

***The College of Physician and Surgeons of  
Ontario's Submission on Bill 179 – The  
Regulated Health Professions Statute Law  
Amendment Act, 2009***

**September 25, 2009**

The College of Physicians and Surgeons of Ontario (CPSO) appreciates the opportunity to provide feedback to the Standing Committee on Social Policy on Bill 179, *the Regulated Health Professions Statute Law Amendment Act, 2009*.

As you are aware, the CPSO is the licensing and regulatory body for Ontario doctors. Currently, there are close to 35,000 doctors registered with the College. The CPSO registers new physicians, deals with complaints and reports, and disciplines doctors when necessary. The core function of the CPSO is to regulate the medical profession in the public interest. This includes ensuring that anyone who receives a license to practice medicine in Ontario has the skills and training to do so safely and effectively. Ensuring patient safety in all areas of medical care is the CPSO's top priority. In broader terms, the CPSO works to ensure the best possible care for the people of Ontario by the doctors of Ontario.

Our submission will focus on the following issues:

- 1) Supervisor and Audit provisions;
- 2) Interprofessional Care and Scope Expansions;
  - a. Prescribing
  - b. Pharmacists
  - c. Midwives
  - d. Optometrists
- 3) Other sections of the Bill
  - a. Unique Identifier
  - b. Professional Liability Insurance
  - c. Expert Committees
  - d. Dispensing
- 4) Additional RHPA Revisions proposed by the CPSO
  - a. Greater discretion re: investigating complaints
  - b. Non-Council Public Member

## **General Comments**

Bill 179 is a substantive piece of legislation, which not only makes significant amendments to the *Regulated Health Professions Act (RHPA)* but to numerous other health care Acts. Through Bill 179, the government is proposing significant changes to the health care system in terms of how health professionals interact with one another and how the government interacts with health regulatory colleges.

The CPSO has been a longstanding supporter of the Interprofessional Care (IPC) model. We have also been an ongoing and active participant in previous discussions relating to health regulatory college accountability, individual professions' scope expansions and IPC. Most recently, the CPSO contributed to the comprehensive consultation process conducted by the Health Professions Regulatory Advisory Council (HPRAC). We are pleased to see our feedback on many issues incorporated into the Bill.

The CPSO generally supports Bill 179 but we have a few very significant areas of concern which are outlined in the submission, together with suggestions to address them.

While we recognize that the Bill is intended to be enabling, we are concerned that many important details have been left to regulation. This limits our ability to provide feedback on a number of issues. Continuing consultation between the regulatory colleges and government will be extremely important in order to fill in the missing details. While we will provide specific comments during these consultations, it is our general view that discussions about regulation development and implementation of the Bill should build on the extensive work that has already been done.

As we have previously communicated to government, the CPSO is very concerned about the supervisor and audit provisions in Bill 179. In addition to our comments about the provisions themselves, which are set out below, the CPSO is very concerned that

the introduction of these provisions has moved the focus of discussion away from the important access and IPC initiatives contained in the Bill. It had been our understanding that improving access and facilitating IPC were the primary goals of the proposed legislation.

## 1. Supervisor and Audit Provisions

This section gives very broad discretion to the Minister to appoint a supervisor for a regulatory college and permits the Minister to give the supervisor all the powers of council. In effect, it allows government to take over all the functions of a self-regulating body for virtually any reason.

This new power was included in the Bill without previous consultation and was completely unanticipated by the CPSO and other regulatory colleges. We fail to understand what problems Ontario's health regulators pose that could justify such an extraordinary power—one which enables the government to completely suspend the functioning of self-regulatory bodies in Ontario.

The CPSO believes that these provisions are unnecessary and demonstrate a lack of trust in self-regulation.

