



**Submission from the Ontario College of Family Physicians (OCFP)**

**to**

**The Health Professions Regulatory Advisory Council (HPRAC)**

**In Respect to**

**The College of Physiotherapists of Ontario &**

**The Ontario Physiotherapy Association's Submission**

**For a Review of the Scope of Practice of Physiotherapy**

**The Health Professionals Regulatory Advisory Council**

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The Ontario College of Family Physicians (OCFP) wishes to thank the Health Professions Regulatory Advisory Council (HPRAC) for this opportunity to respond to the College of Physiotherapists of Ontario and the Ontario Physiotherapy Association's scope of practice submission, in response to HPRAC's request for review. The OCFP appreciates the government's interest in enhancing interprofessional collaborative care (IPC). At the outset, we would like to express our interest in, and support for, interprofessional collaborative care and for physiotherapists as key members of interprofessional teams.

## **About OCFP**

The Ontario College of Family Physicians (OCFP) is the Ontario Chapter of the College of Family Physicians of Canada (CFPC). The OCFP is a provincial, voluntary, not-for-profit organization whose mandate includes undergraduate, post-graduate education, the continuing professional development of family physicians and the maintenance of high standards of medical care and education in family practice.

The OCFP is the voice of family medicine in Ontario and represents more than 8,236 family physicians who provide patient care for remote, rural, suburban, urban and inner city communities throughout Ontario. The building and maintenance of high standards of practice, the continuing professional development of our members and improved access to high quality family medicine services for all residents of Ontario are at the heart of our organization.

The College strives to improve the health of Ontarians by promoting high standards of medical education and care in family practice, by contributing to public understanding of healthy living, by supporting ready access to family physician services, and by encouraging research and disseminating knowledge about family medicine.

### **Objectives of the Ontario College of Family Physicians**

- To support and advance the professional competence of members of the Ontario College of Family Physicians, a chapter of the College of Family Physicians of Canada, through the provision of programs of continuing medical education;
- To ensure the highest quality of health care for the people of Ontario by promoting and encouraging the highest standards in the practice of family medicine in Ontario;
- To make representations to governments, agencies, commissions, inquiries, and such other bodies as may be appropriate, and to enlighten the general public opinion and direct the formulation of public healthcare policy in the Province of Ontario;
- To serve and further the interests of The College of Family Physicians of Canada, in Ontario, and carry out such duties as are required by the By-Laws of the National College, provided such interests are not inconsistent with the laws of the Province of Ontario;
- To maintain liaison with the undergraduate and graduate programs in medicine of the Ontario universities in order to promote high standards of training for family practice in Ontario;
- To establish awards and other recognitions of outstanding contributions and services to family practice in Ontario; and
- To perform such other lawful things as are incidental or conducive to the purposes and objects of the Ontario College of Family Physicians, a chapter of The College of Family Physicians of Canada, which include generally the maintenance and improvement of the health of the citizens of Ontario, and the enhancement of the interests of the members of medical and other health professions in Ontario.

### **Overall Perspective on Interprofessional Collaboration (IPC)**

Interprofessional Collaboration (IPC) is built upon the bedrock of mutual trust and respect. It can be enabled; it cannot be legislated. As in other submissions to HPRAC, the OCFP is emphasizing that the most significant enablers to IPC include system and practice supports that exist outside of measures to change legislation or to expand scopes of practice. Key enablers including compensation and funding; interprofessional education and training that supports collaborative practice; quality improvement programs; interprofessional communication policies, protocols, guidelines; team building and skill development; flexible organizational structures; patient/caregiver involvement; health human resource planning; and, integrated health records, are key to moving IPC forward and overcoming a long history of silos of professional education and practice. The OCFP believes that it would be more effective if these key enablers were developed

to support physiotherapists working together in teams with family physicians, specialists and interdisciplinary health professionals. Moreover, it's our experience that focusing on enhancing scope of practice, particularly without attention to these enablers, can actually foster independence, rather than interdependence and collaboration and therefore contribute to silos. Changes in systems of care and organizational practices would enhance collaboration much more productively than legislative changes or scope of practice expansion.

## **OCFP's Response to the College of Physiotherapists of Ontario & the Ontario Association of Physiotherapist's Scope of Practice Submission**

While there was a very short timeframe allocated for this response, which precluded the opportunity for extensive consultation, OCFP's submission reflects our membership's position on IPC, which includes extensive consultation from previous submissions to HPRAC's process and it specifically includes the views of several family physicians with extensive experience working in Sports Medicine, in partnership with physiotherapists, who hold academic teaching positions with different departments of family medicine, and are directors for Family Medicine Residency Programs.

