé afin qu'ils développent un mécanisme de cueillette de données qui permettrait l'identification de ces professionnels.

Nous savons tous que les professionnels de la santé sont les piliers de notre système de santé. D'ailleurs, l'accessibilité à des services de santé dans sa langue constitue par le fait même bien plus que le respect de la culture pour l'utilisateur de services. Il s'agit d'un élément essentiel à l'amélioration des conditions de la santé et à l'appropriation de la santé par la communauté.

Une prestation de qualité est aussi étroitement associée à la capacité des professionnels à promouvoir la santé, à faire des diagnostics et interventions efficaces, à offrir des traitements et à assurer des services auprès des utilisateurs.

Pourquoi est-ce donc si difficile d'obtenir des services en français en Ontario? Certainement, il existe des professionnels francophones travaillant dans nos différents organismes de la santé. Le problème, c'est qu'ils ne sont pas identifiés comme tels. Ils se retrouveraient isolés au sein de leur établissement ainsi que leur association ou ordre professionnel pour lesquels les services de santé en français ne sont pas une priorité de premier ordre.

D'ailleurs, plusieurs études ont démontré que les barrières linguistiques proviennent du fait que l'utilisateur de services de santé et le professionnel ne parlent pas la même langue. Dans notre cas, l'insuffisance du niveau d'anglais de l'utilisateur peut causer certains problèmes et peut même avoir des répercussions graves sur sa santé.

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L'accès aux services de santé dans sa propre langue est d'ailleurs considéré comme un facteur-clé de l'efficacité des soins et traitements reçus. Les barrières linguistiques ont un effet défavorable sur l'accès initial avec le professionnel. D'autres études démontrent que les patients qui ont de la difficulté à s'exprimer en anglais, dans notre cas, ont un taux d'utilisation des services d'urgence plus élevé et leur état de santé est plus précaire car ils ont recours tardif à des services de spécialistes ou de diagnostics. Ils ont également un accès réduit aux services de santé mentale et de counseling, qui sont offerts majoritairement en anglais ici en Ontario.

Le manque de communication avec le professionnel peut même occasionner une baisse de l'utilisation de services préventifs, comme c'est le cas de la mammo-

graphie chez les femmes francophones en Ontario. Il peut également augmenter le temps passé en consultation ou à subir des tests et des examens qui serviront à établir un diagnostic ou un traitement approprié.

En plus, une communication inadéquate augmente la probabilité de l'utilisateur de ne pas comprendre le traitement suggéré ou de suivre la podologie recommandée, et aussi, pour le professionnel, cela augmente la possibilité de faire un diagnostic erroné.

Présentement, l'identification des professionnels de la santé demeure en grande partie invisible. Si nous désirons avoir des données fiables, une action prioritaire doit être faite par notre gouvernement afin d'obliger les ordres réglementés de la santé à identifier leurs membres qui sont aptes à offrir des services professionnels de santé en français.

L'article 69 de l'annexe M du projet de loi 171 stipule que « L'ordre détermine et consigne la langue préférée de chacun de ses membres. » L'identification de la « langue préférée » n'est pas suffisante car elle propose un processus aléatoire d'identification de la langue du professionnel.

Nous demandons donc que cet article réfère aux « langues officielles utilisées par chacun des membres lors de l'offre des services » au lieu de « la langue préférée » comme mentionné dans l'article 69.

En bref, nous proposons que l'article 69 de l'annexe M du projet de loi 171 mentionne que « L'ordre identifie et consigne les langues officielles utilisées lors de l'offre des services pour chacun de ses membres ». De cette façon, la loi exigera des ordres réglementés de la santé de recueillir des données linguistiques sur les services de santé qui sont offerts dans les deux langues officielles par leurs membres. Nous aurons ainsi accès à des données fiables qui pourront ensuite être utilisées lors de la planification des ressources humaines en santé aptes à desservir la population francophone de l'Ontario.

Merci.

Le Président: Merci. We have about one minute per caucus, starting with Ms. Martel.

M^{me} Martel: Merci pour être venue cet après-midi. Je voudrais demander pourquoi les mots « la langue préférée » ne sont pas suffisantes pour répondre à vos besoins. Je voudrais savoir la différence exacte à propos de « la langue préférée » et « les langues officielles utilisées ».

M^{me} Fontaine: Pour nous, lors des interventions précédentes qu'on a eues avec les ordres, on nous disait qu'on identifiait la langue du professionnel parce qu'il a demandé de recevoir leur publication en français. On sait que sur leur terrain ou dans des organismes où ils travaillent, qui sont majoritairement anglophones, à ce moment-là ils vont demander d'avoir les communications en anglais. Donc, à ce moment-là, on perd tout de suite là l'identification de ce professionnel francophone. Donc, si on lui demande s'il est apte à offrir des services dans une des langues officielles ou dans les deux langues officielles, on a vraiment le professionnel qui peut offrir des services en anglais, naturellement, mais aussi en français.

Cela va aider au niveau de la planification des ressources humaines, surtout dans les régions où il y a beaucoup de pénurie. Ça va aussi appuyer le développement de nouveaux programmes de formation post-secondaire pour combler cette pénurie de personnel.

M^{me} Martel: C'est à cause du fait qu'on a besoin d'une meilleure identification du nombre de professionnels?

M^{me} Fontaine: Oui, un nouveau systématique. Donc, quelque chose de formel avec lequel les ordres pourront nous donner des rapports sur leurs membres qui peuvent offrir des services en français.

M^{me} Martel: Okay, merci.

M. Khalil Ramal (London-Fanshawe): Merci beaucoup pour votre présentation. Je sais que cette loi reconnaît les langues officielles—le français et l'anglais—et je comprends que vous avez un problème avec l'article 69 qui parle de la langue préférée. Pourquoi?

M^{me} Fontaine: Le problème que j'ai avec « la langue préférée », comme j'ai expliqué à M^{me} Martel, c'est que ça ne permet pas d'avoir un mécanisme officiel au niveau du système qui permet d'identifier les professionnels qui offrent des services de santé ou des soins de santé en français. Ça permet aux ordres d'identifier les professionnels qui offrent des services en français de différentes façons, qui ne seraient pas la même façon dans tous les ordres. Ils peuvent demander des publications en anglais alors qu'ils sont aptes à offrir des services en français. Ils peuvent, par exemple, dans certaine cas leur demander si leur formation avait été en français, et c'est comme ça qu'on identifie les professionnels, mais on sait que dans la réalité, beaucoup de professionnels vont à des instituts comme McGill à Montréal ou Concordia, qui sont des institutions anglophones. Donc, ce n'est pas un processus qui nous donne des données fiables.

M. Ramal: Je pense qu'un autre officiel dans le ministère de la Santé a communiqué avec le peuple, spécialement de la communauté francophone de l'Ontario, en deux langues—like, an e-mail pour votre organisation en anglais, parce que c'est automatique, the e-mail system. Mais en général ils répondent en français et en anglais en même temps.

M^{me} Fontaine: Parce que dans le passé, on a aussi communiqué avec l'Office des affaires francophones pour nous appuyer dans nos démarches et aussi, il y a eu des communications avec le ministre Smitherman pour lui faire part de nos préoccupations à ce niveau-là.

M. Ramal: Okay. Merci.

The Chair: Mrs. Witmer?

Mrs. Witmer: Thank you very much for your presentation. I recognize the time is up.

Le Président: Merci.

BOARD OF DIRECTORS OF DRUGLESS THERAPY–NATUROPATHY

The Chair: The next presentation is the Board of Directors of Drugless Therapy–Naturopathy.

Ms. Angela Moore: Good afternoon, Mr. Chair and members of the committee. My name is Angela Moore and I am the chair of the Board of Directors of Drugless Therapy–Naturopathy, the regulatory board for naturopathic doctors under the Drugless Practitioners Act. I'm also a naturopathic doctor, although I'm not in active practice at this time. Accompanying me is our public member, Marianne Park.

The naturopathic profession has been regulated in Ontario since 1923 and, as such, is one of the oldest regulated professions in the province. This means that the transition to the RHPA should be relatively smooth compared to professions that are being regulated for the first time. The board and the naturopathic profession are very supportive of regulation under the RHPA. The Drugless Practitioners Act is a seriously outdated piece of legislation. It does not allow the board to regulate the profession efficiently or effectively, or in a way that is compatible with the requirements of the RHPA. HPRAC has recommended the regulation of NDs under the RHPA three times, most recently in its New Directions report, issued last April. We are very pleased that that recommendation is finally being implemented.

Having said that, I'd like to raise a few issues with respect to Bill 171 that are of concern from a regulatory perspective. Each of our comments is motivated by a desire to continue the current scope of practice of naturopathic doctors in Ontario. In other words, we wish to ensure that under the RHPA, NDs can continue to offer patients the level of care they are receiving now under the Drugless Practitioners Act, and have been for some time. The ministry has repeatedly stated that this is their intention as well, and clearly HPRAC also agreed with this objective.

The first matter I'll address today is to confirm that NDs will have access to the natural substances they use for treating patients. This is rather complicated, because it relates to the intersection of federal and provincial laws with respect to the regulation of drugs.

Naturopathic doctors are educated in the use of a wide range of natural substances that they have prescribed, dispensed and compounded safely and effectively for years. Recently, however, as the federal government undertakes the regulation of natural health products, some natural substances that are not considered safe for the general public are being moved to prescription-only status on federal drug schedules. Federal law requires that prescriptions be issued by health care practitioners who have the specific authority to prescribe under provincial law. In Ontario, this authority is granted under the controlled acts set out in subsection 27(2)8 of the RHPA. On page 183 of the New Directions report, HPRAC states: that "optimal care cannot be offered to patients unless naturopathic doctors have access to substances consistent with naturopathic practice."