It is the CPSO's view that the government already has the power it needs under section 5 of the *RHPA* to ensure regulatory colleges fulfill their statutory duties in the public interest. The Minister of Health and Long-Term Care already has the authority, for example, to require health colleges to provide reports, require college councils to make, amend or revoke a regulation and **“to do anything that, in the opinion of the Minister, is necessary or advisable to carry out the intent of this Act, the health profession Acts or the *Drug and Pharmacies Regulation Act.*”** In addition, there are numerous oversight mechanisms in place that ensure the accountability of health regulatory colleges. For instance:

- Health profession regulators have the greatest proportion of public representation on our governing councils (boards) appointed by the government compared to other professional regulators and, our public members serve on all our committees;
- We are required to circulate all of our proposed regulations for public comment before they are approved by council (these are often amended based on input received);
- All regulations approved by our councils must be further approved by the government (through the Cabinet);
- Our council meetings and discipline hearings are open to the public;
- Our registration practices are reviewed by and audited for the Office of the Fairness Commissioner to ensure that they are transparent, objective, impartial and fair;
- Our registration and complaints decisions are subject to external appeal by an arms-length, specialist tribunal—the Health Professions Appeal and Review Board (HPARB);
- All our adjudicative decisions are subject to appeal through Ontario’s courts;
- Our Quality Assurance and Patient Relations programs are subject to the scrutiny of an arms-length body—the Health Professions Regulatory Advisory council (HPRAC);
- Significant regulations and policy issues related to regulated health professions are scrutinized by the Health Professions Regulatory Advisory council (HPRAC); and
- We provide extensive information about the individual members we regulate directly to the public.

Given the broad range of oversight tools available to the Minister, we believe that no additional authority is required.

Medicine has a long tradition of self-regulation in the public interest. These new powers, which were not discussed with the colleges during any of the extensive

preliminary consultations, fundamentally undermine professional self-regulation in Ontario.

The introduction of such significant and broad government powers to intervene in the activities and decisions of self-regulating professions demands a strong and clear rationale which we have not received. Further, we believe that any decision regarding whether to undertake such a dramatic intervention into the affairs of a regulatory body of a self-governing profession requires careful thought. We remain concerned, for instance, that extensive media coverage of a particular case could result in a rush to judgment and an inappropriate decision to appoint a supervisor or auditor.

The CPSO recommends that these provisions be removed from the Bill.

### **Proposed Alternative to the Supervisor and Audit Provisions**

As noted above, the CPSO believes that section 5 of the *RHPA* as currently written affords the Minister sufficient powers to intervene in the affairs of a regulatory college where necessary. If the government believes that the Minister's existing powers are not sufficient and that a provision for the appointment of a supervisor is necessary, the CPSO recommends that this section be amended to provide that this extraordinary power shall only be used in exceptional cases where a college does not comply with the Minister's request under section 5 (1) d and, the Minister demonstrates that there is a risk to patient safety.

The amendments would also serve to facilitate early resolution by allowing the college to comply with the Minister's directions and provide some procedural safeguards.

Specifically, the CPSO recommends that the supervisor provisions be amended to require the Minister to first turn to existing powers under section 5 to address any issues relating to a regulatory college. Only where the college does not fulfill the requirements set out in section 5 (1) d would the Minister move to appoint a supervisor. The Minister

would have to demonstrate that patient safety was at risk and would be required to follow certain procedural steps:

- Require the Minister to provide written notice to the affected college (not less than 60 days) which outlines the requirement that the college did not fulfill,
- Give the college an opportunity to make written submissions to the Minister,
- Give the college an opportunity to comply with Ministerial directions and avoid the appointment of a supervisor, and
- Ensure that the powers granted to the supervisor are limited to those which are necessary to address the requirements outlined in the Minister's notice and do not reach over into other areas

We believe that the CPSO's proposed amendments to the supervisor provision would help ensure that government intrusion into the affairs of self-regulating professions is limited to exceptional cases where the public is at risk and the Minister's existing powers under section 5 (1) d of the RHPA are insufficient to enforce a directive from the Minister. They will also provide some procedural safeguards for the college affected and mitigate the impact on Ontario's self-regulating model for the health professions.

**The wording of our recommended amendments are attached in Appendix "A".**

With respect to the auditor provision, we do not believe that an amendment would remedy this section. Given the regulatory colleges' already extensive reporting requirements to the Minister (as noted above) and the fact that the government has failed to articulate any rationale to justify introducing such new audit powers for self-funded bodies, we urge the Committee to remove this provision from the Bill altogether.

