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Ms. Annie Schiefer
Health Professions Regulatory Advisory Council
55 St. Clair Avenue West
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Dear Ms. Schiefer,

Attached please find the Ontario Medical Association's (OMA) comments on the proposed changes to the scope of practice of physiotherapy, dietetics, medical laboratory technology, medical radiation technology and pharmacy.

The OMA is committed to working together to improve care and address the barriers to interprofessional collaboration in health care settings. However, the OMA stresses the importance of patient safety in addressing professionals' scope of practice. As you will see from our response, the OMA is concerned about the impact the proposed changes will have on the quality of care provided to patients. The OMA emphasizes the importance of both training and ongoing skills maintenance in handling complex medical issues including diagnosing, prescribing and treating illnesses.

We hope HPRAC will include the OMA's views in the preliminary review of the proposed regulatory changes to scope of practice. We look forward to participating in ongoing dialogue on this important issue.

Sincerely,

Ken Arnold MB BCh
President



ONTARIO MEDICAL ASSOCIATION

Submission to the Health Professions Regulatory
Advisory Council
Respecting
Issues Related to Scope of Practice:
Dietetics
Physiotherapy
Medical Radiation Technology
Medical Laboratory Technology
Pharmacy

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The Ontario Medical Association (OMA) thanks the Health Professions Regulatory Advisory Council (HPRAC) for the opportunity to provide input on the proposed scope of practice changes. A number of the proposed changes to the scope of practice of physiotherapists, medical radiation technologists, medical laboratory technologists, dietitians and pharmacists may serve as good discussion points in developing a functioning model for interprofessional care. However, some of the proposed changes do not support interprofessional care, but rather an independent approach to health care that presents risks to patients. The OMA has consistently supported interprofessional collaborative initiatives and discussions on improving access to care and will continue to do so. However, the OMA must continue to emphasize its position: as steps are taken to improve patient access to health care we must ensure that patient safety is not compromised.

We begin with general comments on the proposed changes and then address those specific recommendations that we believe do not meet HPRAC goals and that are of high importance to the OMA.

Focus on Current Scope of Practice.

The OMA is committed to supporting interprofessional care. The health professionals involved in this review are practitioners who undertake care within specific parameters. The professions focus on expanding scopes of practice either through developing existing controlled acts or adding new acts to their repertoires. Some of the suggestions are appropriate and will function along an existing continuum of care. However, the OMA strongly believes that the most useful approach to improving interprofessional collaboration is to assist all health professionals in fulfilling their current scopes of practice to the fullest extent.

Training and Education.

The level of training required for many of the expanded and additional controlled acts suggested by the Colleges and Associations is tantamount to that required by physicians practicing in these areas of health care. Physicians undertake activities based on best

practices and clinical knowledge that is gained through extensive training and education. The OMA is not satisfied that other health professionals have sufficient training and education to undertake many of the tasks that they have requested. It is therefore useful to acknowledge this fact and articulate clearly the requirement for physician consultation.

The OMA would also stress the importance of having diagnostic tests interpreted in the appropriate clinical context with knowledge of the patient and the background as well as the psychological and social aspects of illness. Currently a health care provider who is authorized to do so, will order a lab test, interpret the results, discuss the results with the patient and formulate follow-up plans. The OMA believes that the professions asking for an increase in their scopes of practice do not have the educational background or training to do this.

Clarity in Purpose of Review

It is the OMA's understanding that the HPRAC review project has, as its goal, improving quality patient care in a collaborative environment. However, it appears that some professions' proposed changes may inadvertently cause further fractionation instead of integrating care. Certain medical conditions demand physician attention; management of these complex cases should not be delayed or undermined because of practitioners' unwillingness to share care or make referrals. This will create more silos of care rather than fostering collaborative care.