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Contrary to what HPRAC recommended, schedule P does not give the naturopathic profession the controlled act of prescribing. Instead, the ministry believes that it

can use the authorities under subsection 117(1) of the Drug and Pharmacies Regulation Act to, in effect, exempt the natural substances used by NDs from the prescription requirement in federal law.

Because of the importance of this issue, the board retained a legal counsel who is an acknowledged expert in this area. It is her view that the ministry's solution would be susceptible to successful challenge from the federal government that has jurisdictional primacy in this area.

Accordingly, to address any doubt or ambiguity, the board asks the committee to amend schedule P by giving naturopathic doctors prescribing authority as recommended by HPRAC, namely,

"That naturopaths be authorized to prescribe, dispense, sell and/or compound drugs that are consistent with naturopathic practice, as prescribed in regulations."

This is an issue of great concern for the naturopathic profession and for their patients. If NDs don't have access to these substances, patients will no longer be able to receive the care they are now receiving.

The second issue I want to address relates directly to regulatory effectiveness. Previously, when existing regulated professions were brought under the RHPA, the statutory regulatory bodies that existed pre-RHPA were legally continued as the new regulatory colleges under the profession-specific acts.

This is not the approach that's taken in schedule P, and it's going to cause problems if it goes ahead as it is now, because as soon as schedule P is proclaimed, the Drugless Practitioners Act and the board will cease to exist. This means that investigations, complaints and disciplinary procedures that are in process at that time would have to be abandoned. Neither the transition council nor the new College of Naturopaths and Homeopaths would have authority to complete those procedures. The old board would have no ability to enforce outstanding disciplinary actions. Basically, the old board would not be in existence anymore. The assets and liabilities of the board would not be transferred to the transitional council, nor to the ultimate college. Those assets include staff as well as our registration list and various databases that would be critically important to regulation of the profession after proclamation. I believe that committee members will agree that none of this would be in the public interest.

As schedule P is currently drafted, upon proclamation, the current officers and directors of the board would have to set about winding up the board. There would be no transition into the transition council or into the College of Naturopaths and Homeopaths.

Our discussions with the ministry have suggested very clearly that this is simply an oversight. We hope that the government will bring forward amendments to address this. Our written submission to the committee puts forward recommended wording to resolve this issue. That wording is based on the statutory formulations used previously under the RHPA.

Now I'd like to turn to the wording in schedule P relating to the authorized act of communicating a diag-

nosis. The board understands that both the wording and application of this controlled act raise a number of complex issues and interprofessional sensitivities.

However, we are concerned that the adjective "naturopathic," which is being used to modify diagnosis in paragraph 4(1)5, will result in difficulties. The other professions that have access to this controlled act don't have such a modifier in their authorized act statement. For example, there isn't a "dental" diagnosis or a "chiropractic" diagnosis or a "psychological" diagnosis, and it's not clear why there should be a "naturopathic" diagnosis. Our concern is that in future, this modifier will be interpreted to restrict the scope of naturopathic practice. Currently, NDs are required by the board to formulate diagnoses for all patients using the tools that are available to the profession. These tools include such things as a comprehensive history, physical examination, and laboratory tests that registrants are authorized to perform.

The Chair: One minute.

Ms. Moore: The diagnosis that's arrived at would not differ from a "medical diagnosis," for example, in the case of an acute ear infection. We're concerned that the current wording in Bill 171 will be interpreted as prohibiting NDs from communicating a diagnosis.

Mr. Chair, I'm sorry that I've taken up so much time. I had hoped to leave more for questions and comments. I'll stop here so there's at least a little bit of time.

The Chair: Okay, 20 seconds per caucus for questions.

Mr. Fonseca: I'd just like to thank the Board of Directors of Drugless Therapy-Naturopathy. What I can say on behalf of the government is that many of your concerns are being addressed in motions. In the short time I have, I'll just mention one here: "Bill 171 does not reduce the naturopaths' current scope of practice"—and the ministry will address the issue of including "disease" in diagnosis through a government motion. That will be one, but I have many that will address your concerns.

The Chair: Mrs. Witmer?

Mrs. Witmer: This is an excellent presentation. Certainly this allows us to move forward and address some of your concerns.

The Chair: Ms. Martel?

Ms. Martel: With respect to the communication of a naturopathic diagnosis, if you drop the "naturopathic," are you content with what remains?

Ms. Moore: Yes.

Ms. Martel: Okay. So the issue is making sure "diagnosis" stands alone.

Ms. Moore: It's a qualifier.

Ms. Martel: Thanks.

The Chair: Good. Thank you very much.

ONTARIO MEDICAL ASSOCIATION

The Chair: The next presentation is from the Ontario Medical Association.

Dr. David Bach: Good afternoon, ladies and gentlemen. I'm Dr. David Bach, and I'm pleased to be here

today, undertaking one of my last formal functions as the president of the Ontario Medical Association before our annual general meeting this weekend. I am an academic radiologist and practise at University Hospital, London Health Sciences Centre.

I would like to begin my remarks today by acknowledging all three parties, and Minister Smitherman in particular, for working with the OMA to address some very serious deficiencies in Ontario's medical audit system. I believe that the amendments being made to the Health Insurance Act through schedule G of Bill 171 faithfully implement the substantial amendments recommended by Justice Cory in his 2005 report on medical audit practice in Ontario.

This has been the single biggest issue for the medical profession over the past several years, and I am very pleased to be able to go into my annual meeting on Saturday and report that important progress has been made in this area. Although our membership will be pleased and relieved by this information, they are likely to come away from the meeting this weekend with the message that just as we are emerging from one procedural quagmire, we are faced with another one in the form of the amendments to the procedural code and the quality assurance provisions under the Regulated Health Professions Act as a result of Bill 171. This is a concern for our members.

It appears that the government is being driven by recent very unfortunate high-profile cases to make amendments to our regulatory processes in order to deal with so-called bad apples. The OMA certainly understands the need to deal with problem providers, but we believe that there are already processes in place to do this. If hospital committees or regulatory colleges are not fulfilling their clear responsibilities, we should deal with that issue directly. We do not need new rules that abandon any semblance of fair process for our providers.

There have also been suggestions that more reporting is consistent with patient safety. While improvements in the system may well be the goal, we need to be careful about how we use the "patient safety" terminology, and I'm going to go into that for about 30 seconds.

The patient safety movement is based within the quality improvement framework. Quality improvement has two principal purposes: The first is to raise the standard of care provided by all practitioners. The second is to deal with the shortcomings in the system or with an individual's performance that will help individuals to perform better.

1650

Patient safety is predicated on the understanding that the majority of bad things that happen to patients are not due to bad providers. Rather, they are due to the fact that the delivery of health care today is highly complex, with a great number of variables that affect health care outcomes. Patient safety seeks to move away from the "name, blame and shame" approach to one where problems are openly and critically reviewed in a safe environment so that we can learn what went wrong and, hopefully, how to prevent a similar event in the future.

The airline industry has been a real leader in this field. It has redesigned its entire approach to safety to incorporate a sense of shared responsibility for safety, coupled with a rigorous yet confidential review of all incidents and a commitment to systemic change in response to incident analysis. I believe we would do well to follow its lead.

It is important to know that the patient safety approach does not ignore the fact that some actions, generally known as acts of moral turpitude, do require a punitive approach. The key is to be very clear about the boundaries.

Our regulatory colleges have their roots in the punitive model, and it is only over the course of the past decade that they have acknowledged that the vast majority of provider problems can and should be handled within the quality assurance context. The fact remains, however, that colleges have had some difficulty with the transition, in part because their members do not truly believe the colleges have embraced the quality assurance philosophy and partly because the colleges are still charged, at the end of the day, with meting out punishment to members who have transgressed.

Bill 171 will only exacerbate this confusion. Between the many amendments that undermine due process, the rush for disclosure at the expense of undue prejudice and the blending together of disciplinary and quality assurance functions, it is difficult to see how I can assure my members that self-regulation continues to be a fair and useful process or that Ontario remains an attractive jurisdiction for physician recruitment and retention.

Although the OMA is concerned about all of the procedural issues raised by Bill 171, the loss of an independent quality assurance function is of particular concern. Perhaps I might spend a moment and read to you an excerpt from the 2006 advice to the minister by his advisory council, HPRAC:

"For professionals involved in college quality improvement processes, whether peer practice assessments or continuing education, the culture surrounding their participation is vital. They must have the confidence that when changes are identified as necessary in their own practice, or in the practice of a health care team of which they are a part, there is no link to the discipline process. Rather, the link is to enhanced competence, continuing improvement and outcome evaluation. Not only are there benefits to the individual and the health care team, but new aggregated knowledge can be shared with other members of the profession.

"For this reason, HPRAC is recommending that the quality improvement and quality assurance role in colleges be distinct and separate from the discipline process."

It is difficult for me, as a physician, to reconcile this very good advice with some parts of Bill 171, which gives the QA committee the authority to direct the registrar to impose particular sanctions upon a member, and also gives the new inquiries, complaints and reports committee the authority to directly exercise the powers of the QA committee.

I appreciate that schedule M is difficult to follow because of the complexity of the legal issues and I ask you, as a committee, to consider seeking an outside legal opinion from a trusted source, perhaps from the judiciary, to guide you with respect to how the law undertakes the delicate balancing act between justice and fairness in other realms.

I will close by returning to the medical audit situation. The government has recognized that introducing a fair audit process in no way suggests they take a lax approach to billing improprieties. I ask you to bring that same logic to bear here and recognize that fair process in no way implies support for practitioner malfeasance. I ask you to further recognize that quality assurance and dealing with bad apples are two very different processes and need to be kept separate.