## 2. Interprofessional Care and Scope Expansions

### Interprofessional Care (IPC)

The CPSO supports government efforts to identify ways to improve access to care and acknowledges that IPC is one of the constituent elements in resolving health human resource shortages. The CPSO has been consistently supportive of IPC. We frequently provide assistance and insight on regulatory matters to other colleges via consultations and ongoing collaborative relationships, and we encourage our members to work collaboratively with members of other regulatory colleges.

The CPSO supports expanding the scope of health professions to reflect the knowledge, skill and judgment of each profession but we emphasize that care should be provided in a collaborative fashion that breaks down silos and avoids duplication.

Providing expanded access to additional controlled acts to a variety of health care professions is only one element of IPC. Effective IPC depends on attention to broader issues: funding mechanisms, electronic health records and a comprehensive resource planning process, among others. Expanding scopes without a careful analysis of the system impact risks duplication of care and increased costs. It may also contribute to mismanagement of patient care and associated health risks. And finally, it will have limited uptake in the absence of rational payment schemes.

The CPSO notes that other legislative changes might have an equal or more significant impact on access to care and IPC. For example, the requirement under the *Public Hospitals Act (PHA)* that physicians, dentists or midwives must provide an order for all treatments received by inpatients frustrates professionals in their ability to deliver quality care and may lead to conflict. It creates a practical barrier to proceeding with safe and timely delivery of care (many times professionals who wish to proceed with an activity well within their scope of practice are barred from performing it in the hospital setting

because of this requirement) and may present a cultural barrier by perpetuating an apparent hierarchy among the professions.

This CPSO urges the Ministry of Health and Long-Term Care (MOHLTC) to review all of the systems issues and the network of laws pertaining to health care settings in order to take a systems approach to resolving the access to care crisis.

### **Scope Expansions**

In general, the CPSO supports expansions for other scope for other regulated health professionals, as long as these expansions are:

- consistent with the knowledge, skill and judgment of the professionals involved;
- subject to a rigorous regulatory structure;
- supportive of a truly collaborative, team-based approach to care as opposed to parallel care (i.e. professions working independently without appropriate interprofessional interaction (i.e. parallel care));
- safe for patients; and
- accompanied by educational initiatives for both the public and health care providers to ensure that people understand the changes that are being made.

We are concerned, however, that in the rush to expand scopes to facilitate access, ensuring that the expansion is kept within the parameters of the profession's knowledge, skills and judgement may not be receiving the rigorous analysis required. There is a significant difference between competence to do individual procedures or controlled acts and the ability to manage a patient's care in its entirety, especially if care is not provided in a collaborative fashion.

We are especially concerned about the lack of detail set out in the Bill which leaves significant aspects of its application to regulations which have not yet been considered. The true nature of the expanded scopes cannot be determined without the full context.

## **(a) Prescribing**

The Bill expands authority to prescribe to a number of additional health professions. In order to safely prescribe, in most circumstances a health care professional must be able to do so in the context of the patient's whole health picture. In the absence of the ability to diagnose and to understand the potential complexities of the patient's various health issues, prescribing can only occur safely when it is undertaken in collaboration with a health professional who has the range of controlled acts that are essential to seeing "the whole picture".

An example that illustrates our concern is the treatment of glaucoma. This is a complex disease. While optometrists have the training required to undertake a specific activity, such as prescribing medication for primary open angle glaucoma, where this is indicated in regulation, we would not expect them to have the requisite knowledge, skills and judgement to independently manage the complexities of the disease process in its entirety.

As well, the CPSO is of the view that stringent educational requirements must be put in place by regulatory colleges to ensure that all health professionals have the necessary knowledge, skill and judgment to effectively and safely prescribe the drugs designated in their respective regulations. With appropriate training, prescribing can be a useful component of non-physician health care, provided that this is done within a collaborative context.

## **(b) Pharmacists**

After a lengthy consultation process, the HPRAC released its "Critical Links" report which made specific recommendations regarding pharmacist prescribing that limited the circumstances in which pharmacists could prescribe.