Patient Safety and the Delegation Model

The OMA stresses that patient safety demands appropriate assessment, appropriate treatment and appropriate follow-up of the patient. There is a fundamental difference between performing a delegated act within a specific framework and performing a controlled act on one's own initiative. The delegation model exists to protect the public from the consequences of controlled acts that present risks to patients if not performed within strict guidelines. Well-designed delegation models can and do cover most eventualities. Moreover, nothing in the current scopes of practice obliges professionals working under medical directives to perform procedures they judge to be harmful. Physiotherapists, MLTs, MRTs, dietitians, and pharmacists can and should seek clarification and guidance from the

ordering physician, lab director or delegating medical/scientific staff. Many of the changes proposed in the submissions could result in physicians no longer acting as team leaders, but rather as team consultants. Having physicians move into a more executive role in health care will not address patients' needs in Ontario.

Underserviced Areas

Most of the submissions to HPRAC argue that expanding scopes of practice will enhance medical care provided to underserviced areas. While the OMA agrees that this is an important objective, we question whether the proposed changes to scope of practice will have a significant impact on care provided in underserviced areas. There is no evidence to support the notion that expanding scope of practice will increase the number of health professionals practicing in underserviced areas. Expanding scopes of practice may only change the nature of health care provided by health professionals in urban hospitals and care settings.

Additional Demand on Scarce Resources

The OMA is concerned by the unintentional results of allowing a broad range of health professionals to order numerous laboratory and diagnostic tests. We do not believe this will improve patient care, but it will increase demand on stretched resources through duplication of testing and possibly an increase in unnecessary testing.

Professional Liability

Serious consideration will also have to be given to professional liability associated with providing incorrect advice based on interpretation of lab test results. We also stress that it is the responsibility of the ordering professional to interpret results and plan the follow-up. Certain aspects of the proposed changes may lead to poor follow-up as test results may not be reviewed properly or at all by the appropriate care provider.

Comments on Proposed Changes to Scopes of Practice.

Physiotherapy

The OMA agrees that the *Physiotherapy Act* should reflect the current scope of activities undertaken by physiotherapists. The OMA is concerned by a number of the requests put forward by the College of Physiotherapists of Ontario and the Ontario Physiotherapy Association (OPA). First, the OMA would like to comment on the OPA and College's request to **diagnose and communicate a diagnosis**. The submission states that diagnosing is a "core element of physiotherapy practice, critical to serving population needs. It is taught and tested in physiotherapy educational programs as an expected entry to practice competency". However, in its current form, the scope statement regarding diagnosis is too broad.

The act of diagnosing requires an understanding of not only the physical symptoms of an illness, but also the physiological and medical aspects of illness as well as the underlying psychological and social context. Incorrect diagnoses may lead to complications and conditions that are avoidable with appropriate medical assessment. The OMA suggests that consideration be given to allowing physiotherapists to communicate a diagnosis within appropriate profession-specific parameters.

Physiotherapists should maintain their primary focus on physical relief of pain and the return of musculoskeletal function, acknowledging that physiotherapy is an appropriate modality in the treatment of some diseases involving other systems.

The OMA suggests that there may be indications to **probe a wound** outside of the emergency department/operating room but the safest approach is to have those with special training in wound management perform debridements. Probing a wound should be a delegated act.

The OMA also has concerns with physiotherapists **administering medications by inhalation**, as well as **managing medications after initial orders**. Both of these procedures pose significant potential risk to the patient and should remain delegated acts.

The OMA agrees that specially trained physiotherapists may be utilized for the **reduction of dislocated joints** in circumstances where there is a threat to nerves, soft tissues, or cartilage and where the reduction can be completed safely without sedation. The OMA believes, however, that the regulations should require that the patient be referred to an appropriately trained physician for review following the reduction. The reduction of fractures and maintenance of the reduction is clinically challenging, even for physicians with training and expertise in the area. Determining severity and whether or not a surgical intervention is required are difficult undertakings. In addition, the ability to **interpret x-rays** is critical to the successful setting and casting of fractures. The OMA does not believe that physiotherapists are trained to set fractures.