Thank you for your attention, ladies and gentlemen. The OMA submission on Bill 171 has been provided to the clerk. I hope you will consider our recommendations in the context of my comments today.

The Chair: Thank you. Your timing was perfect. Unfortunately, no questions, though.

COUNCIL OF ONTARIO MEDICAL OFFICERS OF HEALTH

The Chair: The next presentation is by the Council of Ontario Medical Officers of Health.

Dr. Graham Pollett: My name is Graham Pollett. I'm the chair of the Council of Ontario Medical Officers of Health and medical officer of health with the Middlesex–London Health Unit. With me today is Howard Shapiro, associate medical officer of health with the Toronto public health department. We're here today representing medical officers of health and associate medical officers of health in local health units across Ontario.

The shortage of qualified public health physicians is impeding the proper functioning of the public health system at the local and provincial levels. Since SARS, the situation has become worse rather than better. We believe that Bill 171, as now presented, has the potential to add to these problems. Allow me to explain.

The Council of Ontario Medical Officers of Health strongly supports the creation of the Ontario Agency for Health Protection and Promotion, as described in Bill 171. It will provide scientific leadership for public health in this province. It will help recruitment and retention of public health physicians, in the long term, by providing educational support, technical assistance for difficult issues or cases and a new, highly desirable career opportunity.

Unfortunately, in the short term, the agency threatens to make a critical physician shortage worse, as people will most likely leave their current positions for opportunities at the agency.

I will provide a picture of the current shortage of public health physicians through examples from the areas represented by the members of this committee.

Mr. Fonseca's and Dr. Kular's ridings are located in the region served by the Peel health department, the province's second-most-populous health unit. It has taken that health unit over two years to successfully recruit a medical officer of health, due to the lack of interested and properly qualified people. During that time, the medical officer of health position was covered by a physician three years out of the specialty training program and later by a physician who was present on a half-time basis. Currently, there is also a vacant associate medical officer of health position at Peel.

Mr. O'Toole's riding is located in the area served by the Durham region health department. Two associate medical officer of health positions have been vacant for close to a year, leaving a single physician, the medical officer of health, to provide medical coverage for this large health unit.

Mr. Ramal's riding is located in the area served by the Middlesex–London Health Unit, the health unit that employs me.

The associate medical officer of health was called away from her health unit by the chief medical officer of health. This was to provide much-needed medical expertise during a rubella outbreak in Oxford county, where there was no full-time medical officer of health. Currently, there is still no full-time medical officer of health for Oxford county.

Recently, the Middlesex-London medical officer of health and associate have agreed to cover the Perth District Health Unit while it recruits for a full-time medical officer of health.

Also, the physician director of the Middlesex–London Health Unit travel clinic is currently serving as acting medical officer of health for the Chatham–Kent Health Unit. Chatham–Kent has been without a full-time medical officer of health for over two years.

Mr. Mauro's riding is served by two health units: Northwestern and Thunder Bay. In the Northwestern Health Unit, Dr. Sarsfield has announced his plans to retire as medical officer of health at the end of this year. The Thunder Bay District Health Unit recently underwent a one-year process to hire a new medical officer of health.

Mr. Leal's riding is in the Peterborough health unit area. Until new legislation was passed eliminating the mandatory age of retirement, special permission was required from the Minister of Health and Long-Term Care for Dr. Humphreys to continue as medical officer of health. Despite Dr. Humphreys's willingness to continue working, we think this would not have been necessary if there was a strong pool of people available to apply for the position.

The final report of the provincial government's capacity review committee highlighted that 29% of the current complement of medical officers of health and associates plan to retire within the next five years. Who will fill these positions?

The effects of this shortage of public health physicians are not limited to local public health units.

The public health division at the Ministry of Health and Long-Term Care is also having challenges hiring qualified people. A review of the public salary disclosure list shows that the number of full-time physicians on staff at the public health division has gone from six in 2003 to three in 2006. To the best of our knowledge, all three of those physicians listed as working for the public health division are currently on medical leave, and there are a further nine physician vacancies at the public health division. In fact, there are so few qualified physicians at the public health division that the chief medical officer of health position was recently covered for approximately three weeks by a physician with no public health experience.

1700

Why, then, is the Council of Ontario Medical Officers of Health speaking to this committee about what largely appears to be a human resources issue? We are here today because the proposed amendments to the Health Protection and Promotion Act through Bill 171 have failed to address this critical shortage of public health physicians.

In the past five years, this province has produced two valuable reports which speak directly to this situation. The very first recommendation by Justice O'Connor in the Walkerton report reads: "The Health Protection and Promotion Act should be amended to require boards of health and the Minister of Health, acting in concert, to expeditiously fill any vacant medical officer of health position with a full-time medical officer of health."

This recommendation was made in 2002, yet today, nearly a third of the 36 health units in Ontario do not have a full-time medical officer of health appointed by the minister. Something needs to be done to ensure that the Legislature is informed of the progress on this issue and that the chief medical officer of health is empowered to deal with this issue.

To that end, we recommend the following: (1) that the Health Protection and Promotion Act be amended so that the chief medical officer of health is required to report to the Legislature as part of his or her annual report on vacancies for medical and associate medical officers of health, physician vacancies in the public health division and measures taken to address these vacancies; (2) that the Health Protection and Promotion Act be amended to require, where a board of health has failed to duly appoint a medical officer of health, that the chief medical officer of health appoint an assessor to provide a report on the reasons for this and recommended actions to be undertaken to remedy the situation.

The shortage of physicians entering public health as a specialty will not be addressed if medical students do not see the role of medical officer of health as desirable. Strengthening the functions of this role, as recommended by the late Justice Campbell, would help attract new candidates to the field.

To this end, we recommend that the Health Protection and Promotion Act be amended, as suggested by the late Justice Campbell, such that: (1) the local medical officer

of health has full chief executive officer authority for local public health services and is accountable to the local board of health; and (2) the local medical officer of health has independence matching that of the chief medical officer of health to speak out and to manage local infectious outbreaks.

In the words of the late Justice Campbell, "Local medical officers of health and public health units, the backbone of Ontario public health, require in any reform process a strong focus of attention, support, consultation and resources.

"The Ontario government has a clear choice. If it has the necessary political will, it can make the financial investment and the long-term commitment to reform that is required to bring our public health protection against infectious disease up to a reasonable standard."

We strongly urge that this committee recommend to the Legislature the four amendments we have identified in this presentation. We believe this will demonstrate, through action, the commitment of the provincial government to strengthen public health in Ontario.

The Chair: There are only about 15 seconds left, so there will be no questions. Thank you very much.

COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

The Chair: The next presentation is the College of Physicians and Surgeons of Ontario. You have 10 minutes.

Dr. Rocco Gerace: Thank you very much. My name is Rocco Gerace. I'm a physician and the registrar of the college. With me is Lisa Brownstone, who is director of legal services at the college.

I would like to thank you for the opportunity of being here today and tell you that we are very supportive of this legislation and that it will go a lot further than the existing legislation in allowing the profession to regulate itself in the public interest. Notwithstanding the improvements, we think that there are changes which would be preferable. While we've circulated a submission, I would like to highlight a few of these.

Firstly, we think it would be advantageous for the legislation to allow a legal chair, a jurist or a senior legal counsel, to chair discipline panels. Increasingly, discipline hearings are becoming complex and litigious, and rather than having professional members and public members deciding legal issues, they should decide the facts at hand. We think a jurist would go a long way to expediting these procedurally demanding hearings.

Secondly, we think that, in very selected circumstances, search warrants should allow entry into the dwellings of the member. Occasionally, doctors maintain critical information in their homes and successful prosecution of serious cases is dependent on this information. More recently, we had an issue with a doctor providing cosmetic surgery against a condition that had been imposed and in fact harming patients. It was only because we were able to garner the records from his home that we were able to prosecute.

Thirdly, while the legislation demands that doctors be notified of a complaint within 14 days, and we agree with this for the most part, there are rarely circumstances where, in the interest of preserving evidence, longer time is needed. We would ask that consideration be given to changing that for exceptional circumstances.

Finally, I'd like to address the issue of transparency. We are concerned that this legislation actually decreases the amount of transparency available to the regulatory body. Currently, severe findings are put on the public register on our website indefinitely. This legislation would allow this information to be removed from the website after a period of six years with application. We think this is regressive, and we think the profession should have the opportunity to be sufficiently transparent to ensure that there's public trust in the system.

There's a total of 14 recommendations in our submission. I won't go over them all, but I would be happy to answer any questions that anyone might have.

The Chair: Thank you. We have quite a bit of time for questions, so we will start with Ms. Witmer.

Mrs. Witmer: I'd like to focus on recommendation 2, the search warrants. Do you want to just speak to that issue?

Dr. Gerace: Sure. Currently, when a search warrant is obtained, the investigators have the right to enter a doctor's premises. With the change in the legislation, this would be precluded. Very rarely doctors will keep critical information within their residence that is crucial to the investigation and ultimately to a prosecution. So we think there should be an allowance with respect to that to allow investigators, with appropriate protection, to be able to go into a physician's residence.

Mrs. Witmer: Would you just expand on the disclosure of member information of a serious nature after the six years?

Dr. Gerace: Of course. Currently, with the combination of statute and bylaw, all serious matters, serious findings from a discipline panel remain on the public register indefinitely, so the public will always have access to that information. With the revisions to the legislation, the member will have the ability to apply to have that information removed at the six-year mark. We continue to believe that that information should be public and stay public indefinitely.

Mrs. Witmer: Forever?

Dr. Gerace: Yes.

Mrs. Witmer: To better protect the public?

Dr. Gerace: The public will be aware of serious findings.

Mrs. Witmer: What about that provision for separate pre-hearing panels?