The following points summarize OCFP's response to the three major scope of practice changes and the future considerations, proposed by College of Physiotherapists of Ontario and the Ontario Physiotherapists Association.

### **1. Revisions to Scope of Practice Statement to Reflect Activities, Roles and Responsibilities & Formulating a Diagnosis:**

The OCFP supports the position that the Physiotherapy Act (PA) should accurately reflect the current activities, roles and responsibilities of physiotherapists (PT) and moreover, that PT activities follow the Act. It is disconcerting to learn, as the College suggests is the case, "that the evolution of the practice and education of physiotherapists has resulted in an array of competencies that are regularly performed yet many are not authorized under the PA (p. 8)." With respect to the scope of practice statement, the

College points to “diagnosing” as an activity illustrating this disconnect, suggesting that physiotherapists are trained to formulate and communicate diagnosis within their scope and the notable absence of this ability in the PA has many impacts at the point of care in regards to delaying treatment, complicating interprofessional interactions, confusing third party payers’ etc.

It is the OCFP’s position that:

The request to include “diagnosis” in a scope of practice statement that applies to all physiotherapists (irrespective of varying levels of education and experience), is too broad a request and raises many concerns related to education and training that require further interprofessional discussions.

Formulating a diagnosis, for example within the cardio respiratory system, as is proposed, requires broad-based medical training and continuing professional education (CME). Family physicians have extensive medical training, provide extensive CME proof and are well-trained to take a generalist approach to care by looking after the whole person, in the context of the family and community. Attention is focused not just on the disease process, but also on the individual patient’s response to the illness or injury. A clearer understanding of the physiotherapist’s education and training is required before this request can be considered. While physiotherapists are well trained in their MSK realm, there are many conditions in the medical sphere that they are not trained to diagnose. For example, calf pain may not be a gastrocnemius strain, it could be a DVT. Shoulder pain may not be a rotator cuff injury, it could be referred pain from the diaphragm. Not having the training to diagnose these rare but important conditions is a gap that this proposal fails to recognize and address.

This scope of practice expansion request should be further explored through discussions about standardized education and training, interprofessional guidelines and collaborative practice. Making amendments to the authorized activities and adding new terminology to the PA in and of itself will not facilitate IPC. As stated above, systems of care and organizational practices enhance collaboration more effectively.

One of the notable barriers to IPC is a lack of understanding among the different professionals about each other's scopes of practice. The "complicating interprofessional interactions and confusion among the third party payers and the public" that the College describes is illustrative of this barrier. It is OCFP's position that clarification of scope of practice, particularly among health professionals, in close, trusting, working relationships is the solution rather than expansion of scope. It's arguable that scope expansion will assist with the goal of clarity for other health providers, the public and health care funders, but rather, system and/or organizational changes would be more effective in achieving this goal.

Some physiotherapists may have extensive training (e.g. advanced practice) and often pick up on underlying causes that have not been diagnosed. Family physicians (FP) value this experience, skill, knowledge and insight. However, more often than not, FPs do not receive notes back from the physiotherapists, communicating the "diagnosis". This is not helpful to the patient's well-being or to improving continuity of care. Hence, the focus here is not one of expanding scope but of improving collaborative practice and communication, in the best interest of patient-centered care. Again, this is a system of care and organizational issue, with regards to enhancing IPC.

While the College emphasizes accountability measures via the regulatory rigour of the College standards and regulatory mechanisms to support the proposed scope of practice changes, there is still an issue of medical legal responsibility that needs to be addressed before physicians could be accepting of the changes.

## **2. Authority for Five Additional Controlled Acts for Physiotherapists with Demonstrated Competence**

While the College indicates that the proposed five additional controlled acts are within the scope of practice of physiotherapy, the OCFP would like to raise the following issues:

The request for communicating a diagnosis raises the same concerns for OCFP as outlined above for inclusion of diagnosis in the scope of practice statement and formulating a diagnosis. This is too broad of a request and raises many concerns related

to education and training that requires further interprofessional discussions.

Moreover, “communicating” is the underlying concept for successful IPC. This raises additional concerns, for example when the PT is working with a patient who does not have a family physician.

Administration of medications by inhalation raises a concern for OCFP members. For example, one should worry if an asthmatic required inhalation medications and whether or not the PT is adequately trained to manage complications (e.g. if the inhalation medication is not helpful). This situation raises not only safety in quality care issues but also potential liability issues.

Medication management after the initial order is not something our Members agree with; this should be a delegated act.

Putting an instrument or finger beyond verges for assessment or treatment may be considered “invasive” not to mention sexual harassment in certain settings by certain patients. In other words, health care professionals may be comfortable with this eventually, but patients may not necessarily be comfortable.