In 2008, the CPSO Council approved the PAPE (Pharmacist Authorization or Prescription Extensions) agreement. PAPE was also agreed to by the Ontario College of Pharmacists. PAPE formalizes the practice of pharmacists extending prescriptions under certain circumstances (e.g. the medication is for a chronic or long-term conditions; no narcotics; patient has a stable history while on the medication; the extension must be reported to a prescriber within one week).

Bill 179 is inconsistent with the recommendations of HPRAC and the substance of the PAPE agreement: it simply says that pharmacists are authorized to prescribe drugs. The CPSO cannot support this section as drafted without assurance that the significant previous work in this area will be included in regulation. The CPSO's position is that pharmacists have a key role to play in managing medication but this must occur in collaboration with a prescriber and only after a diagnosis has been made.

### **(c) Midwives**

It goes without question that patients come first – urgent situations require the most qualified person to act. However, as with the glaucoma example, the CPSO is concerned that expressly authorizing midwives to undertake the controlled act of intubation beyond the larynx of a newborn fails to take into account the complexities of the situations in which this need would arise. Intubation must be part of a program of airway management, and should not be provided as a stand-alone intervention.

Our additional concerns relate to systems issues – evidence shows that in order to perform a medical act competently, it is necessary to perform it with relative frequency. Realistically, most midwives would not have the opportunity to perform this act often enough to ensure competence. It is worth noting that this College does not submit that midwives should be prevented from acting in order to save a patient's life. On the contrary, the *RHPA* in its current form permits midwives to intubate under delegation and in emergencies. In our view, this is the safest approach for this act and this profession.

#### **(d) Optometrists**

We have concerns about optometrists treating glaucoma and prescribing glaucoma medication, as described in section (a).

We are concerned that in the absence of specific legislative or regulatory requirements that such prescribing take place in association with a physician, doing so would lead to unacceptable patient risk.

#### **Unique Identifier**

We endorse the introduction of the requirement for a unique identifier in Bill 179. This College has been an advocate for the development and introduction of MINC (the Medical Identification Number for Canada). MINC has been developed to identify every individual in the Canadian medical education and practice system. MINC numbers will be issued to all individuals at the time of first (even temporary) entry to any aspect of the Canadian medical education or practice systems, including undergraduate students, postgraduate trainees, applicants to MCC examinations, and physicians of any registration status. While MINC is currently in use only by doctors, it is capable of being used for all health professions.

Once assigned, MINC numbers remain unchanged throughout the individual's entire medical career. Assigned numbers are never to be re-used, even after the death of the individual. Individuals carry the same MINC number, even if they leave Canada and return, move between jurisdictions, or change registration status. In addition, for research and planning purposes, data may be obtained through the non-nominal use of MINC numbers.

MINC is currently being used by all Canadian provinces except for Ontario and New Brunswick. The adoption of MINC by Ontario now would be especially timely with the

anticipated implementation of the labour mobility chapter of the Agreement on Internal Trade (AIT) through Bill 175, the *Ontario Labour Mobility Act*. It would also facilitate the province's health human resources planning. Given that both of these initiatives impact not only physicians but all health professions, it is significant to note that MINC is being built on a platform that could over time be expanded to all health professions.

We are concerned that, as currently drafted, the Bill's proposed amendments to subsection 36.1(2) of the *RHPA* may not be sufficiently clear that MINC is the model intended by the MOHLTC for physicians. The benefits of the unique identifier will not be realized if a consistent unique identifier is not adopted to avoid multiple identifiers and prevent unnecessary duplication. We believe this section could be amended to explicitly state that MINC will be the unique identifier assigned to physicians with potential for expansion to other health professions in the future.

### **Expert Committees**

The CPSO welcomes changes to the current process for approving drug regulations, as the current process is extremely cumbersome. The proposed drug approvals expert committee as well as the new drug approvals process set out in the Bill will improve on this. However, we note that the composition of this important committee is not set out in the Bill. The CPSO believes that there should be physician representation on this committee given the expertise of physicians in the area of medications and drugs. The provision in Bill 179 also appears to authorize expert drug committees to amend drug lists without enacting new regulations. The CPSO believes that an expert committee should not be authorized to amend drug lists without consultation.