Dr. Gerace: As you may know, we currently have difficulty given the requirement in respect to the composition of panels for the discipline committee. If we have multiple panels to consider motions before the hearing actually begins, there's the potential for actually exhausting the number of panel members we have available to sit. It's not the case now. We've not encountered any

difficulty, and so we feel that that provision is unnecessary.

Mrs. Witmer: Thank you very much.

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

Ms. Martel: Thank you for being here. Actually, some of your concerns were echoed yesterday by the registrar for the Royal College of Dental Surgeons of Ontario. I just want to focus on a couple around the search warrant. I've looked at this a couple of times, and I can read it both ways. So I really do suggest the government change the wording on this one—because as it stands, it is confusing about what the intent is. I'm hoping the intent is to include a house, because that would have followed from what we did on Bill 140, but it needs to be cleaned up in its current composition.

1710

I guess what I want to focus on, and I don't mean to put you on the spot, but I'd be interested on your views—you might have heard the presentation done by the OMA. I want to ask about quality assurance and the changes that are being proposed by the government around the QA committee directing the registrar to impose sanctions. The second concern raised was that this would give the new inquiries, complaints and reports committee the authority to exercise the powers of the quality assurance committee.

As the registrar for the college that will have to deal with this, what are your views about the proposed changes in that area?

Dr. Gerace: I think the changes are fine. It's interesting that the greatest criticisms we get from the profession are not having taken adequate steps to protect the public. What can happen in the quality assurance stream is that a doctor could be entirely uncooperative through the process. Keep in mind that the vast majority of doctors want to practise well. When the deficiencies are identified, they are very keen to become educated, and do so. Within the quality assurance stream currently, there is a provision for a suspension if the doctor fails to co-operate, and really this puts into statute what already exists in regulation.

In respect to the investigative stream, I think that's intended when there are issues around education. If there is a course that would be helpful for the physician, rather than go to a full disciplinary hearing, it will allow the committee to ask the doctor to take that course. I think Lisa might want to comment. The doctor always has the right to take that decision to divisional court if they're concerned about its propriety.

The Chair: We need to move on. I'm sorry. Mr. Fonseca.

Mr. Fonseca: I'd like to thank the College of Physicians and Surgeons of Ontario for your presentation. I'm glad that your representatives are meeting with the ministry. We are going to be addressing two of your concerns that you've brought forward. The search warrant and dwellings issue will be addressed in a motion, and the six-year application period to re-register is being addressed through a motion.

I want to ask a question around transparency. This legislation is about better protection for patients. The bill is going to enhance all regulatory colleges—their complaints procedures—by giving patients increased access to information and improved communications, and streamline that process.

I know that this has been somewhat contentious in terms of what access patients should have and how quickly they should have it. Can you give me your thoughts on that?

Dr. Gerace: Our main concern in respect to the legislation was that this information would be removed, and I'm pleased to hear that that information will stay on the register and changes will be made in respect to that.

Other information, I think, requires discussion. There should be adequate information on the public register to assure the public that regulation is occurring appropriately. We have to ensure public trust.

If there are other suggestions around what might additionally be on that register, I think we should talk about it. The concern, always, is the unintended consequences of including too much information. And so, if there is a plan to include more information, I would urge that there be an open debate around the proposed information to be included, to have that assurance.

Mr. Fonseca: Do you have a suggestion in terms of what information?

Dr. Gerace: No. We haven't really addressed that in this submission.

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

Dr. Gerace: Thank you.

ONTARIO COALITION OF MENTAL HEALTH PROFESSIONALS

The Chair: The next presentation is the Ontario Coalition of Mental Health Professionals. Welcome.

Ms. Naseema Siddiqui: Good afternoon, Mr. Chairman and members of the committee. My name is Naseema Siddiqui, and I am the chair of the Ontario Coalition of Mental Health Professionals. The coalition is made up of voluntary associations that represent approximately 4,300 members. These are unregulated practitioners in the province. The coalition has been advocating the statutory regulation of mental health professionals for many years.

We welcome the introduction by this government of the Psychotherapy Act, 2006. We participated in the consultation initiated by HPRAC and Minister Smitherman that led up to the introduction of the act. The coalition believes that the act reflects the key public policy issues of protection of the public, choice of practitioners and access to services, and diversity, which are the cornerstones of the RHPA.

I will now ask Kevin Stafford, chair of the coalition's advocacy committee, to comment on the Psychotherapy Act, 2006, on behalf of the coalition.

Mr. Kevin VanDerZwet Stafford: Thanks, Naseema. I'm Kevin VanDerZwet Stafford. I'm chair of the advo-

cacy committee. I'm a marriage and family therapist in private practice in Guelph. I'm very pleased to address this committee on the Psychotherapy Act on behalf of the Ontario Coalition of Mental Health Professionals.

I'd actually hoped that my husband, Bryan, and our two children would have been here to pay witness to these hearings today. However, you'll understand that through the eyes of a seven-year-old, swimming lessons were of far greater interest than these committee hearings.

The Chair: They are to us, too.

Mr. VanDerZwet Stafford: Maybe we should all go swimming.

Many members of the public mistakenly believe that regulation is already in effect and are unaware that they are being treated by practitioners who are not legally accountable. Anyone can hang out a shingle in Ontario saying that they provide mental health services and answer to no one about their training and competence to practise.

The coalition of mental health professionals welcomes the Psychotherapy Act as a long-overdue answer to the vast pool of unregulated practitioners who are currently not accountable for the mental health services they provide to an unsuspecting public.

The coalition supports the Psychotherapy Act because it meets key public policy objectives that underlie the Regulated Health Professions Act. Among these are:

Public protection: The Psychotherapy Act provides legal accountability for the thousands of practitioners delivering psychotherapy services, with entry-to-practice standards, continuing education, complaints and disciplinary procedures.

Choice and access to service: The new College of Psychotherapists will capture a broad range of professionals practising as counsellors, counselling therapists, psychotherapists, marriage and family therapists, etc., thereby ensuring that the public continues to have a choice of qualified practitioners and access to much-needed services.

Finally, and significantly important, I believe, is diversity. The multidisciplinary nature of the new college will ensure that diverse communities can access services that are culturally competent and culturally relevant.

One small example would be my own marriage and family therapy practice in Guelph, which caters largely but not exclusively to the gay-lesbian-transgendered community.

I'd like now to address specialty subtitles. It is in the very nature of mental health services to be inclusive of a broad range of practitioners who are specialized in areas of practice, such as marriage and family therapy, pastoral counselling, art therapy, addiction therapy, etc. Establishing specialty subtitles in or under the act would give the public an additional tool in accessing the most appropriate practitioners to meet their mental health needs in a time of crisis.

The coalition was very disappointed that there was no provision in the Psychotherapy Act for specialty titles

under the two protected titles of “psychotherapist” and “registered mental health therapist.” As a result, we are proposing an amendment to section 8 of schedule Q to add subsection (4) to read, “Specialty subtitles shall be designated under the protected titles of ‘psychotherapist’ and ‘registered mental health therapist.’”

Some stakeholders are calling for the involvement of professionals already regulated under the Regulated Health Professions Act in setting up the new regulatory regime under the Psychotherapy Act. Let me be clear. The coalition feels very strongly that there is the necessary expertise, both clinical and academic, in the currently unregulated sector to meet the challenge of setting standards for entry to practice and dealing with all the attendant policy issues.

One such issue is: Who should be authorized to perform the authorized act? As an example of the expertise in the unregulated sector, Beth Symes, the coalition counsel, has already conducted initial research comparing Alberta and Ontario, as cited in our brief. The coalition recommends strongly that a critical mass of appointees to the transitional council be drawn from the unregulated sector.

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In conclusion, I would like, on behalf of the coalition and Naseema, our chair, to thank the committee for the opportunity to express our very strong support for swift passage of the Psychotherapy Act in the current session.

The Chair: Thank you. Fifty-five seconds per caucus, starting with Ms. Martel.

Ms. Martel: Thank you for being here today. The amendment around section 8 I am pleased to see because the question was, who is a registered mental health therapist, right? We need some other subcategories to ensure that we are really including all of those who are unregistered, and I trust that the new college will have the capability of determining the educational requirements associated with those categories.

Just briefly, because I’m trying to compare very quickly: The authorized act that you set down on page 6—is there a difference between that and the one that is currently in the act? I’m trying to read quickly, but I didn’t get there fast enough. Is there a change or are you endorsing the authorized act that appears right now in Bill 171?

Mr. VanDerZwet Stafford: We’re endorsing it.

Ms. Martel: So it’s the one that’s there now. Okay. Thank you.

The Chair: Mr. Fonseca?

Mr. Fonseca: I’d like to thank the coalition for your fine presentation and I’d like to address your concerns.

Within the RHPA proper, it does allow the council to make regulations, and I’ll just read from regulation 95(e), which is already in the RHPA, as I said: “defining specialties in the profession, providing for certificates relating to those specialties, the qualifications for and suspension and revocation of those certificates and governing the use of prescribed terms, titles or designations by members indicating a specialization in the pro-

fession.” So it is allowed. You will be able to have your different designations, be it marriage and family therapy or social worker or whatever it may be within mental health professionals.

As we build what is deemed our HealthForce Ontario, we want to make sure that everybody is included and that the public is well aware of the professionals they are seeking out for the therapy they need. Thank you.

The Chair: Ms. Witmer?

Mrs. Witmer: Thank you very much. Your members have done a good job of letting us know your concerns and the need for swift passage. We appreciate this information. It will be very helpful.

The Chair: Thank you for being with us.

ONTARIO PUBLIC SERVICE EMPLOYEES UNION

The Chair: The next presentation is the Ontario Public Service Employees Union. I would ask if you would state your name for Hansard.