The College indicates that currently PTs with demonstrated competence are ordering MRI and diagnostic ultrasound under medical directive/delegation and they are looking for independent authority, as in some other provinces. It is the OCFP’s position that allowing physiotherapists this independent authority may not only result in duplication of ordering, leading to excessive impacts on an already stressed system with wait time issues but it may not necessarily be in the best interest of the patient. Physicians mention anecdotally that they have experienced situations where physiotherapists have requested that they order imaging tests but the physician did not feel it was indicated. There is some evidence that less comprehensively trained individuals tend to order more tests. A better approach is to ensure collaborative team based discussions between the PT and other health providers to ensure the appropriateness of ordering. While this request may be further discussed to support access issues in underserved areas, as in the case of Manitoba, this is a different issue and in general the OCFP does not see this action as

necessary to support IPC; in fact it precludes IPC.

**3. Removal of Limitations in other Statutory Provisions to Enable:  
Ordering of Xrays; Ordering of Laboratory Tests; Permitting treatment in hospital  
permitting referrals to specialists; Permitting access to physiotherapists without  
physician referral**

It's interesting that the very issues that are perceived by the College to be limiting IPC can also be perceived as enhancing IPC, if the right system incentives and organizational structures were in place. For example, the College notes that under the current legislative environment, physiotherapists are limited in their role by needing alternate authorization such as medical directives/delegations/orders. Also, they are required to refer to other health professionals (e.g. physician or specialist) to assist in the diagnosis or for an order of referral. It's the OCFP's position that if enablers as outlined in the first statement of this proposal were in place, then these requirements would actually lead to IPC and there would be a synergistic relationship.

Ordering lab tests does not make sense because the PTs could not interpret them without knowledge of all of the medical problems of the patient.

It's the OCFP's position that allowing physiotherapists the independent authority to refer to specialists without collaborating with the client's family physician, does not support collaborative practice and will lead to additional pressures on an already short supply of specialists. Indeed, collaboration with a family physician may result in a care plan that doesn't require specialist's care.

In a health care system that is already stressed economically, independent ordering by physiotherapists, in addition to other health professionals that may pursue this same request, raises economic concerns.

In terms of permitting public access to physiotherapists without physician referral, the OCFP sees this as problematic given the variance in PT's education and the important

role of family physicians with respect to communicating a diagnosis.

Currently access to PT's in this province is not a problem. The other issue, based on our Members correspondence with some physiotherapists is that Ontario does have “open access” for the public in that a referral to access a PT is not necessary but insurance companies may require a referral. So, further discussion and clarification is required with affected parties.

Finally, there are billing issues to be sorted out as part of these discussions. Specialists and family physicians cannot bill for a referral when one is made by allied health care professionals. Presently, there are concerns on many fronts with this request and this request has not been successful in other arenas (e.g. optometrists referring to ophthalmology). Therefore, much more dialogue on the issue with the concerned/affected parties must take place.

#### **4. Future Considerations**

Regarding the College's future practice suggestions around 1) setting or casting a fracture of a bone or dislocation of a joint 2) applying or ordering the application of electricity for electromyography and nerve conductive studies and 3) medication management after initial order, especially in a cardio respiratory setting, it is anticipated that these requests will require extensive education and training and further discussion to achieve physician acceptance.

The College's submission mentions physiotherapy helping with the chronic disease population and geriatrics. This is a growing population with many complex needs that will place high demands on the health system and providers. The physiotherapist's expertise is of great value in managing these client's multidimensional needs but this is a complicated population that is best managed within a team-based environment, with a family physician and/or specialist. Although the College recognizes that physiotherapists may not perform a controlled act or treat someone where it is reasonably foreseeable that there may be harm to the patient (per Section 30 of the RHPA – treatment where risk of harm), and the College has identified ways to mitigate risk of harm, this population is

sufficiently complex that the proposed scope changes require further discussion in terms of potential impacts.

## Conclusion

In summary, the OCFP recognizes and supports the concepts that all regulated health professionals work to their maximum competence and capability, that they optimize their skills to ensure access to high quality care, and health professionals be regulated in a manner that maximizes collective resources. The OCFP also recognizes that there are many physiotherapists in advanced practice roles with demonstrated ability to support the requests in the College's proposal. However, expanding scopes of practice without *first* ensuring the key IPC enablers are well established, as outlined in the first statement of this submission, may have the counterproductive effect of fostering independence and undermining IPC. Moreover, the changes to the scope of practice statement are too broad of a request that raises many concerns related to education and training that require further interprofessional discussions. Much can and should be done to improve the system and organizational supports for IPC before scope of practice expansion becomes the focus. While many of the requests are well intentioned, much more dialogue with the concerned/affected parties is required before any of this can move forward in a general/global sense.