These provisions also allow the Minister to appoint expert committees to consider issues other than drugs. This is a broad power with no clear parameters set out. It is not clear why the Minister needs this power and in what circumstances it might be used. The CPSO objects to this unlimited power. Depending on the subject matter of the

committee, there is the potential for these committees to inappropriately interfere with the regulation of health professions.

### **Dispensing**

Bill 179 makes amendments to the sections of the *Drug and Pharmacies Regulation Act (DPRA)* related to dispensing. Only certain sections of the *DPRA* will apply to physicians who dispense outside of a pharmacy (e.g. in their office). For example, section 156 of the *DPRA* – which sets out requirements with respect to record keeping and labeling – will not apply to a physician. Instead of this provision, the regulation making authority under the *Medicine Act* has been expanded somewhat to allow the CPSO to make regulations relating to record-keeping, labeling, etc. Other professions who have the controlled act of dispensing also have regulation-making authority to make regulations relating to dispensing. It is not clear why the *DPRA* would not apply to all professions who dispense drugs. The CPSO believes that all professions who dispense drugs should meet the same basic standards and that the standards in the *DPRA* should be the benchmark. The CPSO has supported and advocated for common standards for all dispensers.

Bill 179 also enables remote dispensing and the CPSO is supportive of this initiative as long as the accountability of the dispenser remains clear.

### **Additional Requests**

The CPSO is also seeking amendments to the *RHPA* related to the complaints and discipline process. Given that Bill 179 opens up the *RHPA*, the CPSO is requesting two additional amendments that we believe will improve the timeliness and efficiency of our complaints and discipline processes and enhance the effectiveness of the CPSO as a regulator.

1. Discretion regarding Investigating Complaints (Section 25 of the Health Professions Procedural Code)

Currently, the Inquiries, Complaints and Reports Committee (ICRC) is required to investigate every complaint unless it deems the complaint frivolous, vexatious or an abuse of the process. A number of other regulatory authorities in Canada have greater discretion to decline complaints when an investigation is not in the public interest. The colleges could do their work more efficiently if we had the ability to decline to investigate a complaint if it did not relate to professional misconduct, incompetence or incapacity of a member and did not raise a public safety issue. Currently, such complaints consume CPSO staff and committee time and can compromise the CPSO's ability to manage more critical issues. This amendment would enable the CPSO to stay focused on issues that concern patient safety and care and member professionalism.

2. Allow Non-Council Members of the Public in the Constitution of Quorum for the ICRC and Discipline Committees

Currently, the *RHPA* stipulates that quorum for most of the CPSO's seven statutory committees requires at least one public member of council; two public members are required for quorum for each panel of the Discipline Committee. As the MOHLTC is well aware, this College has at times been in the unfortunate situation of not being in a position to achieve quorum due to the unavailability of public council members for ICRC and discipline panel work.

A number of other Canadian regulators may appoint non-council members of the public to committees. The CPSO is recommending that Bill 179 be amended to allow non-council members of the public to be appointed to committees and to contribute to the proper constitution of quorum for ICRC and Discipline committees. We would seek to use public members of council first before turning to non-council appointees. Such an amendment would allow these important committees to fulfill

their responsibilities more efficiently and effectively. The pool of eligible public members participating on the ICRC and Discipline committees would be “vetted” by government.

**The wording of our recommended amendments are attached in Appendix “B”.**

### **Conclusion**

The CPSO thanks the Committee for this opportunity to provide comments on Bill 179. We hope that you will consider all of our comments and recommendations to enhance the government’s objectives of increased access to care and improved quality of care for the people of Ontario.