Mr. Smokey Thomas: Smokey Thomas.

Ms. Patty Rout: Patty Rout.

The Chair: And congratulations on your recent election. You have big shoes to fill.

Mr. Thomas: Thanks, Ernie. I appreciate that.

Good afternoon. My name is Smokey Thomas, and I am the newly elected president of OPSEU. With me is Patty Rout—Patty is our newly elected first vice-president and treasurer—and Patrick Fry-Smith. Patrick is from ambulance dispatch.

It is appropriate that we meet here today during National Medical Laboratory Week, and we would draw your attention to the fact that 85% of decisions about diagnosis and treatment are based on laboratory results.

Thank you very much for this opportunity to speak about this bill, which is of great importance to many of our 125,000 members, not just those in health care.

OPSEU’s concerns around Bill 171 fall into four areas: One is the accountability of the new Ontario Agency for Health Protection and Promotion. Two is the plan to transfer about 600 workers from the provincial public health laboratories out of the Ontario public service and into the new agency. Three is the omission of a strong worker safety role for the new agency. Fourthly is the broad definition of “psychotherapy” and its sweeping implications for many public sector professions.

OPSEU continues to call on the government to rebuild Ontario’s public services and repair the damage caused by more than a decade of cuts to funding, staff and services. Nowhere has this damage been more evident than in Ontario’s public health protection system—from the Walkerton tragedy in 2000, through the 2003 SARS crisis, to the Toronto legionnaires’ outbreak in 2005. Each of these events revealed significant flaws in our health protection and surveillance systems, flaws that resulted directly from conscious policy decisions by government, ongoing underfunding and chronic neglect.

OPSEU actively contributed to both the O'Connor commission's Walkerton inquiry and Justice Campbell's SARS commission, and we have endorsed many of their key recommendations. This includes the call by both commissions to create a new Ontario Agency for Health Protection and Promotion as an agency of the Ministry of Health and Long-Term Care under the operational authority of the chief medical officer of health and the direction of a competent board appointed by the Minister of Health, and to transfer the Ontario public health laboratories to this new agency.

However, we have a number of very serious concerns about this act and its ability to achieve these objectives.

We note that the proposed agency will operate at a very long arm's length from both the Minister of Health and Long-Term Care and the chief medical officer of health. The chief medical officer of health will be neither a member of the new agency's board nor on its senior management team. The CMOH will also have authority to direct the agency's activity only in emergency and outbreak situations.

This runs directly contrary to Justice Campbell's recommendation that the CMOH have a hands-on role at the agency, including a seat on the board. Indeed, as he noted in his final report, the model put forward in this bill represents a completely opposite approach and ignores important lessons from SARS.

By establishing the new agency outside of the Ontario public service, the bill will undercut both the agency's accountability to the minister and the minister's direct accountability to the public for the agency's operations. It will reduce the transparency of the agency's operations while making it much more difficult to improve coordination between the public health labs, the ministry's public health branch and the rest of the health care system. It will do nothing to ensure that the new agency receives adequate funding from the ministry to reverse past cuts and to meet the public health challenge of the future. Finally, it will create unnecessary uncertainty and dislocation for the almost 600 OPSEU members who work in the provincial public health labs and will increase the risk of service disruptions and other problems during this important transition.

Justice Campbell recommended the establishment of whistleblower protection for health care workers to ensure prompt reporting of public health risks to the authorities. The government has yet to take action on this.

Under recent changes to the Public Service Act, Ontario public service employees, including employees at the provincial public health laboratories, will soon have whistleblower protections—protections which they will lose if the new agency is established outside the OPS.

OPSEU therefore recommends that the act be amended to establish the new agency within the Ontario public service and under the authority of the chief medical officer of health in his or her capacity as an assistant deputy minister within the Ministry of Health and Long-

term Care. This would allow the government to ensure the necessary independence and expertise of the new agency's board and senior management while preserving direct accountability to the minister and the public for its operations.

I would now like to hand it over to Patty to finish up.

Ms. Rout: Worker safety: Although not a formal recommendation, it is noteworthy that Justice Campbell amended the name of the new agency—Ontario Agency for Health Protection and Promotion and Worker Safety—in the section devoted to recommendations regarding the agency.

OPSEU strongly endorses the following recommendations which were made by Justice Campbell:

—that the Ontario Agency for Health Protection and Promotion should have a well-resourced, integrated section that is focused on worker safety research and investigation and on integrating worker safety and infection control;

—that any section of the Ontario Agency for Health Protection and Promotion involved in worker safety have, as integral members, experts in occupational medicine and occupational hygiene and representatives of the Ministry of Labour, and consult on an ongoing basis with the workplace parties;

—that the Ontario Agency for Health Protection and Promotion serve as a model for bridging the two solitudes of infection control and worker safety;

—that the Ontario Agency for Health Protection and Promotion serve as a model for bridging the two solitudes of infection control and worker safety;

—that the Ontario Agency for Health Protection and Promotion ensure that it become a centre of excellence for both infection control and occupational health and safety; and

—finally, that the mandate of the Ontario Agency for Health Protection and Promotion includes research related to evaluating the modes of transmission of febrile respiratory illnesses and the risk to health workers. This research should also identify the hierarchy of control measures required to protect the health and safety of workers caring for patients with the respiratory illnesses.

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Justice Campbell describes how the two solitudes of infection control and worker safety contributed to the spread of SARS and the chaos created in Ontario's health system and beyond.

OPSEU believes that it is critical to broaden the mandate of the proposed new agency, as a necessary first step to demonstrate the importance of worker safety and to make the critical links between worker safety and the safety of the public. It is a grave error to try to separate the health and safety of patients and the public from the health and safety of workers.

These changes would help ensure that the new agency's structure and mandate are more consistent with Justice Campbell's recommendations—

The Chair: One minute.

Ms. Rout: Okay.

In the meantime, if a new agency is established outside of the Ontario public service, we want to know:

—that successor rights will apply to all OPSEU members;

—that participation in the OPSEU pension plan will be grandfathered;

—that no OPSEU member will be laid off; and

—that no services will be privatized, downloaded or contracted out.

You have the rest of the presentation before you. Thank you.

The Chair: Thank you. We appreciate the presentation, and it certainly will be read.

ONTARIO KINESIOLOGY ASSOCIATION

The Chair: The next presentation is by the Ontario Kinesiology Association. I hope I'm close.

Ms. Conny Glenn: Close.

The Chair: I am an engineer; I'm trained, not educated.

Ms. Glenn: We share a kinship, then.

Mr. Jeff Leal (Peterborough): And a great engineer, too.

The Chair: Well, thank you. Hansard, please note that Mr. Leal said I'm a great engineer; I may need that as a job reference after October.

You have 10 minutes. Please state your names for Hansard first.

Ms. Angela Pereira: Thank you very much for the opportunity to present to you this afternoon. My name is Angela Pereira. I'm the current president of the Ontario Kinesiology Association. Our membership thanks you very much, as well, for the opportunity of presenting to you today.

I'll tell you a little bit about the background of the Ontario Kinesiology Association to give you a little bit of reference.

First of all, the OKA has been the representative body for the profession of kinesiology for 25 years in Ontario. We're currently comprised of two branches: the Ontario Kinesiology Authority, which manages certification and handles quality-of-service issues; and the Ontario Kinesiology Society, which provides membership services and promotes the profession.

To become a certified member, you must obtain a minimum of a four-year bachelor of science degree in kinesiology, with core competencies in anatomy, physiology, biomechanics, motor control and learning.

There are currently 13 universities in Ontario that offer kinesiology degrees.

Our current membership of 1,500 is primarily female, which comprises about 72%, and the vast majority are 26 to 30 years of age—41.5%. A full one third work in private rehabilitation clinics, with almost another one third working with employers providing ergonomics, health and safety, return-to-work, and wellness services. The remainder work in the health care system, in insur-

ance sectors, and also as physical fitness or activity consultants.

At this point, I'd like to introduce you to Conny Glenn, our executive director, who will talk to you a little bit further about what the regulation means to us.

Ms. Glenn: Thank you very much for allowing us to come and present today.

As Angela mentioned, I'm the executive director for the Ontario Kinesiology Association. I was formerly the president for a couple of years, as the initiative toward regulation began. I do work in private practice, as well, as an ergonomist.

I'd like to begin by thanking the Minister of Health and Long-Term Care, the Honourable George Smitherman, for moving forward with this legislation. We feel that it's long overdue to have a look at the regulation of kinesiology.

I'd also like to thank HPRAC, the Health Professions Regulatory Advisory Council, for their hard work during this process. We spent the last couple of years working with them. We felt that the process was very fair, very thorough, and they did an excellent job. So we commend them for that.

We'd like to unequivocally state that we are in full support of Bill 171 and that we are in full support of regulation for kinesiology and the other professions. Regulation, of course, exists to protect the public, and we believe it's imperative that the public be afforded that protection when they seek out the services of kinesiologists. That's why we would like to see this bill continue to progress forward. We see this as the next logical step in the evolution of the profession of kinesiology, and we see that as being in keeping with the evolution of health care here in Ontario.

Health care truly seems to be moving from a sick-and-illness model toward a health-and-wellness model, and that's one that we fit in very well with. I don't think I need to explain to the members here today the epidemics we're facing, the alarming rates of obesity, diabetes, cardiovascular disease and certainly the musculoskeletal disorders that are threatening the very economic stability of a lot of businesses. Currently, musculoskeletal disorders affect several hundred thousand people on a regular basis, and what we're seeing is a huge cost to businesses in terms of having to deal with and manage this.