The OMA expresses serious concern with the broad range of **tests and x-rays** that physiotherapists propose to add to their scope of practice. The OMA cannot support these changes. Allowing physiotherapists to order the various diagnostic tests they seek will undoubtedly place additional stress on resources in high demand. The OMA believes physiotherapists lack the training to interpret these test results. The OMA also emphasizes the additional strain that would be placed on access to MRIs and CT scans, two of the Ministry's priorities in the wait time strategy, should physiotherapists gain ability to order these tests in the future.

Dietetics

The OMA submits that while dietitians do partake in several of the activities they have requested as controlled acts, we do not support all of the requests put forward by the College of Dietitians of Ontario and Dietitians of Canada, namely **psychotherapy** being added to the dietetic repertoire. Psychotherapy is a complex therapeutic process which the OMA does not believe lies within the scope of dietitians.

The regulation of psychotherapy is complex and has been an ongoing matter for review and discussion. Psychotherapy is a complex process involving a relationship between the patient and the psychotherapist. The practitioner requires comprehensive training to carry out psychotherapy. There is little evidence to demonstrate that a dietitian is qualified to carry out this act, much less assess the outcome of such treatment. The ongoing evaluation of the therapy by the practitioner is critical to ensure that the treatment is achieving its intended goals.

As part of **dispensing drugs**, the College and Association request that dietitians be able to adjust dosage of medication in response to monitoring health (e.g. insulin adjustments). The OMA believes that dietitians should be able to adjust insulin levels so long as this remains a delegated act that is done in consultation with physicians.

In addition, dietitians must demonstrate that they possess detailed knowledge of normal human physiology and of pathological changes that occur during the disease process so that an accurate differential diagnosis of any ensuing problems is made. Without this training, the OMA cannot support dietitians **treating minor ailments**. We would ask for some clarification on the details surrounding this request.

Finally, the College and Association would like dietitians to initiate orders for lab testing within the ambit of medication therapy management. The OMA believes this should only be done through consultation with the prescriber.

Medical Laboratory Technology (MLT)

The OMA has a number of concerns with the submission of the CMLTO, OSMT and CSMLS. MLTs propose rewording the statutory scope of practice along the lines of the statement for the profession devised by the American Society for Clinical Laboratory Science: "...the design, performance, evaluation, reporting, interpreting and clinical correlation of clinical laboratory testing in the management of all aspects of these activities". This scope of practice statement is far too broad.

As part of this expanded scope, MLTs would like to perform the controlled acts of **administering a substance by injection** and **putting an instrument, hand or finger, beyond the opening of the urethra and beyond the labia majora**. The OMA is troubled by these which the CMLTO specifies are related to allergy testing and PAP testing.

It is difficult to imagine a scenario where an MLT would be the only individual available to perform these procedures (e.g. no nurse or physician available). Performance of allergy testing and procurement of a PAP specimen should be part of a clinical examination that includes obtaining an appropriate clinical history and full examination. In rare and unusual circumstances where an MLT must provide these services, it would be better addressed through a specific medical directive or a delegated act from a physician who has properly trained and assessed the competency of the individual MLT to perform the task.

The OMA cautions against allowing MLTs to interpret and define clinical correlations of **laboratory testing** for a number of reasons. First, there is nothing in MLTs' training that would allow them to undertake a proper assessment. There is also a risk of unnecessary duplication of tests since the MLT may not be aware of tests that have already been performed in other laboratories. Some abnormal test results will be expected based on the clinical history of the patient (e.g. an increased glucose on a patient receiving glucocorticoids). In these situations, the MLT may add on tests that are of no value. Moreover, selecting which tests to perform should be driven by the clinical history and differential diagnosis not solely by other laboratory tests. Finally, the patient may have indicated to their physician that they do not want to have specific tests performed.