## **APPENDIX “A”**

The College of Physicians and Surgeons of Ontario recommends that section 5 of the *Regulated Health Professions Act* be amended to read as follows (new wording appears in bold text):

### **Powers of Minister**

- 5.(1) The Minister may,
- a) inquire into or require a Council to inquire into the state of practice of a health profession in a locality or institution;
  - b) review a Council's activities and require the Council to provide reports and information;
  - c) require a Council to make, amend or revoke a regulation under a health profession Act or the *Drug and Pharmacies Regulation Act*;
  - d) require a Council to do anything that, in the opinion of the Minister, is necessary or advisable to carry out the intent of this Act, the health professions Act or the *Drug and Pharmacies Regulation Act*.

### **Council to comply with Minister's request**

(2) If the Minister requires a Council to do anything under subsection (1), the Council shall, within the time and in the manner specified by the Minister, comply with the requirement and submit a report.

### **Minister may appoint a College supervisor**

**(2.1) If a Council does not comply with the Minister's request under subsection (1)(d), the Lieutenant Governor in Council may appoint a person as a College supervisor, on the recommendation of the Minister, for the limited purpose of fulfilling the Minister's requirement.**

**(2.2) In deciding whether to make a recommendation, the Minister must be satisfied that there is a risk to patient safety.**

**(2.3) Before the Minister makes a recommendation to the Lieutenant Governor in Council under section 2.1 of the Act in respect of an affected College, the Minister must send to the Registrar of the affected College a written notice**

- (a) advising the affected College of the purpose for which the Minister is making the recommendation and the specific requirement which was not fulfilled;**

- (b) advising the affected College of the powers and duties it will ask the Lieutenant Governor to bestow on the College Supervisor**
- (c) inviting the affected College to provide the Minister with submissions with respect to the recommendation; and**
- (d) specifying the time in which the affected College must provide its input to the Minister, which must not be less than 60 days from the date the Minister sends the notice.**
- (e) On making the recommendation, the Minister must provide the Lieutenant Governor in Council with a copy of the College's submissions.**

**(2.4) The Lieutenant Governor in Council must specify the powers and duties of a College supervisor appointed under this section and the terms and conditions governing those powers and duties.**

**(2.5) The powers and duties of a College supervisor are limited to those powers and duties necessary to address the requirement identified by the Minister in his or her recommendation for the appointment of a supervisor.**

**(2.6) the Council continues to have the right to act respecting any matters outside the scope of the duties of the College Supervisor, and any such act of Council is valid without any approval of the College supervisor.**

### **Regulations**

**(3) If the Minister requires a Council to make, amend or revoke a regulation under clause (1) (c) and the Council does not do so within sixty days, the Lieutenant Governor in Council may make, amend or revoke the regulation.**

### **Idem**

**(4) Subsection (3) does not give the Lieutenant Governor in Council authority to do anything that the Council does not have authority to do.**

### **Expenses of College**

**(5) The Minister may pay a College for expenses incurred in complying with a requirement under subsection (1). 1991, c. 18, s. 5.**

## **APPENDIX “B”**

The College of Physicians and Surgeons of Ontario recommends that the *Regulated Health Professions Act* be amended as outlined below.

### **Greater Discretion to Investigate Complaints**

The College of Physicians and Surgeons of Ontario recommends that Bill 179 be amended by adding the following:

Section 25 of the Health Professions Procedural Code is amended by adding the following:

- s. 25(4.1) Despite subsection (1), a panel shall not be selected to investigate a complaint if, in the opinion of the chair of the Inquiries, Complaints and Reports Committee, the complaint does not relate to professional misconduct, incompetence or incapacity on the part of a member.

### **Counting Non-Council Public Members towards Quorum for the ICRC and Discipline Committee**

The College of Physicians and Surgeons of Ontario also recommends that Bill 179 be amended by adding the following:

[For the ICRC Committee]

Sub-section 25(2) is amended to read:

A panel shall be composed of at least three persons, at least one of whom shall be a resident of Ontario who is not a member of the College.

[For the Discipline Committee]

Sub-section s.38(2) is amended to read:

A panel shall be composed of at least three and no more than five persons, at least two of whom shall be residents of Ontario who are not members of the College or

A panel shall be composed of at least three and no more than five persons, at least one of whom shall be a person appointed to the council by the Lieutenant Governor in Council, and at least one of whom shall be a resident of Ontario who is not a member of the College.