Just a couple of quick stats to bring you up to speed in case you're unfamiliar: The estimated costs for cardiovascular disease in Canada were approximately \$19 billion, and it's still the leading cause of death—very alarming, given that it's highly preventable. I think that's the common theme we see with the disorders that I'm discussing with you today, that they are manageable, they are treatable and they are preventable. The very services that kinesiologists provide allow for the costs to be reduced. We would like to urge you to move forward with the bill because we feel it's in the best interests of the public to regulate kinesiology and allow the public further access to kinesiology services.

We are experts in human movement and exercise. Once regulated, the public will be allowed the protection and the comfort of knowing that the providers of kinesiology services are well qualified, that they're accountable for their actions. We're ready to step up to that challenge and to be accountable for what we do on a regular basis.

We'd like to sum up here today that we feel this is a very valuable and important piece of legislation that should move forward. It protects the interests of the public by protecting them, allowing them an access and a mechanism to challenge and question what kinesiologists do. It protects the integrity of the profession, and that's paramount in importance to us, that we're seen as being a consistent profession, that it's clearly understood what we do and how we offer that to the public. Last but certainly not least, it impacts on the economy of Ontario. These diseases and conditions that I've mentioned are running rampant. They are costing not only the health care system but the economy of Ontario. We see headlines on a regular basis that are pointing this out. I bring to your attention today's business section of the Toronto Star and yet another headline, "Obesity Eats into Bottom Line, Study Warns"—just another example of exactly the sort of thing that I'm discussing. So in terms of protecting the economy of Ontario, I think it's imperative that this bill move forward and that we continue to be able to offer those services with a high level of accountability to the province of Ontario.

The Chair: Are you finished?

Ms. Glenn: Yes.

The Chair: We have not quite a minute for each caucus. We'll start with Mr. Fonseca.

Mr. Fonseca: I'd like to thank the Ontario Kinesiology Association for your fine presentation. We often find that many presenters have come and said, "We've waited so long, and we're so happy that you are in sync with what we're doing." Actually, we are catching up to many of you in terms of being able to provide alternative health care services.

Can you tell me the impact this legislation will have on your profession? You've mentioned assurances for the public. Will you see an increase in numbers? We formed the Ministry of Health Promotion a year and a half ago in the government of Ontario. We want to move with you. We'd like to know how this will help you.

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Ms. Glenn: I think we can address that very easily. I think we're going to see more kinesiologists getting into health care. As we mentioned, there are 13 universities here in Ontario that graduate kinesiologists, and one of the things we're seeing is that they're devising specialized streams. For example, the University of Ottawa is at this moment putting together a stream that would specialize kinesiologists in physical activity counselling; we know that that's certainly an area where we're well needed. We're seeing kinesiologists begin work with family health care teams in that very role. So I think you're going to also see that kinesiologists, by virtue of

the fact that there are a number of extremely strong programs here in the province, are going to be able to unburden some of the health care providers in other areas. For example, we have kinesiologists right now who work providing case management services; we know there are also nurses who do that, and we certainly value the service they provide there, but there's a shortage of nurses in this province. So we are a bright, young pool of people—

The Chair: I need to move on. Mrs. Witmer.

Mrs. Witmer: I'll be very brief. We're thrilled that there's going to be the new college established. There's definitely a need in the province for the services you provide. I wish you all the best. We certainly would never hold up this part of the bill.

Ms. Martel: Can you describe to the committee the association's governance and quality assurance branch—because that's established now through the association, not through a college.

Ms. Elyse Sunshine: My name is Elyse Sunshine. I'm counsel to the association.

Recognizing that this was, in essence, a self-governing profession without the legislative teeth, we modelled ourselves after the RHPA and separated, under one roof, the association, which is the promotional body, from the regulatory body, the authority. We kept as close as humanly possible to the RHPA in the hopes that ultimately we would find ourselves where we are today and be able to divide off the regulatory branch from the promotional body. So—

The Chair: Thank you. My life is governed by this. I'm sorry. We're out of time.

ONTARIO COLLEGE OF SOCIAL WORKERS AND SOCIAL SERVICE WORKERS

The Chair: The next presentation is the Ontario College of Social Workers and Social Service Workers. Welcome. Please state your names for Hansard. You have 10 minutes.

Dr. Rachel Birnbaum: My name is Rachel Birnbaum. I have the privilege of being the president of the Ontario College of Social Workers and Social Service Workers. With me is the registrar of the college, Glenda McDonald, and legal counsel for the college, Debbie Tarshis.

I wish to thank the members of the committee for agreeing to hear our presentation this afternoon.

The college is the regulatory body for social workers and social service workers in Ontario, with approximately 11,500 members. The college is seeking amendments to Bill 171 to ensure that the bill recognizes the key role played by almost 7,000 social work members currently working in settings delivering psychotherapy services and enables them to continue playing that role by being included in the proposed legislative framework of Bill 171.

As you know, no one disputes that social workers have the skill, judgment and qualifications to provide psychotherapy services. The college is pleased that Minister Smitherman has made a commitment to present a legislative amendment that will recognize the profession of social work and to ensure that social workers who provide psychotherapy services associated with the new controlled act will continue to be able to provide these important services in the province of Ontario. The college wants to ensure that we are able to regulate our members effectively and in the public interest with respect to the provision of psychotherapy services.

In the interests of time, the following are the key amendments to Bill 171 being sought by the college. Other recommendations can be found in our written submission, which I believe you all have.

(1) That schedule Q be amended to provide positive authorization for social workers to perform the controlled act related to psychotherapy.

(2) That schedule Q be amended to permit social workers to use the restricted title “psychotherapist,” provided that this title is used in conjunction with the restricted titles “social worker” or “registered social worker.”

(3) That schedule Q be amended to exempt social workers from the holding-out provision in the Psychotherapy Act, 2006, provided that they comply with the Social Work and Social Service Work Act, its regulations and bylaws, so that a social worker would be able to represent that he or she is qualified to practise as a psychotherapist in Ontario.

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

The Chair: Thank you. We have about a minute and a half or better for questions. We will start with Mrs. Witmer.

Mrs. Witmer: Thank you very much. As I said to one other group, we’ve heard from the social workers and maybe that’s because we have so many students in our community who are part of the program.

You refer to the doctoral degree and the use of the title “doctor.” Do you just want to expand on that as to why you see that being so important and so necessary?

Dr. Birnbaum: Yes. As an academic who has earned the degree of a Ph.D., a doctoral degree, I think it is important that we be allowed to call ourselves “doctor.” In our submission, you will find our response to that very issue, which supports that we be allowed to call ourselves “doctor.”

Mrs. Witmer: I certainly do support that.

I guess the other key issue for you was the fact that you were excluded at first—

Dr. Birnbaum: Yes.

Mrs. Witmer: —from the provision of psychotherapy. But it appears that the government has indicated that they will be introducing amendments to deal with that. Are you pretty confident that the issue is going to be addressed?

Dr. Birnbaum: I am not aware of that issue.

Ms. Glenda McDonald: We’ve been assured that there will be an amendment introduced. I think we’re still working with—we hope we’re working with—the government to ensure that the amendment is consistent with our public policy recommendations on this matter: that there is positive authorization, that social work is treated on an equal footing with the other professions that have been authorized to perform the controlled act. So those are key issues. To our knowledge, it’s not there yet.

Mrs. Witmer: I guess this is it. At first I had heard that that definitely was there, but now you’re expressing some reservation as to what that might look like.

Ms. McDonald: That’s correct.

The Chair: Ms. Martel?

Ms. Martel: Thank you for being here today even though we had an earlier presentation by the association, who expressed, of course, similar concerns.

I look at your series of amendments on page 4. They gave us a single amendment. Maybe legal counsel might have a better idea of this. I’m not sure if you’ve seen what the association has put forward—because I don’t want to be in a position of putting forward different amendments. I’m not sure if you’re in a position to comment on what they’ve put forward and whether that addresses the college concerns as well.

Ms. Debbie Tarshis: The college would be pleased to carefully consider the language that has been proposed by the association, and it’s our intention to do that.

Ms. Martel: Have you had a chance to do that yet?

Ms. Tarshis: Not a sufficient chance to do that.

Ms. Martel: So it would be useful, I suspect, if we have some further conversation so that whatever goes forward reflects the needs and the concerns of both. We’ll have to do that outside of this hearing process.

The Chair: Mr. Mauro?

Mr. Bill Mauro (Thunder Bay–Atikokan): Thank you very much for your presentation and for acknowledging the efforts of Minister Smitherman in this regard, and also for acknowledging that it was never the intention to exclude social workers from the controlled act related to psychotherapy.

In your list of hoped-for amendments, number 3, I’m wondering if you could expand for me a little bit on this “holding out” provision in the Psychotherapy Act, 2006.

Ms. Tarshis: Schedule Q sets out a restricted title of “psychotherapist” and “registered mental health therapist,” and then there is a restriction that a person not hold themselves out as being qualified as a psychotherapist in Ontario. So the two really go together.

The college is very concerned that there will be confusion among the public as to those qualified professionals who are qualified to provide psychotherapy services, which is the basis for the college’s recommendation that social workers be permitted to use the title “psychotherapist.” So the two go hand in hand.

Mr. Mauro: Understood, then. Thank you for that.

The Chair: Thank you. We appreciate your being with us.

We will start the next presentation with one caution: that there may be a vote. So if the bells ring, we will have to recess, and then we will complete after the vote.

ONTARIO DENTAL HYGIENISTS' ASSOCIATION

The Chair: The next presentation is Michelle Clement. Welcome.

Ms. Michelle Clement: Thank you. Good afternoon.

The Chair: You need to state your name for Hansard.

Ms. Michelle Clement: My name is Michelle Clement, and with me today Margaret Carter, who is the executive director of the Ontario Dental Hygienists' Association. I am a registered dental hygienist who has been working in Belleville, Ontario, for the past 18 years.