Making changes to the *Act* to allow MLTs to **inject substances into veins or arteries** for testing or therapeutic purposes requires comprehensive knowledge and training to understand and monitor the effectiveness and safety of these procedures. This appears to be well outside the current scope of training of MLTs.

The OMA believes MLTs are not trained to undertake **testing for prenatal and antenatal care, maternal serum, cervical, colorectal screening, PSA and diabetes management.**

The OMA requests that the CMLTO and authors clarify what is meant by MLTs having the capability to **suggest "appropriate antibiotic use".**

Medical Radiation Technology (MRT)

The OMA is generally supportive of the joint submission of the CMRTO and OAMRT. The OMA's main concern is that any proposed changes to the *Medical Radiation Technology Act* should be for the purpose of clarification or to better reflect current common delegated practices.

The OMA is concerned about one aspect of the MRT submission. There is potential for MRTs (non-therapy MRTs) to move away from evaluation of the technical sufficiency of diagnostic images and tests towards implementing changes to the procedures and performing additional procedures based on the MRT's assessment of the patients and images (stress testing, for example). The OMA would emphasize that in this instance, there needs to be a clear indication that controlled acts in this context must be delegated.

The OMA believes the CMRTO and authors should clarify the reasons why and circumstances under which MRTs should perform procedures beyond the larynx.

Pharmacy

The OCP claims its submission and scope of practice statement accurately reflects what pharmacists do today. In a hospital setting, it is true that pharmacists often perform these activities. Such occurrences are a desirable form of inter-professional care. However, this arises within the context of a specifically defined relationship with the physician. Strict limitations are put in place such that pharmacists are delegated certain responsibilities. The OMA is concerned that some of the changes proposed by the OCP may compromise patient safety outside of the hospital setting. In certain instances, the OCP is seeking to step outside of its intended role and into the field that should be managed by physicians and medical teams in response to the acuity of care required.

The OCP identifies family physicians as being “increasingly unavailable for consultation in a timely manner” and uses this reasoning to support its recommendations for an expanded scope. The OMA respectfully disagrees with this rationale as it implies that pharmacists are substitutes for the physician. Alternatively, emphasis should be placed on increasing the supply of family physicians and having both professions maximize their distinct capacities in a collaborative practice model.

Pharmacists provide a unique and essential service to patients due to their extensive knowledge of medication therapy. In addition to compounding and dispensing drugs, pharmacists inform patients about the effects and interactions of medication use. However, there are a number of activities that are not within the purview of pharmacists –typically because they require the ability to provide a differential diagnosis. While the OCP recognizes that diagnosing does not fall within the realm of pharmacist scope of practice, some of the changes it recommends arguably require this skill. Moreover, if the proposed changes were implemented, pharmacists would be in a conflict of interest situation. They would be diagnosing and treating while, at the same time, selling drugs for treatment.

The OCP provides suggestions to HPRAC on possible amendments to the *Pharmacy Act*, the *Drug and Pharmacies Regulation Act*, the *Laboratory Specimen and Collection Centre Licensing Act*, the *Public Hospitals Act*, the *Health Insurance Act*, and associated regulations. Some of the specific proposed amendments are discussed below.

The OCP suggests that the scope of practice statement for pharmacy be amended to include the **“promotion of health, prevention and treatment of diseases, dysfunction and disorders through medication and non-medication therapy.”** According to the OCP, this change would incorporate the cognitive components of selling, compounding and dispensing a drug. The OMA is concerned about the focus on “promotion of health and prevention and treatment of diseases” advanced in the OCP’s submission. This is the role of physicians. Such responsibilities cannot be dissociated from the process of conducting a diagnosis. Screening and counseling initiatives are an integral part of the treatment that physicians

provide. This may involve hosting educational clinics, giving advice on smoking cessation, dealing with women's health issues or administering other types of therapeutic interventions. It would be a disservice to the patient to disconnect these elements of care from the patient's overall medical condition.