It is an honour for me to be here today representing a profession that I love, and one that has evolved over the last 50 years from "cleaning ladies" to self-regulated dental health professionals. The process we are involved with here today is an opportunity to continue this evolution and for this government to improve the accessibility and affordability of dental hygiene services for the public of Ontario by the provider of their choice.

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In its 1996 report, HPRAC found that the ladder system of education of dental hygiene at the time was basically equivalent to the two-year training programs elsewhere in Canada and the United States. HPRAC was also of the opinion that the same skills and judgement are required to make the decision to proceed or to refer under self-initiation as under a standing order. Therefore, according to the HPRAC recommendation, no changes in the education and training were necessary to carry out the same decision-making process.

Since the 1996 report, dental hygiene has become a direct-entry, two-year program. As self-regulated professionals, we must participate in a quality assurance program. As lifelong learners, dental hygienists set goals for learning and focus on activities that complement their practice setting and enhance their knowledge and skills. Ethical and professional dental hygienists do not act in a manner that would compromise their patients' health, nor do they jeopardize their own ability to earn a living by committing professional misconduct.

HPRAC recommended an amendment to the Dental Hygiene Act to allow dental hygienists to self-initiate, subject to appropriate restrictions in regulations and standards. During the negotiations in 2006, we reiterated the confidence we had in the CDHO, our regulatory college, to do its job in the public's interest. Since the beginning, our college has been committed to appropriate regulations and standards of practice to make self-initiation a reality for our profession.

While there is a definite need and a willingness of dental hygienists to investigate alternative practice settings, dental hygienists have often been stymied by dentistry in denying an order. I believe you heard from a colleague of mine yesterday, Sheryl Sasseville, who

spoke eloquently of the challenges that she faces in providing care in long-term-care homes. For reasons that remain unclear, dentists have been reluctant to enter into professional arrangements with dental hygienists.

Periodontal disease is among the most prevalent chronic diseases affecting children, adolescents, adults and the elderly. Recent research indicates an association between periodontal disease and heart disease, and a probable bidirectional association between diabetes and periodontal disease. Since cardiovascular disease is multifactorial, all known means of prevention should be implemented, including oral hygiene maintenance. The prevalence of diabetes is increasing over time, taking an immense financial toll on Canadians, costing \$9 billion in health care, disability, work loss and premature death. Evidence shows that periodontal therapy, i.e., scaling and root planing, leads to improvement in glucose control. We must take immediate action to give Ontarians access to the preventive services of a dental hygienist. We must make oral health part of overall health for Ontarians.

In October 2005, Minister Smitherman invited the Ontario Dental Hygienists' Association and the Ontario Dental Association to discuss the order issue. At that time, I was the president of the ODHA, and along with my executive colleagues and the help of a negotiator, we worked with the dental association and discussed areas of dental health that both associations could mutually and cohesively work together on. During these discussions, we also attempted to understand each other's position with regards to the order.

I believe we accomplished two things during these negotiations. The ODHA accepted the challenge of negotiating and collaborating with dentistry to resolve a 14-year struggle, and these negotiations proved that both professions—dentistry and dental hygiene—could collaborate and work together in areas of mutual concern.

I would like to share my time with the ODHA and ask Marg Carter to say a few words.

Ms. Margaret Carter: Thank you. First and foremost, I would like to say how thrilled we are to be here to speak to Bill 171. It's a momentous occasion for our profession. I would also like to thank Michelle for generously sharing her time with the ODHA, the professional association representing the interests of dental hygienists in Ontario. The ODHA has been speaking on behalf of the profession since it was established in 1963.

Dental hygienists are highly skilled in helping clients to attain and maintain optimum oral health. As members of the oral health care team, they are responsible for professional treatment that helps to prevent gum disease, and they provide a process of care that involves assessing the oral condition, planning treatment according to individual needs, implementing the treatment plan, and evaluating the success of the treatment and planning for the future.

Once the Dental Hygiene Act is amended to remove the order requirement, Ontario consumers will have more affordable and more accessible dental hygiene care. A

conservative estimate of cost savings for ordinary Ontarians is 30%. Allowing dental hygienists to provide care without a dentist's order and to provide these services outside of a dentist's office removes the almost insurmountable obstacle to care for seniors, the uninsured, low-income families, students attending school away from home, those in long-term-care homes, as well as those in rural and remote areas.

Dental hygiene is a mobile profession, and a growing number of dental hygienists are prepared and committed to taking their services to those underserved groups. Passage of Bill 171 will allow the public this oral care service and the right to choose their health care provider.

Dental hygienists have provided care for more than 50 years in Ontario and know when it is safe to provide these services and when to consult with a family physician, nurse practitioner or dentist. There has never been a single complaint related to scaling and root planing against a dental hygienist. The dental hygiene regulatory college has never had to discipline a dental hygienist for an incident caused by improper or inappropriate scaling and root planing.

In 1995, and again in 1996, after extensive review, HPRAC concluded that the order requirement for "teeth cleaning" serves no public policy purpose and should be removed, subject to regulations developed by the dental hygiene regulatory college.

On behalf of the members of the Ontario Dental Hygienists' Association and dental hygienists in Ontario, ODHA would like to thank the government for moving forward with the amendment to the Dental Hygiene Act and, in doing so, fulfilling a promise made to the profession and providing Ontarians with access to much-needed preventive oral health services.

Ms. Clement: In my final point, I would like to discuss the concept of inter-professional collaboration among health care professionals. I was privileged to participate in the summit on advancing inter-professional education and practice held last June. Inter-professional care is care provided by a multidisciplinary team of health care professionals who work in synergy and learn from each other in order to provide comprehensive services to patients in various health care settings.

Ladies and gentlemen, I would like to thank Minister Smitherman for the incredible amount of hard work that he put forward into this bill, and I'm asking you to recommend Bill 171 for third reading and the opportunity to move the dental professions forward as role models and, indeed, champions of the change toward inter-professional care.

The Chair: Thank you. We have 25 seconds per caucus, starting with Ms. Martel.

Ms. Martel: Thank you very much to both of you for being here. Thank you, Michelle, for travelling from Belleville to be here. We did indeed hear from Sheryl yesterday, who comes from my riding—she lives in my riding—and who shared her story with me, her ongoing saga of over two years now. So we appreciate that you're here. That's a long way to come. Thank you very much for making the effort.

The Chair: Mr. Fonseca.

Mr. Fonseca: I'd like to thank you for your fine presentation. Our government does believe that when we work together, we're that much stronger in Ontario. Seeing the ODHA and the ODA working together in partnership to make sure that patients have more access: Can you tell me specifically what this will do for seniors in terms of dignity and respect for many who are in long-term-care homes?

The Chair: And you have five seconds.

Ms. Clement: I think Ms. Sasseville may have summarized that quite eloquently yesterday: just being able to provide services for them in their setting where they're most comfortable.

The Chair: Mrs. Witmer.

Mrs. Witmer: Thank you very much, Michelle. It's good to see you again. You too, Marg. I'm sure this is a really happy time. I know many hygienists and they do an outstanding job in providing patient services. So congratulations.

The Chair: Thank you for being with us.

ONTARIO FEDERATION OF COMMUNITY MENTAL HEALTH AND ADDICTION PROGRAMS

The Chair: The next presentation is the Ontario Federation of Community Mental Health and Addiction Programs. The time is yours.

Mr. David Kelly: Hi. I'm David Kelly from the Ontario Federation of Community Mental Health and Addiction Programs. Besides being the longest acronym that you're going to deal with today, the federation works with over 220 mental health and addiction providers across the province, from Red Bay and the James Bay coast all the way down to Windsor. We work to build a better system of provision for people with mental health and addictions. These issues affect one in five Ontarians, and we hope to continue building a stronger and better system.

1800

I firstly want to thank the committee for allowing us this opportunity to come and talk to you today. I also want to thank each and every one of you on a personal basis for the support that you provide to people with serious mental illness and addictions and those providers in your communities. The complexity of these issues and the impact on you, your ridings, your homes, your friends and neighbours is tremendous. Quite honestly, it takes all of us to come together to build a better system. So again, please, my sincere thanks on behalf of our membership for your assistance.

We are here to talk about the regulation of psychotherapy and the Psychotherapy Act, 2006. First let me say that the federation is very, very supportive of building more regulations, better standards and higher quality within the mental health and addiction field. This is important for us to go forward, it's important for you to make sure that we are accountable for the dollars you

fund us, and it's very important for the people who are using these services. So first let me say that we are supportive of going forward with regulations.

We do have some concerns in this process and I'm going to try to highlight those for you now. The first one I want to highlight is the scope of practice. I won't read out the scope, but the problem with this definition is that only certain professionals may be able to legitimately engage in therapeutic relationships. This would draw a line between those who practise psychotherapy, who will be legitimized by the act, and those who do not; for example, peer counselling. Consumer survivor initiatives within mental health and peer counselling within the addiction systems could be negatively impacted by this.

For example, the government of Ontario funds, we know, about a million dollars' worth of consumer survivor initiatives in the southern part of Ontario. We know from that million-dollar investment, we save a total of over \$12 million in acute care costs because of this type of counselling. So it can be a very effective tool to help divert people from higher-cost services. But it's also the outcomes and the support that goes with having peer counselling. So we're just concerned that once we go forward with the scope of practice of that, other components of the mental health and addiction system could be negatively impacted.

Secondly, I'd just point to the controlled act. Many community-based mental health and addiction service providers work with people with serious disorders through a variety of therapeutic relationships. We are concerned, again, by framing it here, that this could impact negatively the duties they provide and the services they provide out into the community.

Thirdly, I point to the harm clause, which has been amended to read "serious bodily harm" rather than "serious physical harm." The effect of the amendment is to include emotional or psychological harm with a pre-existing physical harm. Again, this may mean that the regular work of community-based health workers could be captured as psychotherapy. Those who do not qualify as psychotherapists will be unable to complete their duties or face increased liability issues.

I touch on the liability issues again. Will people still refer to peer-based counselling in the community if it's not covered under psychotherapy? In a sense, will we be disenfranchised in some ways by the process of the regulations of psychotherapy? Again, I want to emphasize our support for the regulations and the building of a college, further standards and further best practices in our field. The government has done a great job. I know both opposition parties have worked toward that and, as I said, the issues are so complex that we need to come together for that.

What we are recommending—we know so many of these issues are going to be decided by the regulations that come out of the transition council. So we are encouraging the government to add to that, and with the people named from the public, a consumer of addiction and mental health services to ensure that perspective is

brought in, and people from the community-based services provision sector to ensure that those complex issues are addressed and met at the college.

Again, the federation is very supportive of going forward. Our concerns are that as we go forward in regulations, we will marginalize service providers in a system that is already marginalized.

The Chair: Thank you. Just over a minute each caucus, and we'll start with Mr. Mauro.

Mr. Mauro: Thank you very much, Mr. Kelly. I appreciate your presentation and your comments about the supportive intent and where we're going with this in the regulation of many of these unregulated professions.

I just would like to share a bit with you in terms of your comments and concerns around the peer counselling piece and some of those groups potentially being unable to continue to practise. In fact, as we see it, under scope-of-practice provisions in the new act, this will not restrict people who are not members of the college from entering into therapeutic relationships with clients. Using your example, it's our feeling and understanding that peer branch counselling would still be able to continue.

Mr. Kelly: That's encouraging to hear. But again, I just point at the intentions, and as we go forward I think you need to hear that voice and the college will need that.

We talk about consumers of mental health and addiction services being the centre of the system. Let's make sure they are here too. Thank you.

The Chair: Mrs. Witmer?

Mrs. Witmer: Thank you very much, Mr. Kelly, for your presentation. You've certainly pointed out that if some of these changes do not occur, it's going to have a negative impact on the delivery of mental health services in the province of Ontario. I guess I would say to you, what could the most serious threat be if the changes are not implemented?

Mr. Kelly: The most serious threat is, I think, that the government will actually lose opportunities to benefit from the interaction between peer counsel, which will actually increase our health care costs and waiting times for services. I also think that areas of the province will be disenfranchised because there will not be enough providers. We face a human resource crisis already in the health care system. We want to make sure those are addressed.

The real tragedy, as you're well aware, is that people often fall through the cracks of mental health and addictions. That's why we need this concerted effort to make sure that we go the right way.

Mrs. Witmer: Thank you very much. I would agree with you that there are a lot of cracks out there, and we certainly need all the providers who are currently providing service.

The Chair: Ms. Martel?

Ms. Martel: Thanks, David, for being here. I know that the government has said that they think peer counsellors in particular are going to be okay under the scope-of-practice provision. But if you look under the "restricted titles" provision, if peer counsellors aren't

defined as either psychotherapists or considered to be registered mental health therapists, then they can't use the title and they can't hold themselves out to do that. Then you've got a problem where people think that psychotherapists, because they have a title, are more qualified and they'd better be going there, or some agencies saying, "We're only going to send people there, not to peer counsellors."

I think the coalition earlier put forward a reasonable amendment that might help here, which is to have some other subcategories of folks who are included and who would have title protection. I wanted to know your views about having some other categories under registered mental health therapists and, if we have peer counsellors there, if that would solve all the problems.

Mr. Kelly: That may be a possible way to go. I would have to look at what their presentation was and their titles, but that may be an opportunity to start distinguishing. This could impact supportive housing providers. There are a lot of other components in the system. That may be a solution to us, and that's why I speak, again, to the need for us to be part of the college, not necessarily the federation, but for consumers and mental health and addition providers to be part of the college, because that way we can start looking and maybe going to those subcategories within the system to ensure that the workers who are presently helping people can continue to do so. That may be a very good solution.

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

ONTARIO COLLEGE OF PHARMACISTS

The Chair: The last presentation is the Ontario College of Pharmacists. State your name for Hansard. You have 10 minutes.

Mr. Gerry Cook: Gerry Cook.

Ms. Deanna Williams: Deanna Williams.

The Chair: It's all yours.

Mr. Cook: Thank you, Mr. Chair and committee members. My name is Gerry Cook. I'm pleased to be here today in my capacity as president of the Ontario College of Pharmacists to provide our comments respecting Bill 171. With me today is our registrar, Deanna Williams, who will answer any questions you may have after the presentation.

The Ontario College of Pharmacists was established under the Pharmacy Act of 1871 and is the largest pharmacy regulatory authority in Canada. We currently regulate 11,000 pharmacists and 3,000 pharmacies.

Overall, our council strongly supports the amendments proposed in this bill, which we believe will streamline regulatory processes and enhance our ability to more effectively regulate the profession of pharmacy in the public interest. We are especially pleased that the proposed legislation gives effect to the regulation of pharmacy technicians as a new and separate class of registrant within the college.

1810

Ontario is the first jurisdiction in North America to formally regulate pharmacy technicians, recognizing the need for trained, accountable and regulated professionals to ensure a safe and effective drug distribution system. Having regulated pharmacy technicians to oversee the technical aspects of dispensing will permit those pharmacists who choose to do so to move with confidence into the cognitive roles for which they have been trained.

The college council was, however, very disappointed that the government did not accept the HPRAC recommendation that health professionals earning a doctorate degree from an accredited university program be permitted to use the "doctor" title as a vocational designation. Soon pharmacists will graduate from the undergraduate program at the Leslie Dan Faculty of Pharmacy at the University of Toronto with a clinical doctorate in pharmacy, or a Pharm.D. degree. The college believes that these graduate pharmacists should be able to use the doctor title, with the caveat, as always, that the health discipline in which they are qualified to practise is clear to the public as well as to other health care providers.

Unlike other health colleges, the Ontario College of Pharmacists is unique in having both the right and responsibility to regulate the people, places and things associated with pharmacy practice in Ontario. The college regulates pharmacists—the people—under the authority of the Regulated Health Professions Act and the Pharmacy Act, and it regulates pharmacies and the sale of drugs—the places and things—under the authority of the Drug and Pharmacies Regulation Act. Accordingly, the proposed amendments to the DPRA in schedule L are of particular interest to this college, and I would like to highlight just a few of them right now for you.

Under the proposed legislation, pharmacists in Ontario will be able to fill prescriptions from prescribers licensed in other Canadian jurisdictions. This is good news for those patients living in northern and eastern Ontario who seek medical services in Manitoba and Quebec and currently cannot have their prescriptions filled when they return home. This amendment, which was approved by college council more than 10 years ago, brings Ontario into line with what is currently permitted in other provinces in the country.

Most important to this college are the enhanced powers under the proposed legislation that will enable us to act faster to close a pharmacy where there is clear or compelling evidence that continued operation of the pharmacy places the public at risk. When counterfeit product was discovered in a Hamilton pharmacy in 2005, the college successfully obtained an injunction from the provincial courts to close the pharmacy in five business days. This process would have taken between three to four weeks under the existing law, which is an unacceptable option.

The Ontario College of Pharmacists applauds the government's efforts in undertaking this enormous review and revision project. We are very pleased and satisfied

with the extensive consultation process undertaken by HPRAC, and we believe that the resulting legislative amendments, as proposed, are sound and well intentioned.

I'd just like to thank you for the opportunity to provide our comments. Deanna and I will be pleased to answer any questions that you may have.

The Chair: Any questions from Ms. Martel?

Ms. Martel: Thank you for being here today. I want to focus on the "doctor" title, because HPRAC made a recommendation—you're not the only group that has been here to talk about that, so I appreciate that. Do you have any sense of why that particular HPRAC recommendation is not being applied, either with respect to your professionals in the college or others who are similarly affected because they have the doctoral level of education that would allow them to do that?

Ms. Williams: We don't really have a sense as to why that might be the case. It could be from a public protection standpoint.

Certainly, the caveat that our college would apply—and we would hope that everyone would—would be that the discipline in which the health professional is trained be clear to the public. There may be some concerns that someone putting a "doctor" name tag on could give the public the wrong information or it could imply that they're a medical doctor, so we would certainly put it in the standard of practice and expect that any pharmacists who use the "doctor" title would clearly indicate that they're a pharmacist.

Ms. Martel: And if not, they'd be subject to the discipline of their particular college. The protection

comes from the college being able to take disciplinary action against someone who does something untoward in that regard; so my assumption is that the colleges are perfectly capable of doing that. A number of them have been around for a long time and could exercise that, if warranted.

The Chair: Mr. Fonseca?

Mr. Fonseca: I'd like to thank the Ontario College of Pharmacists for your comments on the protection of patients and also the access that this will open up.

We've often had the OPA come in and present to us. Can you tell me a little bit about how the OPA feels about your submission, and do they support what you've requested here or some of the comments that you've made?

Ms. Williams: The college has consulted pretty widely on all of the regulatory proposals that are contained within Bill 171 over the years. The OPA is certainly one of our key stakeholders, as are the association of chain drug stores and hospital pharmacy. At the OPA's request, we did give them a copy of the presentation that we were doing today, and they did indicate support for it.

The Chair: Thank you. That concludes our presentations.

I'll remind the committee that proposed amendments must be filed with the clerk by 12 noon on Friday, May 4, and this committee will meet for the purpose of clause-by-clause consideration on Monday, May 7.

We have managed, amazingly, yet again, to finish at precisely 6 o'clock. This committee is adjourned.

The committee adjourned at 1816.

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