The notion of administering "non-medication therapy" is somewhat troubling. Pharmacists are trained to manage pharmaceutical use. Their expertise relates to understanding drugs, their actions, indications, and effects. Thus, the meaning of "non-medication therapy" is unclear. The expression is broad and could encompass numerous types of treatment. At the consultation meeting held by HPRAC on Friday, August 15th, 2008, the Ontario Pharmacist's Association and the OCP indicated this category would include items that are used for symptom control or that contain no pharmacological ingredient. The examples cited were saline nasal sprays, cold compresses, vitamin therapy, and slings. To avoid misinterpretation, the OCP should be as specific as possible and provide an actual list of products that would fall under "non-medication therapy." Given the open ended nature of the terminology used, it is important to define what is meant explicitly.

The OCP has also added "**monitoring and management of medication therapy**" to the scope of practice statement for pharmacy. To accomplish this, pharmacists in both community and hospital practice settings would require **the ability to initiate orders for laboratory testing**. The OCP's request to modify the *Laboratory and Specimen Collection Centre Licensing Act* to include pharmacists as professionals who can order laboratory tests is problematic unless the proposed amendment is worded with extreme clarity. The physician must be consulted before any lab test is initiated as a call for certain medications and lab tests may indicate a more serious underlying condition that requires medical attention. Furthermore, allowing pharmacists to order lab tests unilaterally has the potential to result in duplication of service and increased costs to the health care system if the physician has ordered the same or similar tests. The potential for duplication will also arise if the patient visits multiple pharmacies or consults with different pharmacists, as happens frequently.

Addition of Controlled Acts

The OCP has requested that the pharmacist's scope of practice include the controlled acts of **“administering a substance by injection or inhalation”** and **“performing a procedure on a tissue below the dermis”** subject to terms and conditions related to the pharmacist's role in providing information and education to the public. Pharmacists occasionally need to demonstrate how to use a device or medication (ex. inhaler, insulin injections) but are concerned they will be sanctioned for performing a restricted controlled act.

During the consultation session held on May 9, 2008 by the OCP, the OMA expressed its concern with this proposal. The OMA does not see the need for the addition of these controlled acts given the exception that exists under the Regulated Health Professions Act (RHPA). Under section 29(1) (e) of the RHPA, a professional is permitted to perform a controlled act if it is done in the course of assisting a person with his or her routine activities of living. This is precisely what the pharmacist is attempting to do when showing the patient how to use an inhaler or inject themselves with insulin. The pharmacist is educating the patient about a treatment that the patient may use on a regular basis, not administering the medication or device for the purpose of treating the patient. The OCP claims that the inclusion of these controlled acts allows pharmacists to practice within “clear legislative authority” rather than having to rely on a statutory exception. Furthermore, the OCP asserts that this change establishes the pharmacist's direct accountability to members of the public. However, the statutory exception is no less authoritative than the addition of the controlled acts. Given that the intent behind performing these acts is to inform and educate the public, there is no reason that the RHPA cannot be referred to as the authority for this proposition. The OMA does not encourage amending legislation to achieve a purpose that can already be addressed under existing rules. In fact, the exception under the RHPA more clearly identifies the true need for these acts; that is, providing information related to drug use. However, if the OCP insists on requesting these acts, we would agree that strict limitations should be put in place that specify that the acts are to be performed only as part of informing and educating the patient about medication therapy.

The OCP contends that pharmacists should be permitted to **“dispense a prescription without further authorization from a prescriber under certain circumstances.”** One such circumstance includes **adapting the patient’s dosage regimen.** The OMA has some reservations about this. The physician may have had important clinical reasons for choosing a particular dosage schedule and form. For example, patients with angina or coronary artery disease often require a second dose of amlodipine or atenolol in the evening for the control of their disease process. In this situation, the physician will have made an informed clinical decision as to why the medication should be administered twice daily. If the pharmacist is able to change the dosage regimen, the patient’s condition may be destabilized and he or she may suffer as a result.

The OCP requests that pharmacists be given the ability to **authorize further extensions of prescriptions where there are no existing refills.** This has already been addressed through the joint development and approval of the Pharmacist Authorization of Prescription Extensions (PAPE) Agreement. The College of Physicians and Surgeons of Ontario, the OCP and the OMA have all endorsed this document which permits pharmacists to extend prescriptions under defined circumstances. The limitations in the PAPE agreement are important patient safety mechanisms; for example, pharmacists are only able to extend prescriptions for patients who have stable histories and the physician must be notified within one week if the extension has been given. The PAPE Agreement reflects the present scope of practice of pharmacists and is a positive development in regards to inter-professional care. In particular, it respects the different capabilities of the physician and the pharmacist.

In addition, the OCP asks that pharmacists be given the ability to **adjust the dosage of medication in response to monitoring (e.g. lab tests).** The OCP expects this would occur in a collaborative practice and the OMA supports this direction. However, the OMA recommends that any proposed regulation explicitly mandate that pharmacists only engage in these activities through consultation with the prescriber. In its submission, the OCP indicates that the pharmacist will communicate prescription changes to the physician in a “timely manner.” The OMA believes this is not sufficient. It is not enough to simply inform the physician of the change; rather, the physician must be involved in the process. The physician

has an ongoing responsibility to the patient to prescribe appropriate dosages, follow up on treatment, and if needed, alter medication. To fulfill these professional obligations, the prescriber must be able to assess whether the decision made by the pharmacist is appropriate given the patient's condition. Although the OCP considers pharmacists to possess the knowledge, skills and abilities to adjust medication, the OMA respectfully disagrees. It is debatable as to whether pharmacists have received the requisite training to interpret lab tests and apply the results in a clinical setting. The OMA argues that such an analysis involves elements of diagnosis which are not within the pharmacists' scope of practice or training.

Under the OCP's amended scope of practice, pharmacists would be able to **assess patients seeking advice for minor ailments and recommend appropriate treatment and follow up**. In fact, the OCP identifies this as something that pharmacists already do. The submission details the model used in the United Kingdom in which the pharmacist is the first line practitioner for minor ailments, health promotion and screening. Again, the OMA finds this proposition to be disconcerting as pharmacists are not trained to conduct differential diagnoses or take a patient's history during an examination. The OCP does not consider pharmacists who assess a patient for a minor ailment and then recommend a drug as "communicating a diagnosis." The OMA strongly disagrees. What type of "assessment" is the OCP referring to and how would this not require the skill of diagnosis? It is unclear how the OCP's proposal truly differs from what physicians are currently trained to do. In addition, pharmacists often work in an environment that is inappropriate for a thorough and confidential examination. Ontario, unlike many jurisdictions, makes available a wide variety of medications for "minor ailments" available over-the-counter and the OMA believes this strikes a good balance between access and safety.

Contrary to the assertions made by the OCP, the **impact of the proposed scope of practice on physician workload** is unknown. Permitting pharmacists to adapt dosages, treat minor injuries, and extend prescriptions may allow physicians to reallocate their time and see new patients. However, the result may also be the exact opposite. If the pharmacist authorizes an incorrect dosage or provides the patient with misinformation about their medication treatment, the physician's workload significantly increases. Circumstances such as this do

arise in everyday practice. Physicians have reported instances of pharmacists advising patients to discontinue a course of medication prior to checking with the physician as to the reasons the medication was prescribed, which may be is different from traditional use. There is no way of knowing whether these changes will improve physician workload or add to it. Thus, the definitive statements made by the OCP are misleading.

The OMA looks forward to ongoing discussion with HPRAC to implement effective collaborative care models that utilize the valuable services of all health professionals while maintaining the highest standard of patient safety.

